#107

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Q1: OPTIONAL: This recommendation was submitted by (please provide your first and last name, affiliation, and email address)

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Q2: Title of your recommendation

Expand access to buprernorphine and methadone maintenance treatment

Q3: Please provide a description of your proposed recommendation

Buprenorphine
-remove prior approval on the Medicaid Managed care formularies, if not immediately possible then remove requirements demanding counseling and/or limiting dose, length of treatment. These are out of step with the medical literature.
-publish and promote guidance for physicians to continue treatment of patients who continue to use other drugs, and/or who are not adherent with psychosocial treatment - also to come up to date with the medical literature
-provide emergency dosing sites for people not in care to prevent risky behavior when in withdrawal (ERs? STD clinics?)
-include buprenorphine treatment in all local and state correctional facilities
Methadone
-Rapid expansion of clinics in high need regions allowing some lag in bringing clinics fully up to counseling requirements
-include methadone in all local and state correctional facilities
-review state regulation of methadone programs in light of promoting the End of AIDS

Q4: For which goal outlined in the Governor's plan to end the epidemic in New York State does this recommendation apply? (Select all that apply)	Identifying persons with HIV who remain undiagnosed and linking them to health care , Linking and retaining persons diagnosed with HIV to health care and getting them on anti-HIV therapy to maximize HIV virus suppression so they remain healthy and prevent further transmission , Other (please specify) Preventing HIV and HCV transmission among the growing numbers of young injectors

Q5: This recommendation should be considered by the following Ending the Epidemic Task Force Committee (Select all that apply)	Prevention Committee: Develop recommendations for ensuring the effective implementation of biomedical advances in the prevention of HIV, (such as the use of Truvada as pre-exposure prophylaxis (PrEP)); for ensuring access for those most in need to keep them negative; and for expansion of syringe exchange, expanded partner services, and streamlined HIV testing by further implementing the universal offer of HIV testing in primary care, among others. The Committee will focus on continuing innovative and comprehensive prevention and harm reduction services targeted at key high risk populations, as well as grant-funded services that engage in both secondary and primary prevention. , Care Committee: Develop recommendations to support access to care and treatment in order to maximize the rate of HIV viral suppression. The Committee will promote linkages and retention in care to achieve viral suppression and promote the highest quality of life while significantly decreasing the risks of HIV transmission. Recommendations will also ensure a person centered approach is taken and that access to culturally and linguistically appropriate prevention and health care services is available. , Housing and Supportive Services Committee: Develop recommendations that strengthen proven interventions enabling optimal engagement and linkage and retention in care for those most in need. This Committee will recommend interventions that effectively address complex and intersecting health and social conditions and reduce health disparities, particularly among New York's low-income and most vulnerable and marginalized residents. These interventions will diminish barriers to care and enhance access to care and treatment leaving no subpopulation behind.
Q6: Does this recommendation require a change to an existing policy or program, or the creation of a new policy or program?	Change to existing policy
Q7: Would implementation of this recommendation be permitted under current laws or would a statutory change be required?	Permitted under current law

Q8: Is this recommendation something that could feasibly be implemented in the short-term (within the next year) or long-term (within the next three to six years)?

Within the next year

Q9: What are the perceived benefits of implementing this recommendation?

NY is experiencing a tremendous growth in young injectors who are in need of treatment. It is clear in the medical literature that a combination of opioid maintenance treatment, syringe access and HIV treatment is far more effective at ending the epidemic than are the separate parts. Syringe access and opioid treatment are also both needed to prevent HCV.
Outside NYC there are tremendous waiting lists for methadone but huge barriers to expanding slots.
In regards to buprenorphine, physicians feel compelled to discharge patients from care for continuing other drug use (including marijuana) and for refusing counseling. They are also deterred from prescribing buprenorphine by prior authorization requirements.
A lower threshold, harm reduction approach has the potential to bring more people into care, earlier in the course of drug use and thus prevent transmission of HIV &HCV and overdose deaths.

Q10: Are there any concerns with implementing this recommendation that should be considered?

Diversion of both medications to street sales, where it is purchased most often for self treatment when medical treatment is unavailable, is a concern. Expanding access has the potential to increase this - or it may decrease it as more people get access to care less street market is needed.
It is important to be aware that buprenorphine has far far less likelihood of fatal overdose than any other opioid.
Some consider availability on the street to be in keeping with public health.

Q11: What is the estimated cost of implementing this recommendation and how was this estimate calculated?

I believe methadone programs in NYC charge $60-$100 per week to uninsured patients.
Buprenorphine, out of pocket, is about $6000-9000 per year for generic, plus medical visits, lab testing.
Methadone is less expensive but not always consumer friendly, especially for young injectors who should be targeted.
Medicaid data on this should be easy to obtain.

Q12: What is the estimated return on investment (ROI) for this recommendation and how was the ROI calculated?

There are multiple international studies and older national studies finding that methadone is high highly cost effective.
A recent study on buprenorphine calculated a $35,000-$100,000 per Quality Adjusted Life year but without using the savings of HIV or HCV prevention in the calculation. Another study conducted in 1998 found that if buprenorphine increases access to opioid agonist treatment by 10%, it has a cost-effectiveness ratio less than $45,000/QALY ($70,700/QALY in 2010 US dollars), but this study only considered benefits attributable to reduced HIV transmission.
As an FYI $100,000/QALY is accepted as an appropriate cost in many analyses of various medical interventions.

Q13: Who are the key individuals/stakeholders who would benefit from this recommendation?

People who are misusing opioids, particularly those who inject them.
Family, friends, sex partners.
Physicians - prescribing buprenorphine is very satisfying.
Opioid maintenance is also associated with reductions in crime.

Q14: Are there suggested measures to accompany this recommendation that would assist in monitoring its impact?

Increased patients in opioid maintenance with higher retention.
Increased number of physicians prescribing.

Q15: This recommendation was submitted by one of the following

Respondent skipped this question