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Innovative Payment to Scale up Access to Medications for Opioid Use Disorder

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Shatterproof

Despite the ongoing opioid epidemic in the United States, the three FDA-approved medications that are effective in treating opioid use disorder (OUD) – methadone, buprenorphine, and naltrexone – remain significantly underutilized. Current data suggest that under 35% of people with OUD received treatment in the previous year.[1] Barriers to access include a lack of belief in agonist treatment, stigma associated with addiction, and insufficient reimbursement.[2] Additionally, efforts to scale up access to these drugs face considerable regulatory barriers. In particular, methadone can only be dispensed in heavily-regulated opioid treatment program settings; in part due to these regulations, such programs are not widely accessible.[3]

Buprenorphine has expanded access to medication for OUD since it was approved by the FDA in 2012, primarily because it can be prescribed and managed in office settings so the existing workforce of geographically-distributed physicians can be leveraged. Still, access to high-quality OUD treatment has failed to meet needs. Clinicians continue to face a number of challenges to offering treatment, including fragmented and insufficient financing, system misalignment (e.g., between primary care and addiction treatment), and a lack of education and institutional and psychosocial support. Alternative payment models may offer opportunities to increase the provision of high-quality OUD buprenorphine treatment by aligning payment with evidence-based care and increasing resources for clinicians.

Currently, insurance payment to clinicians prescribing and managing buprenorphine treatment relies on standard fee-for-service (FFS) Evaluation and Management (E&M) codes. This model of payment inhibits innovation in treatment delivery in at least three ways. First, the FFS system does not support integrated care teams that might provide higher value and provides limited reimbursement for evidence-based wrap-around social services which are recommended to accompany OUD treatment. Second, FFS payment may create incentives to avoid patients who are less likely to stabilize (e.g., because the payment rate for the time-intensive induction and stabilization phases, relative to payment for the stable maintenance phase, does not match the cost differential between these visits). Third, E&M codes are not tied to quality of services delivered. In fact, the per-service nature of FFS

reimbursement may incentivize high volume of well-reimbursed services, even if they are low-value or even inappropriate.

Given its dominance in terms of physician revenue, FFS is likely to remain the primary reimbursement mechanism for buprenorphine treatment in many smaller practices. This payment model has some appealing features for incentivizing buprenorphine treatment in the community, including contingency on service delivery which facilitates monitoring by policymakers, clinicians, and payers to ensure that reimbursable services do indeed get delivered and prevent under-provision. Where appropriate, the FFS system should be supported at payment levels needed to encourage buprenorphine provision. Larger practices, however, may be well-poised to transition to an alternative payment model that incentivizes higher-value care, including coordinated therapeutic and behavioral services.

Bundled payment is an alternative payment model that bundles payment for multiple services an individual may receive during an episode of care into a single fixed payment. This model has been used in settings such as joint replacement to compensate for the care associated with a central procedure (e.g., joint replacement surgery) as well as all other care associated with that episode. In the case of OUD, a bundled payment model should cover buprenorphine treatment as well as complementary services. To promote engagement of new patients, the rate would be higher in the initial phases of treatment to appropriately reimburse providers for the higher costs of intake and starting medication.

From the perspective of the practice, a bundled payment would shift the focus from being solely on administration of buprenorphine to a coordinated set of high-value services, including but not limited to medicine. A clinic would organize around team-based provision of evidence-based care (i.e., rather than fragmented, high-volume services) and be rewarded for achieving pre-identified patient-level outcomes. Importantly, bundled payment may also facilitate matching between patients in need of care and available clinicians by offering resources and incentives (e.g., higher payment for early phases of treatment) to engage new patients in treatment.

Improving linkages between patients in need and available providers would address a major challenge that has emerged in efforts to scale up OUD treatment. Currently, most PCP practices are not set up to see patients in acute need outside of business hours or to use resources such as peer support services to match these patients with available providers; evidence suggests that where such specialists exist, they are often paid too little.[4] To engage new patients effectively, practices may need to hire intake specialists and develop relationships with emergency rooms where patients seek overdose treatment. The alignment of a bundled payment would create the incentives for these and other necessary investments.

Beyond an individual practice, bundled payments are more likely than FFS to promote rapid entry of providers with innovative models of care and can be targeted to areas that are particularly in need due to high OUD rates and/or provider shortages. There are several potential challenges with introducing bundled payment into the OUD setting. Episode-based payment can introduce incentives for under-provision, in part because it is difficult to track individual services.[5, 6] This concern highlights the critical role of quality measurement and

tracking of patient outcomes to ensure appropriate care. To ensure quality and deter under-provision of care, triggering requirements could be employed. These requirements could be structural, requiring practices to have certain capacities (e.g., for counseling services), process-oriented where documentation, screening, treatment plans, and coordination are required, and/or (over time) outcome oriented where compliance and utilization is tracked.

Clinicians and payers have been slower to adopt value-based payment in the field of addiction treatment relative to other clinical areas.[7,3] Bundled payment may play an important role in overcoming the limitations inherent in paying for OUD treatment services through FFS E&M codes and offer promise as a supplement to existing models. Of course, whether bundles and other alternative payment models for OUD treatment result in increased capacity of evidence-based care remains to be seen. Rapid evaluation of ongoing efforts by public and private insurers will be valuable to optimize payment policies that support maximizing access to evidence-based OUD treatment.

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Take-Away Points: Access to high-quality opioid use disorder treatment remains insufficient. Alternative payment models offer opportunities to expand treatment by aligning payment with evidence-based care.

- Medications that are effective in treating opioid use disorder remain underutilized.
- Physicians face several major challenges in provision of buprenorphine, including fragmented and insufficient financing.
- Currently, reimbursement for buprenorphine treatment is largely fee-for-service, which may not incentivize evidence-based care. Payments that "bundle" reimbursement for buprenorphine and wrap-around social services would incentivize evidence-based care delivery, facilitate matching between patients in need of care and available clinicians, and promote entry of providers with innovative models of care.