RESOLUTION 50-20

Title:	Remove Clinic-Specific Caps on Buprenorphine Prescriptions
Introduced by:	Nabiha Hashmi for the Medical Student Section
Original Authors:	Amer Abu-kwaik, Connor Buechler, May Chammaa, Jody Chou, Peter Dimitrion, Preetha Ghosh, Aileen Haque, Leya Maliekal, Michael Moentmann, Tabitha Moses, Anneliese Petersen, Brianna Sohl, and Lucas Werner
Referred To:	Reference Committee B
House Action:	REFER

Whereas, in 2017, there were 21.2 opioid overdose deaths per 100,000 persons in Michigan, which is higher than the national rate of 14.6 deaths per 100,000 persons, and

Whereas, nationally, over 2 million people have an opioid use disorder (OUD) but fewer than 10 percent have accessed treatment, and

Whereas, opioid agonist treatment (OAT), such as buprenorphine, is well documented to reduce rates of relapse, decrease self-reported opioid cravings, and increase opioid free urine samples in clinical trials, and is being formulated into extended release and implantable drug eluting systems to improve adherence, and

Whereas, buprenorphine is a long acting partial opioid agonist used in the treatment of OUD and to alleviate the symptoms of opioid withdrawal; it is commonly formulated as suboxone - a sublingual film combined with naloxone, and

Whereas, the Drug Addiction Treatment Act of 2000 (DATA-2000) allows physicians to obtain a waiver from the Narcotic Addict Treatment Act registration requirements to treat OUD with Schedule III, IV, and V drugs or a combination of them (including buprenorphine), and

Whereas, the DATA-2000 law states that physicians are eligible to prescribe buprenorphine-based medications if they pass an eight-hour course through the American Osteopathic Association after obtaining their current state medical license and a valid DEA registration number, then apply for a special waiver, and

Whereas, the DATA-2000 law states that eligible physicians during their first year following certification can treat at one time up to 30 patients, after which physicians may expand their patient cap to 100, and one year thereafter physicians and other qualifying practitioners who meet certain criteria can apply to increase their patient limit to 275, and

Whereas, the SUPPORT act of 2018 expands the ability of certain physicians and other qualified practitioners to treat up to 100 patients in the first year of waiver receipt if they are board-certified in addiction medicine or addiction psychiatry, or if they provide medication treatment in a "qualified practice setting," and

Whereas, between 2016 and 2018, there was a 175 percent increase in the number of providers with buprenorphine waivers; however, as of 2018 there were still an estimated 47 percent of counties in the United States lacking a physician with a buprenorphine waiver, and

Whereas, physicians in the U.S. cite regulations on buprenorphine prescribing as one of the barriers to their ability and willingness to prescribe the medication, and

Whereas, since 1995, France has allowed all registered medical doctors to prescribe buprenorphine without any waivers, specific training, or licensure, and has since seen an 80 percent reduction in opioid overdoses with no resultant difference in buprenorphine diversion rates compared to the USA, which has much more stringent buprenorphine prescribing policies, and

Whereas, a 2015 survey of 706 opioid users in San Francisco found that less than 1 percent of those prescribed buprenorphine reported using it to get high, serving as evidence of the low misuse potential of buprenorphine in the USA, and

Whereas, one-third of counties within the state of Michigan have no medication treatment programs - including opioid treatment programs, buprenorphine, and naltrexone - for substance use disorder available, and only 18 percent of counties in Michigan have access to OAT programs, and

Whereas, as of September 2019, 2,756 Michigan practitioners - including MDs, DOs, APRNs, NPs, and PAs - have obtained a waiver to prescribe buprenorphine but only 54 percent of counties in Michigan had access to buprenorphine prescribers, and

Whereas, Michigan approved the Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules which require any individual or individuals in group practices (excluding pharmacists) who provide buprenorphine or naltrexone treatment to more than 100 individuals at any one time at a specific property to apply for a substance use disorder service program license, and

Whereas, these administrative rules contradict state and federal efforts to expand access to OAT as it severely limits the capabilities of physicians in group practice settings (e.g., family practice offices) to manage patients with OUD with medication treatments; therefore be it

RESOLVED: That MSMS oppose state legislation that attempts to limit the prescription of medication for opioid use disorder beyond those regulations set forth by federal laws; and be it further

RESOLVED: That MSMS advocate the Michigan Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules be amended to remove the cap on the number of patients receiving buprenorphine prescriptions from a single site or group practice as a condition of licensure.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $16,000-$32,000 for legislative and regulatory/industry advocacy.

Relevant MSMS Policy:

Addiction Treatment, Facilities, and Services
MSMS supports enhanced availability of and access to addiction treatment, facilities, and services within the State of Michigan.

Referral to Addiction Medicine Specialists
MSMS encourages the referral of persons with an opioid use disorder who would benefit from medication-assisted treatment to buprenorphine-waivered physicians when the physician has determined that the patient has an opioid use disorder. Further, MSMS encourages physicians to obtain the DATA 2000 waiver to prescribe opioid replacement for individuals with an opioid use disorder.

Relevant AMA Policy:

Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder D-95.972
1. Our AMA's Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.
2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
Our AMA opposes federal, state, third-party and other laws, policies, rules and procedures, including those imposed by Pharmacy Benefit Managers working for Medicaid, Medicare, TriCare, and commercial health plans, that would limit a patient's access to medically necessary pharmacological therapies for opioid use disorder, whether administered in an office-based opioid treatment setting or in a federal regulated Opioid Treatment Program, by imposing limitations on the duration of treatment, medication dosage or level of care.

Support the Elimination of Barriers to Medication-Assisted Treatment for Substance Use Disorder D-95.968
1. Our AMA will: (a) advocate for legislation that eliminates barriers to, increases funding for, and requires access to all appropriate FDA-approved medications or therapies used by licensed drug treatment clinics or facilities; and (b) develop a public awareness campaign to increase awareness that medical treatment of substance use disorder with medication-assisted treatment is a first-line treatment for this chronic medical disease.
2. Our AMA supports further research into how primary care practices can implement medication-assisted treatment (MAT) into their practices and disseminate such research in coordination with primary care specialties.
3. The AMA Opioid Task Force will increase its evidence-based educational resources focused on methadone maintenance therapy (MMT) and publicize those resources to the Federation.

Sources:

1. Center for Behavioral Health Statistics, "Results from the 2017 national survey on drug use and health: detailed tables," Rockville, MD, 2018.
2. "Michigan Opioid Summary | National Institute on Drug Abuse (NIDA)." [Online]. Available: https://www.drugabuse.gov/opioid-summaries-by-state/michigan-opioid-summary. [Accessed: 06-Jan-2020].
3. J. D. Lee et al., "Comparative effectiveness of extended-release naltrexone versus buprenorphine-naloxone for opioid relapse prevention (X:BOT): a multicentre, open-label, randomised controlled trial," Lancet, vol. 391, no. 10118, pp. 309-318, Jan. 2018, doi: 10.1016/S0140-6736(17)32812-X.
4. M. R. Lofwall et al., "Weekly and monthly subcutaneous buprenorphine depot formulations vs daily sublingual buprenorphine with naloxone for treatment of opioid use disorder a randomized clinical trial," JAMA Intern. Med., vol. 178, no. 6, pp. 764-773, Jun. 2018, doi: 10.1001/jamainternmed.2018.1052.
5. R. N. Rosenthal, M. R. Lofwall, S. Kim, M. Chen, K. L. Beebe, and F. J. Vocci, "Effect of buprenorphine implants on illicit opioid use among abstinent adults with opioid dependence treated with sublingual buprenorphine a randomized clinical trial," JAMA - J. Am. Med. Assoc., vol. 316, no. 3, pp. 282-290, Jul. 2016, doi: 10.1001/jama.2016.9382.
6. L. Gowing, R. Ali, J. M. White, and D. Mbewe, "Buprenorphine for managing opioid withdrawal," Cochrane Database of Systematic Reviews, vol. 2017, no. 2. John Wiley and Sons Ltd, 21-Feb-2017, doi: 10.1002/14651858.CD002025.pub5.
7. W. Ling, "Buprenorphine implant for opioid addiction," Pain Manag., vol. 2, no. 4, pp. 345-350, Jul. 2012, doi: 10.2217/pmt.12.26.
8. J. R. Velander, "Suboxone: Rationale, science, misconceptions," Ochsner Journal, vol. 18, no. 1. Ochsner Clinic, pp. 23-29, 01-Mar-2018, doi: 10.1043/TOJ-17-0095.

9. "MAT Statutes, Regulations, and Guidelines | SAMHSA - Substance Abuse and Mental Health Services Administration." [Online]. Available: https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines. [Accessed: 06-Jan-2020].
10. "DATA-2000 law 30/100 patient limit on prescribing Suboxone (buprenorphine / naloxone) for the treatment of opioid addiction." [Online]. Available: https://www.naabt.org/30_patient_limit.cfm. [Accessed: 06-Jan-2020].
11. R. L. Haffajee, A. S. B. Bohnert, and P. A. Lagisetty, "Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment," Am. J. Prev. Med., vol. 54, no. 6, pp. S230-S242, Jun. 2018, doi: 10.1016/j.amepre.2017.12.022.
12. R. Ghertner, "U.S. trends in the supply of providers with a waiver to prescribe buprenorphine for opioid use disorder in 2016 and 2018," Drug Alcohol Depend., vol. 204, Nov. 2019, doi: 10.1016/j.drugalcdep.2019.06.029.
13. W. Kissin, C. McLeod, J. Sonnefeld, and A. Stanton, "Experiences of a national sample of qualified addiction specialists who have and have not prescribed buprenorphine for opioid dependence," J. Addict. Dis., vol. 25, no. 4, pp. 91-103, Nov. 2006, doi: 10.1300/J069v25n04_09.
14. M. Auriacombe, M. Fatséas, J. Dubernet, J. P. Daulouéde, and J. Tignol, "French Field Experience with Buprenorphine," American Journal on Addictions, vol. 13, no. SUPPL. 1. 2004, doi: 10.1080/10550490490440780.
15. M. Fatseas and M. Auriacombe, "Why buprenorphine is so successful in treating opiate addiction in France," Current Psychiatry Reports, vol. 9, no. 5. pp. 358-364, Oct-2007, doi: 10.1007/s11920-007-0046-2.
16. T. J. Cicero, PhD, H. L. Surratt, PhD, and J. Inciardi, PhD, "Use and misuse of buprenorphine in the management of opioid addiction," J. Opioid Manag., vol. 3, no. 6, p. 302, Nov. 2007, doi: 10.5055/jom.2007.0018.
17. S. P. Novak, L. Wenger, J. Lorvick, and A. Kral, "The misuse, abuse and diversion of opioid replacement therapies among street abusers," Drug Alcohol Depend., vol. 146, p. e54, Jan. 2015, doi: 10.1016/j.drugalcdep.2014.09.517.
18. A. Bohnert, J. Erb-Downward, and T. Ivacko, "OPIOID ADDICTION: MEETING THE NEED FOR TREATMENT IN MICHIGAN."
19. "Waiver Totals by State | SAMHSA - Substance Abuse and Mental Health Services Administration." [Online]. Available: https://www.samhsa.gov/medication-assisted-treatment/practitioner-program-data/certified-practitioners?field_bup_us_state_code_value=MI. [Accessed: 06-Jan-2020].
20. Bureau of Community and Health System Substance Use Disorder Service Programs Administrative Rules Office of Regulatory Reinvention, "Michigan Register, Issue No_18-2018, Part 2 Subpart A R. 325.1303," 2018.