Improving Patient Access to Buprenorphine Treatment through Physician Offices in Maryland: Summary of Findings, Recommendations, and Action Steps

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Buprenorphine Advisory Committee

Arthur Burris, M.D.
Peter Cohen, M.D.
Victor Ferrans, M.D.
Michael Fingerhood, M.D.
Michael Franch, Ph.D.
Michael Hayes, M.D.
Yngvild Olsen, M.D., M.P.H.
Rebecca Ruggles
Ken Stoller, M.D.
Eric Strain, M.D.
Patricia Strong
Anthony Tommasello, Ph.D.
Christopher Welsh, M.D.

Staff
Meena Abraham, Dr.P.H., M.P.H., Project Director
Elaine Gisriel, M.S., Project Coordinator

Consultants
Ann Rasenberger, J.D.
Pamela Young, Ph.D.

Introduction

In 2002, the Food and Drug Administration (FDA) approved buprenorphine for use in the treatment of opioid addiction, thereby adding a new tool for the treatment of opioid addiction that could be administered in physician offices. The Center for a Healthy Maryland, an affiliate of MedChi, The Maryland State Medical Society ("Center"), has been at the forefront of attempts to educate and engage Maryland physicians in utilizing this new medication for office-based treatment of opioid addiction. A survey commissioned in 2004 found that only 25 percent of physician respondents were willing to prescribe buprenorphine due to a variety of reasons, including a lack of adequate financial and organizational resources, attitudes about addiction, and lack of positive experiences in caring for addicted patients.

In the spring of 2006, the Center held several meetings with physician experts and learned that major problems exist with third party payers, including inadequate reimbursement for office visits and confusion over prior authorization requirements and procedures. The Center subsequently obtained funding from Open Society Institute-Baltimore to research applicable legal authorities and regulatory practices relating to health plan (both publicly funded and commercial) coverage of substance abuse treatment, and physicians' experiences in prescribing buprenorphine in their practice setting.

This paper summarizes the research conducted by the Center through January 2007, and the findings, recommendations, and action steps that were developed as a result of that research. The complete report is available **at www.healthymaryland.org**

Summary of Laws, Regulations and Government Policies/Practices Applicable to Substance Abuse Treatment in Maryland

The State of Maryland provides treatment for substance abuse, including opioid addiction, for very low-income individuals who qualify for the Medicaid program. Most Medicaid recipients in Maryland are enrolled in a mandatory managed care program called HealthChoice and receive care through a managed care organization (MCO). Under HealthChoice regulations promulgated by the Department of Health and Mental Hygiene (DHMH), MCOs are required to provide certain assessment, coordination and treatment services to enrollees who have a diagnosis of substance abuse.

When a DHMH study in 2000 found that MCOs were not fully complying with these regulations, DHMH convened a workgroup composed of MCOs, providers, advocates and local and state government. The workgroup was successful in developing protocols and procedural mechanisms that MCOs adopted voluntarily, and that significantly improved access to substance abuse treatment for Medicaid recipients enrolled in HealthChoice. That workgroup was recently disbanded.

In 2003, the Maryland Department of Health and Mental Hygiene (DHMH) determined that buprenorphine represented "a significant therapeutic advantage for the treatment of opioid type

dependence over other pure agonist agents such as methadone" and "has a unique mechanism of action." DHMH directed all MCOs to include buprenorphine on their formularies. DHMH also made buprenorphine a mandatory benefit under the Primary Adult Care (PAC), a limited benefit program administered by DHMH that provides primary care, medications and some mental health treatment to low-income individuals who do not qualify for Medicaid.

DHMH established standards for MCO drug use management programs. One of those standards provides that MCOs must have a procedure for supplying an enrollee with an emergency supply of a medication pending approval of the medication if withholding the drug could have an adverse medical outcome.

MCO providers may bring issues with MCO practices to the attention of DHMH through a provider complaint hotline, and if dissatisfied with DHMH's response (which could include an order to the MCO to provide the benefit), may pursue administrative and judicial appeals. DHMH conducts formal evaluations of HealthChoice and the MCO drug use management programs annually.

The six commercial insurance plans that operate in Maryland are subject to regulation pursuant to the Maryland insurance code. Among other things, the insurance code requires mental health and substance abuse parity with physical health benefits, and mandates that commercial health plans and the Maryland Insurance Administration maintain grievance and appeal processes. The insurance code does not apply when a health plan contracts with a company that is self-insured. Self-insured companies provide health care benefits to over half of Maryland residents with health insurance.

Summary of Physicians' Experiences

Telephone interviews were conducted in the fall of 2006 with seventeen Maryland physicians who are certified to prescribe buprenorphine, in order to better understand their experience in using this medication. These interviews revealed that the use of this medication for maintenance in an outpatient setting presents a complex situation involving several considerations for physicians. These considerations are related to the disease of addiction, professional training and experience, business decisions, practice procedures and treatment approach, as well as issues that intersect with and influence a physician's practice such as the requirements of third party payers, medication cost, and governmental regulations.

Physicians described how the disease of addiction affects patient behavior and how that impacts on how they manage their practices. In the opinion of these physicians, the behavioral and psychosocial factors associated with addiction make its treatment different from that of other diseases. Significant differences include the increased time and physician attention required by addicted patients, the need for immediate treatment when initiating buprenorphine treatment for an addict already in withdrawal, and the effects of addict behavior and the detoxification process on both office staff and other patients.

The physicians who participated in the interviews have a diversity of professional specialties that influences their experience and opinions in relation to the interview focus. For example, psychiatrists, specialists in behavioral disorders, voiced some concerns about primary care physicians' understanding of the subtleties of addiction, its co-morbidities, the recovery process, and approaches such as harm reduction rather than cure. This concern about misunderstanding the nuances of addiction also extends to the third party payers who, some physicians believe, do not appreciate that addiction is a chronic disease requiring long-term treatment.

The intersection of these complexities inherent to addiction with the business of medicine causes physicians to make practice management decisions regarding the use of Buprenorphine maintenance. This is the area where the impact of third party payer policies and requirements is prominent. The most salient finding among the private practitioner group (9 of 17 physicians interviewed) regarding business considerations was that most chose to require direct payment by patients (self-pay) for physician services, rather than billing patients' insurance. The reasons for choosing not to seek third party reimbursement include insufficient reimbursement levels for time and services provided, lengthy delays in payments, inconsistencies and variations among payers, perceived "hassles" or obstacles from payers requiring things such as urine testing, counseling, medication authorization on a schedule that may not fit physician's treatment protocols, and prior authorization.

Payer requirements that physicians perceive as obstacles to treatment, for example, prior authorization, are not all unique to buprenorphine. However because of the nature of the disease, physicians see the need for a different approach with this treatment. Although some physicians voiced that there should be no need for preauthorization with any drug, there was general agreement that the conditions under which buprenorphine treatment is initiated precludes any delay caused by a requirement for preauthorization. They referred to this as the "window of opportunity" that occurs when an addict presents to a physician requesting buprenorphine treatment, with the expectation that withdrawal symptoms will be controlled by the immediate introduction of buprenorphine. Physicians noted that if requirements for prior authorization delay the initiation of treatment, which can be for as long as 48 hours, then the addict will return to illegal drug use and may be lost to treatment. Physicians also noted that the authorization delay obstacle affects not only new patients, but also ongoing patients who may run out of medication and need to be reauthorized. None of the physicians interviewed indicated knowledge of the availability of emergency supplies of buprenorphine in these cases. In fact some indicated paying for these supplies themselves.

The high cost of this drug is a significant factor noted by several physicians. They related this cost to both patient access and potential payer reluctance to utilize it for long term treatment. Some physicians were concerned about the ability of self-pay patients to mange the cost over the long term out of pocket, and that this may cause patients to want to decrease dosages before they are ready. Others noted that perhaps one of the reasons payers have restrictive policies regarding the use of buprenorphine for maintenance is that they don't want to pay for an expensive drug for a long time.

Physicians noted that not only does the addicted patient require more physician time and attention due to the psychosocial and behavioral manifestations of the disease, but the payer requirements related to this treatment can also add substantial burdens on the provider as well. They noted that additional time spent dealing with payers for this treatment is widely variable and often appears to be personnel dependent, not as a consistent application of payer policies/procedures. Although physicians reported either choosing not to engage with third party payers at all for this treatment, or frustrations in dealing with some payers, they were not aware of avenues of recourse for their complaints. None was aware that the State has a Provider Hotline for physicians to contact with concerns about Health Choice MCO practices.

The intensity of demand on physicians from both patients and payers with practice-based buprenorphine maintenance treatment was reflected by those physicians who were unsure if they would increase the number of patients they treat, if legally possible. Some voiced objections to apparently arbitrary limits placed by regulation on the number of buprenorphine maintenance patients allowed per provider, but there was not unanimity on wanting to increase that number within individual practices.

Even with the proviso that this treatment is demanding of their time and resources, physicians overall were very positive about the opportunity that buprenorphine maintenance treatment in office-based practice offers addicts for recovery. Some were surprised at how effective it has been for their patients, while others cautioned that it is not a magic bullet for everyone, but offers one more tool for physicians and addicts to use in the process of recovery.

Summary of Findings, Recommendations, and Action Steps

As a result of this research, and input from the members of the Buprenorphine Advisory Committee, a number of recommendations and action steps were developed in three areas: (1) understanding addiction as a chronic disease; (2) prior authorization of buprenorphine by MCOs; and (3) building physician capacity. These categories were defined primarily as a result of the physician interviews. The recommendations and action steps, as well as the findings supporting them, are summarized in the appendix.

I. Understanding Addiction As a Chronic Disease

This research showed that policymakers and health plan staff often do not understand that drug addiction is a chronic disease, and that like other chronic diseases such as high blood pressure or diabetes, it needs to be treated on a long-term basis. Some health plans appear to have reservations about office-based opioid treatment in general, and about physicians other than psychiatrists prescribing buprenorphine. Their actions can have the effect of discouraging primary care providers from prescribing buprenorphine. In addition, health plan policies and practices suggest a lack of awareness and/or concern on the part of health plan staff about the medical consequences of opioid withdrawal and overdose.

The lack of knowledge and awareness about addiction as a chronic disease has the effect of restricting access to buprenorphine for many individuals whose lives could be significantly

improved by this treatment. All health plans should be informed about the current body of research about opioid addiction and treatment. Without this knowledge, MCOs cannot fully meet their obligation under HealthChoice regulations to provide the "most appropriate level of individualized [substance abuse] care to each enrollee." In addition, if health plans and their staffs had a better understanding of the adverse medical consequences that can occur during opioid withdrawal, they might be more likely to assist in obtaining a temporary supply of buprenorphine for the patient pending prior authorization.

The following recommendations are proposed in response to these findings:
1. Physicians, health plans and policymakers should be educated regarding the need for long-term treatment of addiction.
2. MCOs and commercial health plans should incorporate specific capability to manage the patient needing long-term treatment with buprenorphine into their chronic disease management systems.
3. MCOs and commercial health plans should educate providers and staff (including pharmacy technicians) about the severity of potential medical consequences associated with opioid withdrawal and opioid overdose.

The Center plans to take the following action steps to help implement these recommendations:
1. Develop and provide educational programs to physicians, health plans and policymakers regarding the long-term treatment of addiction with buprenorphine.
2. Share the findings and recommendations from this research with policymakers and health plans.
3. Develop and provide educational programs for health plans on the severity of potential medical consequences associated with opioid withdrawal and opioid overdose.

II. Prior Authorization of Buprenorphine by MCOs

The physician interviews revealed that the primary issue for physicians administering buprenorphine treatment to MCO enrollees is the difficulty in obtaining prior authorization of the medication. Physicians reported waiting as long as 72 hours for approval, delays in obtaining responses from MCO personnel, receiving inconsistent responses from MCO staff, and having their medical judgment "second-guessed" by non-physicians. Under HealthChoice regulations, an MCO may not maintain a prior authorization procedure that is so burdensome it has the effect of discouraging treatment and thereby denying access to required benefits.

A major issue is not having an immediately available supply of buprenorphine for patients pending prior authorization. Patients are often in withdrawal from opioids when they present at the physician's office. Delays during the prior authorization process not only prolong the acute distress and risk of adverse medical outcomes during withdrawal (including risk of overdose and death), they can result in the patient returning to illicit substance use, causing the physician to lose the window of opportunity to help that patient end their opioid addiction.

As noted above, DHMH's policy, expressed in its drug use management program standards, is that MCOs should have procedures for supplying an enrollee with an emergency supply of a medication pending approval of the medication if withholding the drug could have an adverse

medical outcome. Some MCOs may already be offering temporary supplies during prior authorization, but if so, their physician providers or pharmacies may need to be informed of this option. None of the physicians interviewed indicated they were aware that they could request a temporary supply of buprenorphine pending prior authorization.

The formation of a new workgroup comprising MCOs, physicians and government officials to address issues with buprenorphine access would be helpful in educating MCOs and physicians about opioid addiction and treatment, would create a forum in which MCOs and physicians can discuss what they can do on their own and together to increase access to buprenorphine, and would involve DHMH in greater oversight of substance abuse treatment by MCOs.

The following recommendations are proposed in response to these findings:
1. MCOs and commercial health plans should make their prior authorization procedures for buprenorphine as efficient, streamlined and transparent to providers as possible.
2. MCOs and health plans should make a temporary supply of buprenorphine immediately available to patients pending prior authorization of buprenorphine.
3. MCOs should educate their providers (both physicians and pharmacies) regarding their procedures for authorizing a temporary supply of buprenorphine pending prior authorization.
4. MCOs should make the above-mentioned procedures available on their website so that physicians and patients have the ability to print off and provide to the pharmacy if needed.
5. DHMH should track access to buprenorphine treatment as a performance measure for MCOs.
6. DHMH should convene a Buprenorphine Workgroup composed of MCOs, physicians, and local and state government staff to identify policies and procedures that pose barriers to treatment, and to develop solutions.
7. DHMH should require MCOs to prescribe and dispense buprenorphine immediately when patients present for treatment.

The Center plans to take the following action steps to help implement these recommendations:
1. Meet with MCOs individually to: understand their procedures for making temporary supplies of buprenorphine available to enrollees; discuss opportunities to streamline prior authorization procedures; and share the Center's findings and recommendations with them.
2. Provide information to physicians regarding various MCO prior authorization requirements.
3. Share findings and recommendations with DHMH to: track access to buprenorphine treatment as a performance measure for MCOs; convene a Buprenorphine Workgroup and recommend/recruit physicians to participate; establish a policy for MCOs that buprenorphine be prescribed and dispensed immediately when patients present for treatment.
4. Monitor whether MCOs are changing their prior authorization practices (including making buprenorphine immediately available) through physician interviews.

III. Building Physician Capacity

Increasing the number of physicians willing to treat patients with opioid addiction in their offices has been the greatest challenge in expanding access to buprenorphine treatment. Building the roster of physicians certified to prescribe buprenorphine is only the first step. As recently as January 2007, only about 50 percent of the 330 certified physicians were actually utilizing their

waiver to prescribe buprenorphine for their patients. Consequentially, patients have found it difficult to locate a physician who provides buprenorphine treatment.

According to the physicians interviewed, a major reason for not prescribing buprenorphine is the insufficient physician reimbursement from MCOs and health plans given the physician time involved. Because of the psychosocial and behavioral manifestations of opioid addiction, treatment is labor-intensive and requires significant time for effective patient management. The response of the majority of physicians in private practice interviewed is to require or negotiate self-pay by patients, whenever possible. Physicians treating enrollees in MCOs with which they contract, however, do not have this option and must accept the MCO reimbursement rate.

MCOs and health plans permit a primary care physician to receive a higher reimbursement rate when they have spent considerable part of the visit counseling the patient. The physician can convert an intensity-based Evaluation and Management (E&M) code to a time-based E&M code by documenting that over half of the visit was spent in counseling the patient. Few physicians, however, seem to be aware of this option.

Another reason that some primary care physicians are reluctant to prescribe buprenorphine is that they feel uncomfortable with their knowledge level about opioid treatment, and would like more peer level support and practical training on the nuances of addiction. Physicians interviewed also expressed a desire for a system where they could report issues and practice management concerns. The need for more addiction treatment training of primary care physicians has also been voiced by some psychiatrists and other substance abuse professionals.

Additional attention needs to be focused on the significant impact of low reimbursement rates on access to buprenorphine treatment, and how to create reimbursement levels that fairly compensate the physician, and are acceptable to health plans. The Center believes that resources to educate and support physicians who are prescribing, or are considering prescribing buprenorphine must be increased if physicians are to feel comfortable with this new modality of treatment. Health plans, local governments and other entities should compile and update lists of physicians who are below their treatment limits and can accept new patients, and make sure patients know how to access the lists.

The following recommendations are proposed in response to the findings described above, and to advance the goal of increasing physician capacity:

1. Physicians should be provided mentoring, resources, relevant policies and procedures, and continuing medical education programs to help them better treat addiction.
2. DHMH should: charge the newly created Buprenorphine Workgroup with, among other things, developing a consensus on codes that accurately reflect level of physician effort; and share the outcome of Workgroup decisions on reimbursement codes with commercial insurance plans.
3. DHMH should conduct a study on the effect of current reimbursement rates on the utilization of buprenorphine and access to treatment for patients.
4. Each MCO should educate its providers on how to convert an intensity-based E&M code to a time-based E&M code if more than half the visit was spent on counseling.

5. MCOs should provide physicians with a menu of practice models that incorporate buprenorphine and all other needed services for the opioid addicted patient population.
6. MCOs and commercial health plans and local county health departments should maintain a list of prescribing physicians who have treatment slots available, and are willing to accept new patients.

The Center plans to take the following action steps to help implement these recommendations:
1. Share the recommendations for increasing physician capacity with DHMH.
2. Meet with MCOs individually to understand their procedures about codes for buprenorphine treatment reimbursement and to share the Center's recommendations.
3. Continue serving as a resource center, providing continuing medical education programs, and providing information regarding policies and procedures impacting treatment to physicians in Maryland.
4. Share recommendation with MCOs and commercial health plans that they should maintain a list of physicians who are not at their treatment limit and are willing to accept new patients.

Communications with DHMH Officials About Regulation and Oversight of MCO Practices

As part of its research, the Center made a number of contacts with senior officials at DHMH to gather information about DHMH's knowledge of problems with buprenorphine access and its oversight of MCO practices relating to substance abuse treatment. Although DHMH officials appeared to have little awareness about physician issues with MCO buprenorphine prior authorization practices, they were willing to listen to concerns and to take steps to begin monitoring buprenorphine utilization and access.

Nadine Smith, RN, oversees the DHMH provider complaint hotline. Ms. Smith reported that the provider complaint hotline had not received any complaints about MCOs restricting access to buprenorphine. (Physicians reported during interviews that they were not aware of the hotline.) Ms. Smith described DHMH's process for investigating and resolving complaints about MCOs and offered to work with the Center in addressing problems with buprenorphine access for MCO enrollees.

Jeff Gruel is the Director of the DHMH Pharmacy Program, which issues standards for MCO drug use management programs and monitors MCO compliance with those standards through an annual evaluation. Mr. Gruel was not aware that physicians were experiencing difficulties with MCO prior authorization of buprenorphine. At the request of the Center, Mr. Gruel agreed to begin tracking buprenorphine denials in the 2007 drug use management program evaluation and to ask his staff to be alert to issues with buprenorphine access.

Tricia Roddy, Director of Medicaid Planning, oversees the annual HealthChoice evaluation. Ms. Roddy said she was aware there were some issues with buprenorphine prescribing and knew that buprenorphine utilization had been low. At the request of the Center, Ms. Roddy agreed to collect data to begin tracking utilization trends of buprenorphine.

Next Steps

As the recommendations and action steps illustrate, much work remains to be done to address existing barriers to patients accessing office-based buprenorphine therapy for opioid addiction. The findings and recommendations to improve access to buprenorphine treatment identified through this research will be shared with physicians, managed care organizations, and policy makers. The Medical Society will seek additional funding to carry out the following advocacy and educational efforts:

1. Work with MCOs, DHMH, and other stakeholders to identify barriers to prescribing buprenorphine in the office-based setting, and to provide on-going feedback and recommendations regarding policies and procedures, particularly issues around prior authorization and reimbursement;
2. Assess policies and procedures, and practice barriers through physician interviews and other reporting mechanisms such as Advisory Committee discussions, etc.; and
3. Provide trainings, information, and resources to support physicians in offering buprenorphine treatment through their practice setting.

Appendix. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

Issues	Legal/Regulatory Findings	Provider Practice Findings	Recommendations	Medical Society Action Steps
I. Understanding Addiction as a Chronic Health Issue				
IA. The need for a long-term approach to treating addiction, similar to other chronic diseases, may not be well understood by policymakers or health plans.	Medicaid MCOs are required to be knowledgeable about treatment for addiction and addiction as a chronic disease. COMAR 10.09.65.11 provides that an MCO must provide "a continuum of substance abuse treatment services that offer access to the most appropriate level of individualized care to each enrollee."	Providers expressed beliefs that insurance companies either don't understand this, or don't want to support long-term treatment.	IA1. Physicians, health plans, policymakers and patients need education regarding the need for long-term treatment of addiction. IA2. Each MCO and commercial health plan should incorporate specific capability to manage the patient needing long-term treatment with buprenorphine into their chronic disease management system. IA3. MCOs and commercial health plans should support opioid addiction being treated in both physician office and drug treatment program settings.	IA1. Develop and provide educational programs. IA2 & IA3. Share the findings and recommendations from this research with policymakers, MCOs, and commercial health plans. IA2 & IA3. Meet with DHMH and Medicaid MCO officials to share the findings and recommendations identified through this research.
IB. The severity of medical consequences related to opioid withdrawal and overdose may not be well understood by policymakers and health plans.	Same as above	Same as above	IB1. MCOs and commercial health plans should educate providers and staff (including pharmacy technicians) about the severity of potential medical consequences associated with opioid withdrawal and opioid overdose.	IB1. Develop and provide educational programs.
II. Preauthorization for Medication				
IIA. The preauthorization process creates significant delays in commencing buprenorphine treatment.	A preauthorization procedure would not permitted if its effect is to discourage treatment and	Physicians lose patient in withdrawal if the window of opportunity for treatment is lost, thereby	IIA1. MCOs and commercial health plans should make their preauthorization procedures as efficient, streamlined and transparent to providers as possible.	IIA1. Meet with MCOs individually to discuss opportunities to streamline prior

Issues	Legal/Regulatory Findings	Provider Practice Findings	Recommendations	Medical Society Action Steps
	deny access to required benefits and MCO is not taking into account the individualized needs of enrollees. COMAR 10.09.66.01A	placingpatients at risk for overdose and/or death.	IIA2. DHMH should track access to buprenorphine treatment as a performance measure for MCOs	authorization procedures, and assist physicians in better understanding the requirements. IIA2. Share recommendation with DHMH.
IIB. MCOs that require preauthorization may not readily offer an immediately available supply of buprenorphine to physicians or patients. Withholding this medication due to preauthorization delays can have serious adverse medical outcomes, including risk of overdose and death.	Section 2.13 of DHMH's Drug Use Management Program guidelines requires MCOs to make available a supply of medication pending approval of a non-formulary preferred medication request when withholding the drug could have an adverse medical outcome. The same standard is presumed to be applicable with respect to formulary drugs such as Buprenorphine. In addition, all seven MCOs have stated to DHMH that they provide an emergency dose of **all** medications pending preauthorization. See DHMH's September 2006 MCO Annual Evaluation of Drug Use Management Programs.	At least one MCO does offer an immediately available supply of buprenorphine pending preauthorization. Other MCOs offer temporary supplies, but their pharmacists and physicians may not be aware of it.	IIB1. DHMH should establish a policy for MCOs that Buprenorphine be prescribed and dispensed immediately when patients present for treatment. IIB2. All MCOs (and health plans) should make a temporary supply of buprenorphine immediately available to patients pending prior authorization of buprenorphine. IIB3. MCOs should educate their providers regarding the immediate availability of buprenorphine. IIB4. MCOs should make the above mentioned policies available on their website so that physicians and patients have the ability to print off and provide to the pharmacy if needed. IIB5. DHMH should convene a Buprenorphine Workgroup composed of MCOs and physicians to identify policies and procedures that pose barriers to treatment, and to develop solutions.	IIB1a. Share recommendation with DHMH. IIB1b. Monitor MCO compliance with policy through physician interviews. IIB2 & IIB3 & IIB4. Meet with MCOs individually to understand their procedures and to share recommendations. IIB5. Share recommendation with DHMH.

Issues	Legal/Regulatory Findings	Provider Practice Findings	Recommendations	Medical Society Action Steps
III. Building Physician Capacity				
IIIA. Due to its psychosocial and behavioral manifestations of the disease, addiction treatment is labor-intensive and requires significant time for effective patient management. Physicians that provide buprenorphine treatment receive inadequate third-party reimbursement for their services and the amount of time needed to spend with patients.	Neither DHMH nor the Insurance Administration regulates the fees paid by MCOs and health plans, respectively. These are a matter of contract between the MCO and the provider. However, MCOs are required to have provider networks "adequate to deliver the full scope of benefits required under HealthChoice regulations" (COMAR 10.09.66.05B(1)), and that often requires paying higher rates to providers.	Many providers think that third party reimbursement is not adequate for the amount of time required for this work. These considerations also limit the number of addicted patients some providers will manage. The majority of private practitioners interviewed elect to require or negotiate self-pay by patients whenever possible. Primary care providers do not have guidance from MCOs or health plans regarding the appropriate codes to use that recognize the time needed for counseling patients or for induction.	IIIA1. DHMH should charge the Buprenorphine Workgroup with developing a consensus (as was accomplished in the past) on codes that accurately reflect level of physician effort, and for related tasks for increasing access to Buprenorphine treatment, that all MCOs will accept. IIIA2. DHMH should share the outcome of workgroup decisions on reimbursement codes with commercial insurance plans. IIIA3. DHMH should conduct further study on the effect of current reimbursement rates on the utilization of buprenorphine and access to treatment for patients. IIIA4. Each MCO should educate its providers on how to convert an intensity-based E&M code to a time-based E&M code if more than half the visit was spent on counseling. IIIA5. MCOs should provide physicians with a menu of practice models that incorporate buprenorphine and all other needed services for the opioid addicted patient population	IIIA1 to IIIA5. Share recommendations with DHMH. III4 & III5. Meet with MCOs individually to understand their procedures and to share recommendations.
IIIB. Physicians have expressed the need for peer level support, practical training on the nuances of addiction, and a system to report issues and practice management	An MCO is required to refer an enrollee to a provider that is "qualified" to provide the service. COMAR 10.09.65.11.	Some psychiatrists and other substance abuse professionals have voiced concern that some primary care physicians may not have adequate training or experience	IIIB1. Physicians should be provided mentoring, resources, and continuing medical education programs to educate them about treating addiction, and relevant policies and procedures. IIIB2. MCOs and commercial health plans	IIIB1 & IIIB2. Continue serving as a resource center, providing continuing medical education programs, and providing information regarding policies and

Issues	Legal/Regulatory Findings	Provider Practice Findings	Recommendations	Medical Society Action Steps
concerns.		with treating patients with addiction	should inform their physician providers of the existence of the Physician Clinical Support System offered by the American Society of Addiction Medicine.	procedures impacting treatment to physicians in Maryland.
IIIC. Access to physicians who can prescribe buprenorphine is limited. The patient limit was increased from 30 to 100 per physician in December 2006 with some restrictions.	MCOs are required to provide access to health care services that address the individualized needs of enrollees. COMAR 10.09.66.01A. MCOs must also have a complete network of providers "adequate to deliver the full scope of benefits as required" under HealthChoice regulations. COMAR 10.09.66.05B(1).	Some patients travel from far distances because they have difficulty finding physicians with capacity who offer this treatment.	IIIC1. MCOs and commercial health plans should maintain a list of physicians who are not at their treatment limit and are willing to accept new patients. IIIC2. Local county health departments should maintain lists of prescribing physicians who have treatment slots available and are willing to accept new patients.	IIIC1. Share recommendation with MCOs. IIIC2. Share recommendations with DHMH and ADAA.