F I S C A L I M P A C T R E P O R T

SPONSOR Sanchez, B. **ORIGINAL DATE** 02/04/11 **LAST UPDATED** 02/21/11 **HB**

SHORT TITLE Buprenorphine Treatment of Opioid Addiction **SB** 232a/SFC

ANALYST Earnest

ESTIMATED ADDITIONAL OPERATING BUDGET IMPACT (dollars in thousands)

	FY11	FY12	FY13	3 Year Total Cost	Recurring or Non-Rec	Fund Affected
Total		Unknown but likely increase			Recurring	General Fund and Federal Fund

(Parenthesis ( ) Indicate Expenditure Decreases)

SOURCES OF INFORMATION
LFC Files

Responses Received From
Human Services Department (HSD)
Department of Health (DOH)

SUMMARY

Synopsis of Senate Finance Committee Amendment

The Senate Finance Committee amendment Senate Bill 232, as amended, inserts a new subsection "C" to ensure that a primary care provider (PCP) authorized to administer buprenorphine receives payment for office-based buprenorphine treatment services.

Synopsis of Original Bill

Senate Bill 232 (SB 232) would enact a new section of the Public Assistance Act regarding access to office-based buprenorphine treatment of opioid addiction. This new section would require the Human Services Department (HSD) to

- ensure that recipients of the substance addiction services that HSD provides have timely access to office-based buprenorphine treatment of opioid addiction. In addition to coverage of buprenorphine, this coverage shall include office visits to providers of office-based buprenorphine treatment of opioid addiction.
- ensure a supply of primary care providers statewide who are authorized and willing to administer patients' office-based buprenorphine treatment of opioid addiction that is adequate to ensure timely office-based buprenorphine treatment.

- exempt any medication-based therapy related to the treatment of opioid addiction from any cost-saving measures that it implements.

For the purposes of this section, "primary care provider" means a health care practitioner acting within the scope of his or her license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services; who initiates referrals to other health care practitioners; and who maintains the continuity of care when appropriate.

FISCAL IMPLICATIONS

Expanding access to benefits and exempting certain services from cost containment efforts may result in cost increase, especially in the short term. HSD reports that "as more providers become certified to prescribe and more Medicaid recipients receive services, costs will increase. Holding any particular service harmless from cost containment efforts limits the Department's options for managing its programs. Specifically, the codes used to bill for a physician office visit is also used to bill for an office visit associated with medication-based therapy for opioid addiction. To hold these office visit codes harmless from future cost containment efforts is particularly problematic as these are frequently billed codes. The Department recognizes the effectiveness of medication-based therapy for opioid addiction and has no plans to apply cost containment action to this service."

SIGNIFICANT ISSUES

According to HSD:

> Ensuring access. Medication-assisted treatment using buprenorphine (prescribed as Suboxone or Subutex) is a therapeutic intervention that allows the individual seeking recovery to access services either through a behavioral health agency or in a primary care setting. Additionally, buprenorphine can be prescribed by a physician and purchased at a pharmacy, much like any other treatment for a medical issue.
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> Because medication-assisted treatment using buprenorphine is a Medicaid covered service, all Medicaid and SCI physical health managed care organizations as well as the Medicaid fee-for-service program pay pharmacy costs for Suboxone and Subutex. In addition, the MCOs pay for as covered benefits, the initial office visit (during which the physician is prescribing) as well as follow-up visits.
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> HSD staff has been meeting regularly with the MCOs to ascertain and resolve any barriers that Medicaid- or SCI-eligible individuals seeking treatment might encounter.
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> Approximately 130 New Mexican physicians have waivers to prescribe buprenorphine. Of these, the majority are practicing in Albuquerque. Each waivered physician may see at one time 30 patients for the first year and 100 patients in subsequent years for office-based treatment with buprenorphine. Assuming these doctors all accept Medicaid patients and are part of each MCO's network, 1,300 patients at any one time could be receiving office-based buprenorphine treatment. It is unlikely that Medicaid can "ensure" an adequate supply of physicians who are authorized to prescribe Suboxone or Subutex. While Medicaid and its MCOs can encourage providers to get the necessary waiver to prescribe Suboxone or Subutex, the program cannot require that providers do so.

Certified primary care providers. At this time, only physicians and doctors of osteopathy may prescribe Suboxone or Subutex. These physicians must have a federal waiver that allows qualifying physicians to practice medication-assisted opioid addiction therapy with Schedule III, IV, or V narcotic medications specifically approved by the Food and Drug Administration. Subutex and Suboxone tablets are currently the only medications approved for this treatment.

OTHER SUBSTANTIVE ISSUES

The Department of Health provided the following background information:

Opiate dependence and abuse remains a significant problem on a national and state level. Opiate dependence may involve the use of illicit substances, such as heroin, or abuse of widely available prescription "painkiller" drugs such as oxycodone and hydrocodone. Opiate dependence is linked to the acquisition of infectious diseases including Hepatitis B, Hepatitis C and Human Immunodeficiency Virus (HIV) as injection can pass infected blood from person to person.

In New Mexico, the overdose death rate from a combination of illicit and prescription drugs increased 150% in the past 5 years from 1.4 per 100,000 in 2004 to 3.6 in 2008 (*NM State of Health Report, 2011*). Adult prevalence of prescription painkiller abuse was estimated at 4.7% in the U.S. and 5.1% in New Mexico (*National Survey on Drug Use and Health, 2007-2008*). This is concerning since roughly 80,000 New Mexican adults who reported nonmedical use of prescription opioids are at high risk for addiction and overdose. In 2009, prescription opioids such as methadone, oxycodone and hydrocodone, accounted for 45% of all unintentional drug overdose deaths (*NM Office of the Medical Investigator and Epidemiology and Response Division, NMDOH).* Even though methadone and hydrocodone overdose death rates decreased from 2008 to 2009, the overdose death rate from oxycodone increased 28% and was the third leading cause of overdose death in New Mexico in 2009, second only to heroin and cocaine (*NM Office of the Medical Investigator* and *Epidemiology and Response Division, NMDOH).*

The number of inpatient hospitalization discharges with a primary diagnosis of heroin and synthetic opiates increased sharply from a total of 363 in first half of 2008 to 662 in the second half of 2009 (*Hospitalization Inpatient Discharge Data, Health Policy Commission*). Treatment admissions for other opiate and synthetic abuse increased from 2.5% of admissions in 2008 to 3.7% in 2009 (*Treatment Episode Data Set, Human Services Division*).

Medication assisted therapy for opiate addiction is a key component of a continuum of treatment options. Medication assisted therapy involves the use of medications, including buprenorphine and Suboxone, as an "opiate replacement" to treat opiate dependence. Buprenorphine programs implemented on a national basis through primary care physicians in France have been associated with a dramatic reduction in deaths resulting from drug overdose and with a reduction in HIV infection prevalence among injection drug users (from 40% to 20%), between 1996 and 2003 (Carrieri MP et al., Buprenorphine Use: The International Perspective, *Clinical Infectious Diseases* 2006, 43: S197-215).

BE/mew