Proliferation of Cash-Only Buprenorphine Treatment Clinics: A Threat to the Nation's Response to the Opioid Crisis

By all measures, the opioid crisis—including the misuse of prescription opioids, heroin, and fentanyl—is a major public health crisis in the United States, and the White House has declared it a national emergency. A key measure to combat this emergency is greater availability of methadone and buprenorphine treatment; this notion is endorsed by the White House Office of National Drug Control Policy, the Substance Abuse and Mental Health Services Administration, the US Surgeon General, the White House Opioid Commission, the National Academy of Sciences, and the World Health Organization, among others. Many medical offices do not accept insurance payments (i.e., they see patients on a cash-only basis) for buprenorphine treatment; this practice raises important ethical questions among the medical profession and the wider community concerning limiting access to important and potentially life-saving treatment of the most vulnerable patients with opioid use disorder.

HOW WE GOT HERE

A brief review of recent history helps to explain how we got here. Opioid agonist treatment with methadone or buprenorphine is the most effective treatment for opioid use disorder.[1] Before 2002, methadone, dispensed through federally regulated opioid treatment programs, was the only option for opioid agonist treatment. Multiple barriers prompted efforts to increase access to opioid agonist treatment. The Drug Addiction Treatment Act of 2000 (DATA 2000) allows physicians who have received a waiver and have had eight hours of training to prescribe schedule III medication (buprenorphine) that has been approved to treat opioid use disorder in their offices instead of in a federally regulated opioid treatment setting. Current regulations allow eligible practitioners to request approval to treat 100 or 275 (previously limited to 30) patients, depending on practice characteristics. Recent legislation has expanded DATA 2000 to physician assistants and advance practice registered nurses under modified training and practice requirements.

Primary care–based treatment revolutionized the capacity of many physicians—especially those in rural and isolated communities, such as the one where A. V. Z. practices—to address the rising tide of opioid use disorder in communities overwhelmed with prescription opioid use disorder. There was a marked increase in buprenorphine treatment providers in some regions, particularly after the cap of 30 patients was lifted to 100 patients.[2] Some practices have adopted a model of buprenorphine provision that does not accept any insurance and requires patients to make out-of-pocket (i.e., cash) payments. The limited research regarding reimbursement practice policies among providers of buprenorphine treatment nationally indicates that 19% to 47% of surveyed practices accept only cash payment for these services.[3,4] A study of 27 273 individuals initiating buprenorphine treatment in 11 states demonstrated that 26% paid primarily out of pocket.[5]

Access to mental health and addiction treatment in the United States is already restricted because of limited insurance coverage and a limited and geographically concentrated workforce, as well as because nearly 50% of psychiatrists do not accept insurance.[6] About one third of US providers of buprenorphine treatment in 2013 were psychiatrists.[2]

From our perspective, the fact that there are clinics that accept only out-of-pocket payments greatly diminishes the credibility of buprenorphine treatment in the broader community, contradicts some of the foundational ethics of our profession, and prevents a much more effective response in improving the access and care of individuals with untreated opioid use disorder. In addition, a very problematic unintended consequence of such clinics is the increasing diversion of buprenorphine, as financially hard-strapped patients try to come up with payment for weekly clinic visits. One study found that the most important risk factor for using diverted buprenorphine was the inability to access buprenorphine treatment.[7]

When medical offices providing buprenorphine accept only out-of-pocket payment, the poor and the underserved have limited access to much needed care. The delivery of potentially life-saving medical care on an out-of-pocket payment basis raises many questions about our professional obligation to provide

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nondiscriminatory care and to serve all classes of patients. The American Medical Association's Principles of Medical Ethics calls for physicians to support access to medical care for all people.

RECOMMENDATIONS

What measures can we take to improve treatment access of individuals with opioid use disorder who are trying to access the most effective treatment of their condition? Each of us can examine our own practices and work to ensure inclusion of the most vulnerable. Professional medical organizations and medical societies could have clear policies against this type of practice. A universal expansion of medication treatment through the roughly 1400 federally funded US community health centers could effectively provide affordable access for many. State mental health agencies could move toward the funding and establishment of not-for-profit medication treatment programs. Loan repayment programs could be structured for physicians, physician assistants, nurse practitioners, and substance use counselors who are trained in addiction medicine and then receive loan repayment contingent on practicing in nonprofit settings. We urgently need good data on reimbursement policies among nationwide buprenorphine treatment practices to tailor policies that address the problem. More initiatives may come to light through the work of individuals dedicated to removing barriers and ensuring access for everyone to this much needed and effective treatment, which would help to save lives, improve social functioning, reduce criminal behavior, and decrease HIV and hepatitis C transmission. AJPH

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CONFLICTS OF INTEREST

No conflicts of interest.

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Grief in Veterans: An Unexplored Consequence of War

Since the wars in Afghanistan and Iraq began in 2001 and 2003, respectively, more than 5400 US military personnel have died in combat.[1] Embarking on a military combat career brings an intrinsic risk of injury, mortality, and the death of comrades. Increasingly, however, US military personnel are facing the added burden of losing comrades to self-inflicted wounds, most of which occur after troops return home from deployment.[2] Indeed, as the number of troops killed in action has declined, the military suicide rate has at times surpassed the combat casualty rate. In a 2017 Iraq and Afghanistan Veterans of America survey, 58% of participants indicated that they knew a veteran who died by suicide, and 65% indicated that they knew a veteran who had attempted to take his or her own life. Not only does the military suicide rate currently exceed the combat death rate, but the military suicide rate now exceeds the civilian rate.[3]

This loss of life may have serious consequences for the health and well-being of surviving veterans. In fact, grief in veterans may well have the same status that posttraumatic stress disorder (PTSD) did in the aftermath of the Vietnam War: largely overlooked. Although there is ample research about the psychological toll of war, much of it has focused on the association between combat exposure and PTSD, depression, and alcohol use and abuse.[4] The limited research on grief that has been conducted among the military community has focused primarily on bereaved military families.[5] Moreover, even public pronouncements on Memorial Day focus almost exclusively on the families of the fallen, ignoring the grief of the troops who served alongside them.

An exhaustive literature search for studies of grief among military personnel who lost comrades in battle yielded only a few studies that explored grief in Vietnam era combat veterans,[6] and these were conducted decades after the war ended. In addition, to our knowledge there is no research that has considered whether grief is a distinct outcome from PTSD in combat veterans. Thus, although we know a little about veterans' grief responses to battle deaths during

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