Role of an Accurate Treatment Locator and Cash-Only Practices in Access to Buprenorphine for Opioid Use Disorders

Despite several studies demonstrating efficacy for opioid use disorder (OUD) medications, their use remains low (1). A previous study estimated that only 30% of patients receive OUD medication after an opioid overdose (2). A major reason for low treatment uptake is thought to be insufficient access to buprenorphine prescribers. In 2000, Congress passed the Drug Addiction Treatment Act to expand access to buprenorphine by permitting qualified clinicians to receive a waiver to prescribe the medication in nonspecialty settings, such as primary care. Despite this policy, the cumulative capacity for treatment in many U.S. regions is insufficient for the estimated number of persons with OUD. Thus, a more recent law increased the maximum number of patients that each clinician can treat to 275 (3). In addition, emphasis has been placed on decreasing workforce barriers so that more clinicians are willing to prescribe buprenorphine (4). However, it is unclear whether these efforts to increase provider capacity have translated into patients having timely access to a buprenorphine prescriber.

The study by Beetham and colleagues (5) used audit methodology to determine whether patients desiring buprenorphine treatment face barriers when seeking a treatment provider. Audit surveys, commonly known as "secret shopper" studies, simulate a real patient interaction to reduce any social desirability and recall bias providers may exhibit in self-reporting surveys (6). In this case, 2 research assistants simulated 30-year-old women who were actively using heroin and seeking to initiate buprenorphine treatment, 1 with Medicaid coverage and the other uninsured and paying cash. The "patients" called selected providers registered in the Substance Abuse and Mental Health Services Administration's Buprenorphine Practitioner Locator, a national repository listing the names and contact information of clinicians with a waiver to treat OUD with buprenorphine. The audit was conducted across 6 U.S. jurisdictions with a high rate of opioid-related morbidity. Each provider was called twice, once by the Medicaid enrollee and once by the uninsured patient, to test for a difference in acceptance by payment type. Of the clinicians with at least 1 response, 62% offered an appointment to the uninsured caller and 54% to the Medicaid caller. These percentages mirror published estimates for the availability of primary care appointments in general for new patients with Medicaid (7). For persons with OUD, timely access to treatment avoids harm from continued use of illicit opioids and may capitalize on a period of motivation for treatment. Thus, a notable finding of this study was that among clinicians willing to provide an appointment, wait times were short—approximately 5 to 6 days—and almost half the providers offered same-day treatment initiation.

This study highlights an important question: What role do self-pay, cash-only practices play in buprenorphine treatment access? Concerns exist that for-profit practices that accept only cash may offer low-quality care, provide only limited monitoring, and increase buprenorphine diversion (8). This study found large variability among states regarding whether Medicaid or cash-only patients had access to more providers, despite all states having expanded Medicaid. In Ohio, almost a third of physicians would make appointments only for self-paying patients, compared with only 10% in Massachusetts. Greater availability of buprenorphine within a region may create less demand for cash-only practices in that region. Consistent with this hypothesis, Massachusetts has implemented innovative approaches to improve access to high-quality buprenorphine treatment in primary care practices (such as nurse case manager–led treatment) (9) and had more than twice the buprenorphine capacity than Ohio in 2012. Therefore, future studies must better understand the nature and effect of self-pay, cash-only practices in filling the gaps in treatment access. For example, are these providers in primary care settings or at standalone addiction treatment facilities? Are they located primarily in regions with below-average numbers of treatment providers? How much, and in what domains, does the quality of monitoring and patient care differ between cash-only and other practices? Exploring these questions further is critical to informing state-specific policies on the best ways to promote access to buprenorphine while minimizing diversion.

Also of note, the cost of treatment initiation for cash-only patients in this study ranged from $180 to $350, not including additional fees that might be charged for laboratory tests or treatment beyond the initial medication induction period. Despite greater appointment availability for self-paying patients, cost may still be a barrier to persons with limited financial resources and may disproportionately deter them from long-term treatment. Thus, even if cash-only practices have a useful role in improving treatment access in specific regions, they may perpetuate inequities in treatment access by payment status (10).

Another major barrier to treatment access highlighted by Beetham and colleagues (5) is the inability of patients to identify waivered prescribers in their region. The authors report that only half of waivered buprenorphine prescribers list their contact information on the Buprenorphine Practitioner Locator Web site. Moreover, of the clinicians listed, 50% were ineligible for the study because of a nonworking phone number, not having a prescriber at the practice, or other reasons. However, a large percentage of the physicians success-

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fully contacted by the researchers were willing to provide a timely appointment to a new patient. A more accurate list of prescribers would potentially improve treatment access and care coordination. For example, an updated registry would help acute care providers, such as emergency room physicians and other first responders, find timely outpatient follow-up for patients.

In summary, using audit methodology, this study captured real-time barriers patients may encounter when trying to find a buprenorphine provider. It emphasized that timely treatment access varies according to payer status, state, and the provider's treatment capacity, warranting further study on disparities in treatment access in these areas. To better inform policy, future efforts should evaluate state policies regarding reimbursement for buprenorphine therapy as well as existing access to treatment. In the interim, however, the findings demonstrate that many existing buprenorphine providers are willing to provide timely care to new patients. The more pressing challenge may be to engage and connect patients to these prescribers.

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