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Opioid Use Disorder – Access to Medication-Assisted Treatment

State plan needed to mitigate barriers

Why we did this review

The opioid epidemic has generated significant national attention in recent years due to the increasing number of opioid-related overdoses and deaths. While prevention efforts are also needed, we reviewed the state's efforts to ensure that the estimated 180,000 Georgians with an opioid use disorder have access to the recommended treatment when it is needed.

Nearly 1,000 Georgians died from opioid-related overdoses in 2016, an increase of 55% from 633 in 2012. The statewide age-adjusted death rate increased from 6.3 to 9.4 deaths per 100,000. Additionally, Georgia has experienced an increase in the number of overdose reversals performed by emergency medical services—from 4,500 in 2012 to 10,000 in 2016.

About Medication-Assisted Treatment (MAT)

MAT is a combination of medication and counseling, in which medication stabilizes the brain's cravings for the substance and behavioral therapies assist with underlying issues that led to the addiction.

Three medications are used to treat opioid use disorder. Methadone and buprenorphine are opioids that have longer effective periods that prevent the peaks and valleys associated with short-term opioids like heroin or oxycodone. Naltrexone blocks the effects of opioids entirely. Due to the varied nature of each individual's addiction, access to all three medications is recommended.

What we found

Georgia has not developed a comprehensive strategy to address all aspects of the opioid epidemic. While recent legislation addressed the availability of opioids, access to the overdose-reversing drug naloxone, and the regulation of narcotic treatment programs, the state's efforts to expand the availability of medication-assisted treatment (MAT) for those with opioid use disorder have been limited.

An estimated 180,000 Georgians have an opioid use disorder, and these individuals are an increasing portion of those served in family treatment and adult felony drug courts, supervised in probation/parole treatment centers, and involved in child removal cases. In fiscal year 2017, fewer than 30,000 Georgians received MAT with methadone and buprenorphine.

Substance abuse experts recommend MAT for treating opioid use disorder. This combination of medication and counseling has been researched extensively and found to be more effective than treatments that focus only on behavioral therapy. Studies have found that individuals with opioid use disorder who obtain MAT—particularly methadone and buprenorphine—are more likely to remain in treatment and abstain from illegal drugs or their drug of abuse than those who receive only counseling or no treatment.

Insured and uninsured individuals seeking to obtain MAT may encounter barriers related to provider availability, awareness of provider types and locations, and treatment cost. Additionally, individuals under the supervision of state entities may be restricted from obtaining MAT. As a result, Georgians may obtain no treatment or obtain treatment from providers that only offer behavioral therapies. These barriers are described below.

- **Provider Availability** – Most Georgians can travel fewer than 20 miles to reach both a narcotic treatment program (NTP), which is licensed to provide methadone, and a physician who has obtained the federal waiver to prescribe buprenorphine. However, individuals in rural areas must generally travel further to reach one of Georgia's 72 NTPs, which can be difficult since patients must visit the clinic daily. While the 764 buprenorphine prescribers distributed across the state have the capacity to treat nearly 50,000 patients, in fiscal year 2017 only 60% actually wrote a prescription for addiction treatment medications and only 17,000 individuals (34%) were served. Georgia has fewer buprenorphine prescribers and less capacity than many states.
- **Practitioner Awareness** – The state has not developed resources to increase awareness of MAT and its providers among practitioners and the public. Practitioners—including physicians, emergency room staff, and county health department nurses—who may see individuals with opioid use disorder generally do not refer patients to MAT providers, which can be partly attributed to a lack of training and resource listing.
- **MAT Cost** – Depending on the medication, MAT costs can total several thousand dollars annually for uninsured individuals. A privately insured individual generally has lower out-of-pocket costs for buprenorphine- and naltrexone-based treatments but likely pays the full cost for methadone because NTPs are generally not included in Georgia insurance networks. While Medicaid members have coverage for all three medication types and counseling, the provider networks generally do not include NTPs (particularly for managed care members), and buprenorphine treatment may be delayed or restricted due to prior authorization or step therapy requirements.
- **State Restriction** – When under the supervision of state entities, individuals' ability to obtain MAT for opioid use disorder is inconsistent across the state. Adult felony drug court judges, community supervision officers, and DFCS caseworkers indicated they had generally not received training on MAT and may prohibit individuals from utilizing it. Agency policies generally did not address this as an appropriate form of treatment.

When individuals cannot access MAT, they may seek other less effective treatments or no treatment at all, increasing the risk of trauma, violence, communicable diseases, and death. Opioid use disorder also results in higher societal costs, leading to increased spending for healthcare, criminal justice, and social services.

Efforts to assist individuals misusing opioids should be derived from a comprehensive strategic plan that identifies priorities, assigns actions to relevant entities, creates timelines, and evaluates outcomes. The Department of Public Health is now developing a plan that will cover the continuum of activities to address the opioid epidemic, from prevention to treatment.

What we recommend

We recommend the continued development of a statewide plan addressing the full continuum of activities related to prevention and treatment. The plan's treatment component should address state activities that will increase access to MAT—including increasing the number of MAT providers; providing resources and training to practitioners, state supervising officials, and the public; and mitigating barriers to public insurance coverage. A detailed listing of our recommendations can be found in Appendix A.

***Summary of responses**: The Departments of Behavioral Health and Development Disabilities, Community Health, Community Supervision, Human Services, and Public Health generally agreed with the findings and recommendations. The Council of Accountability Court Judges provided technical corrections that were incorporated in the final report. The Georgia Composite Medical Board and Council of Juvenile Court Judges declined to comment. Specific responses are included at the end of each relevant finding.*

***Report Revision**: On August 13, 2018, minor revisions were made to the report to correct data. In Appendix D, overdose reversal counts were changed for Region 4. The revisions do not change the report's findings, conclusions, or recommendations.*

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Purpose of the Audit

This report examines the extent to which Georgians with an opioid use disorder have access to medication-assisted treatment (MAT). Specifically, the audit answered the following questions:

1. Is there a sufficient number and distribution of MAT providers able to treat individuals with opioid use disorder?
2. Do practitioners and state agencies direct individuals with an opioid use disorder to available MAT?
3. Are individuals able to pay for the treatment they need for opioid addiction?
4. Where do individuals go when they are unable to access MAT providers?

A description of the objectives, scope, and methodology used in this review is included in Appendix B. A draft of the report was provided to the various state entities under review, and pertinent responses were incorporated into the report.

Background

According to the Centers for Disease Control and Prevention (CDC), more than 680 million opioid prescriptions were filled between 2014 and 2016. These medications treat pain by attaching to receptors in the brain, spinal cord, and other areas of the body to suppress the central nervous system and, at the same time, create feelings of pleasure, relaxation, and euphoria. Common prescription opioids include morphine, hydrocodone (Vicodin) and oxycodone (OxyContin).

***Opioid Use Disorder**: A medical condition that impairs health and function after prolonged opioid misuse*

While opioids have been frequently prescribed for legitimate pain management, their extended use changes the way nerve cells function in the brain, resulting in a tolerance and eventual dependence in the body. This tolerance and dependence can lead to potential misuse, which may result in an opioid use disorder.[1] In some cases, if prescription opioids are no longer available or unaffordable, the individual may seek out illicit drugs such as heroin to fulfill cravings. This further increases the risk of overdose and death.

The CDC estimates nearly 64,000 Americans died of a drug overdose in 2016, a 20% increase from 53,000 in 2015. Nearly 83% of those deaths were due to prescription and illicit opioids. Other consequences of the opioid epidemic include lost productivity, increased criminal justice costs, and increased healthcare costs.

Opioid Epidemic in Georgia

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that in 2012-2014 an average of 4.5% of Georgians aged 12 and older used pain relievers for non-medical use—slightly higher than the national average of 4.3%.[2] This equated to nearly 390,000 Georgians in 2016. SAMHSA data indicates approximately 44% of non-medical users (or approximately 170,000 Georgians) have

[1] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* defines opioid use disorder as a problematic pattern of opioid use leading to clinically significant impairment or distress. At least 2 of 11 criteria must be present in a 12-month period (e.g., taking opioids in larger amounts or longer than intended; using that results in failure to fulfill obligations; experiencing withdrawal).

[2] Based on responses to SAMHSA's National Survey on Drug Use and Health.

a disorder. SAMHSA also recently estimated approximately 0.15% of Georgians had used heroin in the past year, which equates to nearly 13,000 people in 2016.

SAMHSA's survey results indicate certain areas of the state (using treatment regions designated by the Department of Behavioral Health and Developmental Disabilities—see Appendix C) have larger proportions and higher numbers of Georgians who misuse prescription opioids or have developed a disorder. As shown on **Exhibit 1** below, Region 2 (East/Central Georgia) had the highest percentage of individuals who reported non-medical usage of prescription pain relievers (5%). However, the more populous Regions 1 (North Georgia) and 3 (Metro Atlanta) had the highest number of Georgians who reported non-medical use and potentially have an opioid use disorder.

Exhibit 1
Individuals Who May Have an Opioid Use Disorder Are Concentrated in Northern Regions of Georgia, CY 2016[1]

DBHDD Regions	Population (Ages 12+)	Non-Medical Use of Prescription Pain Relievers (%)	Non-Medical Use of Prescription Pain Relievers (#)	Estimated # with Opioid Use Disorder[2]
Region 1 – North	2,278,702	4.49%	102,285	45,005
Region 2 – East/Central	1,105,983	4.96%	54,835	24,128
Region 3 – Metro Atlanta	2,623,744	4.18%	109,777	48,302
Region 4 – Southwest	505,398	4.59%	23,192	10,204
Region 5 – Southeast	954,021	4.77%	45,526	20,032
Region 6 – West/Central	1,186,854	4.30%	50,984	22,433
Statewide	**8,654,702**	**4.47%**	**386,842**	**170,210**

[1] These numbers do not reflect the population that may have a heroin use disorder.
[2] Based on SAMHSA data, which indicates 44% of non-medical users having a pain reliever use disorder.
Source: SAMHSA, U.S. Census Bureau

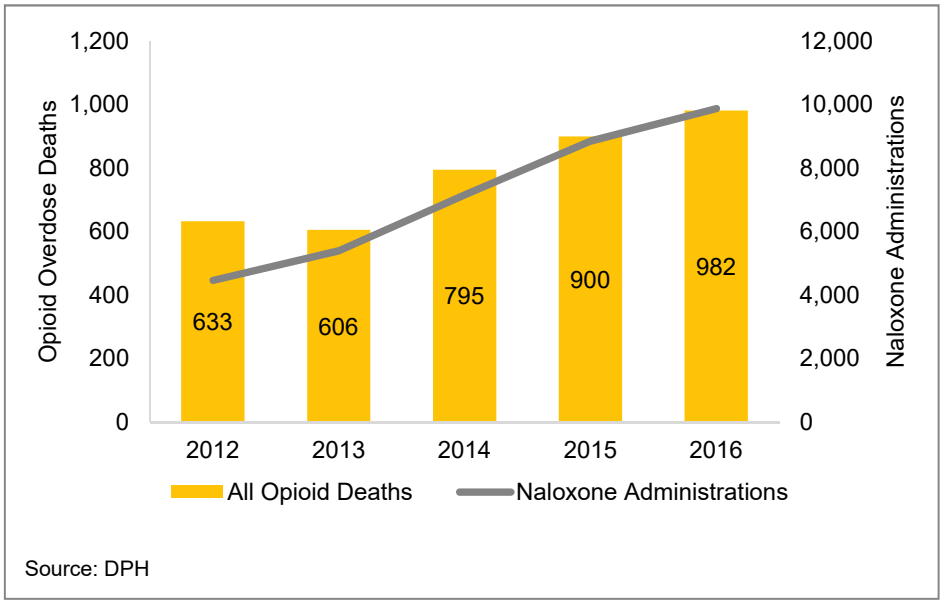
As shown in **Exhibit 2**, the number of statewide opioid-related deaths has increased by 55% from 633 in 2012 to nearly 1,000 in 2016. The statewide age-adjusted death rate[3] also increased from 6.3 per 100,000 in 2012 to 9.4 deaths per 100,000 in 2016. Approximately 70% of Georgia counties (112) had at least one opioid-related death in 2016, with age-adjusted death rates ranging from 3.0 to 34.1 per 100,000.

In addition, Georgia has experienced an increase in the number of overdose reversals performed by Emergency Medical Services (EMS) technicians. As shown in **Exhibit 2**, EMS utilized naloxone to revive individuals who overdosed on opioids nearly 10,000 times in 2016, up approximately 120% from nearly 4,500 in 2012. These administrations occurred at least once in all but six counties in 2016, with rates ranging from 1.8 to 332.3 per 100,000.

Overdose deaths and reversals were prominently concentrated in Regions 1 and 3, comprising approximately 64% of each total. Death and naloxone administration rates were generally higher in rural counties. See Appendix D for information on population, deaths, and overdose reversals by county and DBHDD region.

[3] The age-adjusted death rate is a weighted average of age-specific mortality rates that accounts for the proportion of the population within a particular age group (based on the 2000 U.S. census). Using the age-adjusted death rate controls for age structure differences that may exist in different geographic areas.

Exhibit 2
Opioid-Related Deaths and Naloxone Administrations in Georgia Are Increasing Annually, CY 2012-2016



Source: DPH

Medication-Assisted Treatment

As noted above, opioids target the pleasure centers of the brain, releasing large amounts of dopamine. Opioid use disorder occurs when the brain is "taught" to keep taking the opioid to sustain that level of euphoria, resulting in impaired health and functioning. As a result, substance abuse experts—including federal health entities and national physicians groups—recommend a combination of medication and counseling, known as mediation-assisted treatment (MAT), to assist in recovery.

***Medication-Assisted Treatment**: The use of medications in combination with counseling and behavioral therapies to treat opioid use disorder*

According to a 2016 Surgeon General report, medications for treating opioid use disorder can be used to reduce cravings, lessen withdrawal symptoms, and maintain recovery. The medications help the patient function without illicit opioids while "balance is gradually restored to the brain circuits that have been altered by prolonged substance use." Depending on the severity of the disorder, individuals may utilize medication for weeks, months, or even years.

The Surgeon General report notes, however, that medication alone is not effective for treating opioid use disorder. Rather, the medication stabilizes the patient to help ensure he or she can effectively participate in evidence-based behavioral therapies that will assist with underlying behaviors and issues that led to the addiction. Such therapies prepare the individual for continued self-management and recovery after the treatment ends.

Three medication types are used in MAT for opioid use disorder: methadone, buprenorphine, and naltrexone, which are described below and in **Exhibit 3**. These medications come in various doses and formulations. Due to the varied nature of individuals with opioid use disorder, SAMHSA, CDC, the National Institute for Drug Abuse (NIDA), and other agencies recommend that all forms of MAT be available to improve the patients' chance of recovery.

Exhibit 3
Effective MAT Is Composed of Medication, Counseling, and Lab Testing

		Office-Based Opioid Treatment	
	Methadone	**Buprenorphine**	**Naltrexone**
Medication	-Long acting synthetic opioid -Average dose 60-120 mg -Effectively treats moderate to severe opioid addiction -Daily administration at federally licensed clinic (NTP)	-Long-acting synthetic opioid -Effective for withdrawal maintenance or individuals on lower dosage of opioids -Available by prescription from physician with federal waiver	-Completely blocks the effects of opioids -Must be completely off opioids for 7 to 10 days -Oral form available by prescription from any physician -Injectable form administered monthly by any physician
+			
Counseling	Federally required component of treatment at NTP	Obtained from prescribing physician or an outside provider	
+			
Lab Testing	Federally required component of treatment at NTP	Obtained from prescribing physician or an outside provider	

Source: Literature Review

- **Methadone** – Methadone is an opioid, but unlike heroin or other short-acting opioids, it is effective for 24 to 30 hours. As a long-acting opioid, methadone stabilizes the patient by preventing the peaks and valleys associated with drug-seeking behavior. Methadone is recommended for treating long-time or heavy opioid users.

  Methadone, which has the potential for abuse, can only be obtained for treatment from federally and state licensed clinics known as narcotic treatment programs (NTPs). NTPs operate under federal and state guidelines that include providing medical, counseling, and other services in addition to the medication. NTPs must also employ a medical director and a certain number of counselors to fulfill ratio requirements. Patients must visit NTPs six days a week to obtain their medications in the initial stages of treatment; as they progress, they may be allowed to take home doses to avoid daily visits.

  At the beginning of fiscal year 2018, 72 NTPs operated in Georgia, mostly concentrated in Metro Atlanta and Northwest Georgia (see Appendix E). In February 2017, NTPs served an estimated 10,000 Georgians.

- **Buprenorphine** – Buprenorphine is similar to methadone, but because it has a maximum effective dose, it may not be suited for individuals with severe opioid use disorder. Multiple buprenorphine-based medications have been approved for MAT, with Suboxone as the most common.

  Physicians who are certified in addiction medicine or complete eight hours of training may apply to SAMHSA for a waiver to prescribe buprenorphine to treat opioid use disorder. In their first year, physicians may only treat up to 30

patients; in subsequent years, they can apply to increase the limit to 100 or 275. Federal law requires prescribing physicians to counsel their patients themselves or refer to an outside provider.

According to SAMHSA data, 764 physicians had obtained the waiver to prescribe buprenorphine as of February 2017. Half of Georgia's counties had at least one of these physicians (see Appendix F). In fiscal year 2017, nearly 460 physicians wrote a prescription for buprenorphine medications approved for treatment. These physicians served approximately 16,800 individuals.

- **Naltrexone** – Unlike methadone and buprenorphine, naltrexone completely blocks the euphoric and sedative effects of opioids like heroin, morphine, or oxycodone. Patients must be detoxified of any opioids in their system for 7 to 10 days prior to naltrexone treatment. Naltrexone commonly comes in oral doses but is also available as an extended-release, monthly injection (Vivitrol). Any physician can write a prescription for naltrexone, but it is typically prescribed by addiction specialists.

  According to the Surgeon General, naltrexone may be appropriate for people successfully treated with methadone or buprenorphine; those who prefer not to take the other two medications; individuals who are being released from incarceration into an environment where drugs may be used; and adolescents and young adults with opioid dependence.

MAT Effectiveness

Multiple studies have demonstrated MAT's effectiveness when compared to abstinence-only treatments (i.e., detoxification with counseling) or no treatment at all. According to a literature review[4] sponsored by the American Society of Addiction Medicine (ASAM) and NIDA, there is "substantial, broad, and conclusive evidence" for all three medications' effectiveness.

As shown in **Exhibit 4**, ASAM's review found that all three medications—particularly methadone and buprenorphine—are effective in several metrics, including suppressing withdrawal symptoms, retaining patients in treatment, reducing opioid use, and reducing opioid-related health and social problems. ASAM notes, however, that effectiveness is dependent upon using the medication in conjunction with counseling, social supports, and behavioral change strategies. A summary of the literature review by medication is below.

- **Methadone** – Methadone has been used to treat opioid use disorder for more than 50 years and is the most studied MAT medication. These studies have generally found that methadone is more effective than non-pharmacological approaches in treatment retention and suppression of illicit opioid use. For example, one study of parolees found that those who had received methadone prior to their release remained in treatment seven times longer than those who received only counseling, and only 25% tested positive for opioids compared to 66%. Studies also show that methadone maintenance may reduce criminality and lower healthcare costs for individuals with an opioid use disorder.

[4] Review of 75 empirical articles published between 2008 and 2013.

Exhibit 4
MAT Is More Effective Than Counseling Only or No Treatment

Compared to those receiving counseling only or no treatment, individuals on MAT were:	
More Likely to:	**Less Likely to:**
Remain in treatment Abstain from illegal drugs Avoid returning to their drug of abuse	Contract infectious diseases related to IV drug use (e.g., HIV, Hepatitis C) Engage in criminal behaviors associated with drug use

Source: Literature review

- **Buprenorphine** – Higher doses of buprenorphine are generally comparable to methadone at retaining individuals in treatment, though at any dose it has been found to be more effective than counseling only or no treatment. One set of studies found, for example, that after six months, 50% to 60% of the patients receiving MAT with buprenorphine were still in treatment, compared to 25% to 40% of those receiving abstinence-only treatment. Buprenorphine has also been found to be effective for detoxification compared to non-opioid based approaches.

- **Naltrexone** – Naltrexone is the least researched treatment medication for opioid use disorder, and studies comparing it to other MAT medications are not common. Treatment adherence is generally low for the oral form, unless the individual has external motivators like potential loss of job or criminal justice sanctions. The injectable form (Vivitrol) has been found to increase compliance and proven effective at lowering relapse rates (43% among recipients compared to 64% among non-recipients).

Despite scientific evidence demonstrating MAT's effectiveness, some studies have found that practitioners do not believe medications have a role in treating opioid use disorder and that abstinence-based treatment is sufficient. Likewise, some reports have noted that within the criminal justice system, officials believe MAT is substituting one drug for another and cite concerns over the risk of diversion (i.e., transferring the medication to another person for illicit use). Finally, the perceived stigma about the use of MAT makes patients reluctant to seek out that form of treatment, even when they need it.

Georgia Entities

Numerous state entities are involved with the treatment of opioid use disorders. Healthcare agencies oversee and fund substance abuse treatment services and providers, manage insurance plans that cover substance abuse treatment services, and collect data on opioid misuse and abuse. Other state entities and their staff may have direct contact with Georgians with opioid use disorder or their families through the criminal justice or social services systems. These entities are described below.

State Healthcare Agencies

State healthcare agencies address the opioid epidemic through mission-oriented activities. To perform these activities, agencies receive a combination of state and federal funds.

- **Department of Behavioral Health and Developmental Disabilities (DBHDD)** – DBHDD focuses on policies, programs, and services for people with mental illness, substance use disorders, and development disabilities who are unable to pay for treatment themselves.

  DBHDD's Division of Addictive Diseases funds community service boards (CSBs)[5] and other providers that serve individuals with substance abuse disorders. These providers offer a range of services that include residential and outpatient care, crisis stabilization, and specialty services. Two NTPs are included in the provider network and receive approximately $1 million per year to treat indigent patients.

  The division has been designated by SAMHSA as the State Opioid Treatment Authority (SOTA) to serve as a contact between SAMHSA and NTPs. SOTAs' roles vary by state and may include handling treatment exemption requests or providing NTP accreditation technical assistance. In Georgia, the SOTA maintains the NTPs' registry of active patients, which NTPs must check to ensure patients are not concurrently enrolled.

- **Department of Public Health (DPH)** – DPH's overall mission is to prevent diseases, injury, and disability, as well as promote health and wellbeing. While direct activities related to opioid use have been limited, DPH's Office of Health Indicators has recently begun publishing the number and rate of overdose deaths in the state. Additionally, in fiscal year 2018, DPH began overseeing the state's Prescription Drug Monitoring Program (PDMP), which tracks prescriptions for controlled substances such as prescription painkillers. Practitioners can review the PDMP to identify signs of addiction.

  DPH also oversees healthcare staff and first responders who may interact with individuals with opioid use disorder. Specifically, each county has a health department funded by DPH that provides direct healthcare and population-based services to residents. DPH also regulates Georgia's Emergency Medical Services, which may administer naloxone to reduce the effects opioid overdoses.

- **Department of Community Health (DCH)** – While DBHDD directly addresses substance abuse, DCH operates public and private insurance plans that cover various substance abuse treatment benefits. As the designated state agency for Medicaid, DCH serves nearly two million eligible low-income Georgians. Nearly 1.4 million Medicaid members (primarily low-income children and pregnant women) receive coverage through one of four[6] care management organizations that receive a capitated rate per member from DCH. The remaining Medicaid population (primarily aged, blind, and disabled) receives care through the traditional fee-for-service arrangement. DCH also administers the State Health Benefit Plan, which provides healthcare coverage for more than 646,000 state employees, public school personnel, retirees, and dependents.

[5] CSBs are quasi-governmental organizations that provide mental health and substance abuse services to the public.

[6] Prior to fiscal year 2018, there were three CMOs: Amerigroup, Peach State, and WellCare. The fourth, CareSource, was included in the newest contract.

Additionally, as previously discussed, DCH's Healthcare Facility Regulation Division licenses and inspects healthcare facilities statewide, including NTPs and other substance abuse treatment facilities.

Other State Entities

Several state entities encounter individuals with opioid use disorder while exercising duties related to their missions. In surveys and interviews, criminal justice and social services entities noted that encounters with individuals with opioid use disorders are increasing. These entities are discussed below.

3,647

DCS Day Reporting Center participants, FY 2017

- **Department of Community Supervision (DCS)** – DCS officers supervise approximately 180,000 felony offenders in the community who are on either probation or parole. If the individual has a documented history of substance abuse, supervision requirements may include drug screens or counseling.

  Probationers and parolees who have substance abuse or mental health issues may also be referred to one of DCS's 15 non-residential treatment centers known as Day Reporting Centers (DRC). DRC treatment consists of educational programming, counseling, and close supervision to change criminal behavior. In rural areas, 17 DRC-Lite programs work to transition offenders with drug addictions back into the community. In fiscal year 2017, nearly 3,650 probationers and parolees participated in a DRC or DRC-Lite.

↑81%

Drug-related removals by DFCS, FY 2013-2017

↑58%

Drug-related family preservation stages by DFCS, FY 2013-2017

- **Division of Family and Children Services (DFCS)** – A division of the Department of Human Services, one of DFCS's primary responsibilities is to investigate reports of child abuse or neglect, which have become more prominently related to substance abuse. Between fiscal years 2013 and 2017, the number of children entering the foster care system due to substance abuse increased by 81% from nearly 1,600 to approximately 2,800. The proportion of removals related to substance abuse also increased—from approximately 60% in 2013 to 70% in 2017. DFCS also noted substance abuse is more frequently related to cases in which the child is not removed from the home but the family receives support services—a nearly 60% increase from 4,400 in fiscal year 2013 (comprising 24%) to nearly 7,000 in fiscal year 2017 (comprising nearly 40%).

  According to DFCS staff, when a case is opened, the child's safety and the caregiver's capacity are assessed to determine whether the child can remain in the home. If the caregiver is suspected of having a substance abuse issue (such as an opioid use disorder), they are referred to a substance abuse assessor that recommends a treatment plan that is incorporated into an overall care plan. DFCS cases are closed when a caregiver completes the DFCS care plan.

  If a child is removed from the home, the case is brought before the juvenile court. While all 159 juvenile courts can deal with individuals with opioid use disorders, 17 juvenile courts operate a family treatment court to provide greater supervision over caregivers' progress. Between fiscal years 2014 and 2016, these courts reported a 31% increase in the number of caregivers with an opioid use disorder, from 130 participants in fiscal year 2014 to 170 participants in fiscal year 2016. The proportion of caregivers with opioid use

disorders decreased slightly from approximately 25% in fiscal year 2014 to 20% in fiscal year 2016.

- **Adult Felony Drug Courts** – These accountability courts provide an alternative form of sentencing for nonviolent offenders who meet eligibility criteria (e.g., offenders who are at risk for re-arrest and have treatment needs). Treatment programs are typically 18 to 24 months long and include substance abuse assessments, group/individual/family counseling, drug and alcohol testing of participants, supervision in the community by law enforcement officers, and ongoing judicial hearings. Standards for these courts (as well as family treatment courts and other accountability courts) are established by the Council of Accountability Court Judges.

  Between fiscal years 2014 and 2016, the number of adult felony drug court participants with opioid use disorders increased by approximately 30%, from 1,530 in fiscal year 2014 to nearly 2,010 in fiscal year 2016. The proportion of adult felony drug court participants reporting an opioid addiction increased from nearly 20% in fiscal year 2014 to 22% in fiscal year 2016.

↑31%

Adult felony drug court participants reporting an opioid addiction, FY 2014-2016

Findings and Recommendations

The state does not yet have a comprehensive strategy to address the opioid epidemic, which would include ensuring Georgians have access to MAT.

While action has been taken to address the opioid epidemic in Georgia, the efforts do not derive from a coordinated statewide strategy aimed at preventing and treating opioid use disorder. Such a strategy is necessary to ensure all state entities are taking required action and that state funding is provided to assist this expanding population. A lack of effective action leads to increased costs in the state's healthcare, social services, and criminal justice system.

While this audit focuses on access to medication-assisted treatment, a statewide strategy to address the opioid epidemic must include a full continuum of activities—from prevention to treatment and recovery.

The National Governors Association (NGA) recommends that a state working group or task force develop and execute a strategic work plan that identifies policy priorities, outlines actions and responsible entities, creates timelines, and includes evaluation metrics. Access to treatment is one component of the NGA's recommended plan, along with prevention, early identification, and reducing the supply of illicit opioids. Recent studies by Georgia organizations such as the Criminal Justice Coordinating Council and the Substance Abuse Research Alliance have also recommended a coordinated approach to achieve statewide goals.

Nearly every contiguous and best practice state[7] we reviewed had developed plans that identify priority areas and actions to address the opioid epidemic. For example, Washington's plan includes goals to prevent inappropriate prescribing and medication misuse, prevent overdose deaths, link individuals to treatment, and use data to evaluate success. The treatment goal has multiple strategies and related actions (see **Exhibit 5** for an example). Each action is assigned to a lead party, and the status is monitored in a progress report. North Carolina's plan includes a treatment and intervention goal with metrics such as the number of buprenorphine providers and patients, the amount of state and federal resources available for treatment, and the number of emergency department visits among Medicaid patients receiving MAT.

Under a CDC grant, DPH has begun developing a statewide strategic plan that will include goals and activities for prevention, treatment, and law enforcement. DPH intends to utilize the Attorney General's State Opioid Task Force[8] (created in October 2017) to collaborate with various stakeholders on the final draft and communicate the plan to state and private entities.

Despite the absence of a strategic plan, in recent years, some Georgia entities have taken action to address the opioid epidemic. During the 2017 legislative session, for example, bills were passed to address opioid prescribing, the availability of the overdose reversal drug naloxone, and the regulation of NTPs. Recent action to expand treatment to those with opioid use disorder has been limited to a DBHDD policy change that resulted in the addition of several NTPs to the Medicaid network, as well as time-limited federal grants to DBHDD (see box on page 12) and some courts.

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[7] We interviewed staff from the contiguous states as well as Washington, Ohio, and Massachusetts, which were identified as best practice states by national organizations.

[8] The Attorney General's State Opioid Task Force is intended to be a communication platform for entities active in the opioid crisis who voluntarily join. The purpose of the task force is not to create a strategic plan, assign actions to particular entities, or monitor progress using defined metrics.

Exhibit 5
Washington's State Plan Includes Strategies and Actions to Increase MAT

Goal	Strategy	Actions
Link individuals with opioid use disorder to treatment support services	Expand access to and utilization of opioid use disorder medications in communities	Identify policy gaps and barriers that limit availability and utilization of buprenorphine, methadone, and naltrexone and develop policy solutions to expand capacity
		Provide technical assistance to county health officers to advocate for expanded local access to medications
		Build up supports to help medical providers and staff implement and sustain buprenorphine treatment
		Increase the number of opioid treatment programs that offer methadone and/or buprenorphine

Source: Washington State Interagency Working Plan (excerpt)

While these efforts are notable, a broader statewide strategy is necessary to ensure all relevant entities are collaborating to reduce addiction and overdose deaths in Georgia. Currently, state entities are generally left to determine whether and how they will manage the issue as it pertains to the scope of their work. Over the course of the audit, we identified instances in which this decentralized approach has exacerbated the barriers individuals face when seeking to obtain or maintain needed MAT. As discussed in subsequent findings:

- **Roles and responsibilities are not assigned** – Without a strategy to designate entities responsible for specific tasks, activities necessary for expanding utilization of MAT have not been performed. For example, no agency is clearly responsible for evaluating the need for additional MAT providers or educating and recruiting new buprenorphine prescribers. DPH has broad responsibility to address public health threats but not to take specific actions. DBHDD focuses on providing resources to its own provider network but does not assess statewide need or communicate with the broader provider community. Finally, the Georgia Composite Medical Board licenses and investigates physicians but does not routinely disseminate information on public health topics.

- **No consensus on the merits of MAT** – While some agencies have acknowledged the merits of MAT for individuals with opioid use disorder, other state entities have not created policies that ensure individuals have access to this best practice treatment. For example, the state Medicaid program covers MAT and DBHDD supports this form of treatment, but drug courts or probation programs may restrict individuals from obtaining the treatment. Restriction or allowance may even vary within the same entity depending on the area of the state or the staff to whom the individual is assigned.

- **Insufficient coordination** – Some state policies and practices require cooperation by other agencies to maximize effectiveness. For example, in 2016 DBHDD recognized the need for individuals on Medicaid to access methadone and changed its rules to allow NTPs to become Medicaid providers. Despite the expansion of services for this population, DCH did not notify the CMOs of this new provider group. As a result, managed care members outside metro Atlanta and Northwest Georgia are still unable to obtain methadone, even if a nearby NTP became a Medicaid provider. Likewise, as discussed above, while DBHDD has obtained funding to increase access to MAT and promote its merits, courts and community supervision offices may not allow individuals under their purview to utilize this best practice treatment.

- **Limited funding** – While the state funds MAT through Medicaid, a large proportion of low-income individuals with opioid use disorder are not eligible for Medicaid in Georgia. Because they are likely unable to pay for treatment out of pocket, this uninsured population instead must rely on DBHDD's substance abuse treatment provider network (see page 45 for costs). DBHDD dedicates approximately $950,000 per year to offer sliding scale pricing for methadone at two NTPs that operate in Metro Atlanta and Athens. According to agency staff, DBHDD has been unable to offer MAT within its broader provider network due to lack of funding. As a result, the state must rely on a time-limited federal grant to expand access to MAT for low-income, uninsured individuals (described in the below box and on page 45).

While Georgia provides limited funding to MAT, it does spend significant funds on other activities impacted by opioid addiction. In addition to indirect costs such as loss of workplace productivity, research has shown that opioid use disorder impacts direct costs related to healthcare, criminal justice, and social services. Staff in these state entities indicated opioid use disorder in their area is increasing, leading to more contacts with these individuals in probation and parole offices, adult felony drug courts, and DFCS county offices, as well as higher healthcare costs among those who do qualify for Medicaid. These state costs—a portion of which would likely be mitigated with increased funding for MAT—are described below.

- **Increased criminal justice and social services costs** – A majority of respondents to our stakeholder surveys (including adult felony drug court judges, juvenile court judges, DCS officers, and DFCS county directors) indicated they often see individuals with opioid use disorder, and an even larger majority stated opioid use disorder has increased in their area over the past two years. This has contributed to increased state funding for additional caseworkers to reach recommended caseloads in county DFCS offices. Similarly, individuals who violate terms of their probation or parole (e.g., failed drug screens) may be incarcerated or require additional DCS supervision, both of which require additional state dollars or resources.

Georgia Targeted Response to the Opioid Crisis Grant

In May 2017, DBHDD received a two-year $23.6 million federal grant to address the opioid crisis with prevention, treatment, and recovery initiatives. DBHDD has dedicated approximately $9 million annually for treatment-related activities that include implementing MAT in nine of its provider locations, piloting Vivitrol in the Department of Corrections, and providing MAT training to various stakeholders statewide.

- **Increased healthcare costs** – In a recent report, DCH estimated it paid $174 million for nearly 11,000 Medicaid members with opioid use disorder in calendar year 2016—nearly $16,000 per person compared to approximately $3,600 for all Medicaid members. Nearly 90% ($155 million) of the total was for emergency room visits, inpatient hospital stays, outpatient services, and medications other than those approved for MAT. Approximately 8% ($14 million) was spent on inpatient or outpatient behavioral health services, and only 3% ($4.4 million) was for MAT medications. Just 1,300 members (12% of those with an opioid use disorder) obtained an MAT medication.

  Additionally, as discussed on page 45, DBHDD has paid approximately $7.4 million in each of the past three fiscal years (and an estimated $9 million in fiscal year 2017) on services to address opioid diagnoses, which includes repeated efforts to detoxify some individuals off opioids. This funding supports primarily non-MAT services, which are generally less effective than MAT.

  Studies have found that patients on MAT had fewer healthcare costs compared to those receiving counseling only or no treatment. In one study, for example, total costs for individuals receiving MAT averaged approximately $13,500, compared to $17,000 for those who received counseling only and $31,000 for those who received no treatment for their addiction.

While every individual with opioid use disorder would not successfully recover using MAT, studies have shown this to be the most effective form of treatment for this addiction. Additional funding would likely offset a portion of costs currently incurred.

RECOMMENDATIONS

1. In creating the statewide strategic plan, DPH should involve key stakeholders, including state officers in behavioral health, public health, Medicaid, public safety, corrections, and social services. The state plan should include activities related to preventing, monitoring, and treating opioid use disorder; define lead entities for specific tasks; and create evaluation metrics.

2. The General Assembly should consider directing funds to MAT-related activities within DBHDD, as well as adult felony drug courts and DCS day reporting centers, to ensure access to this best practice treatment among individuals unable to pay for it themselves.

DBHDD Response: *DBHDD agreed with the finding and recommendations and stated it "is in the process of working with other state agencies to develop a comprehensive statewide strategy to address the opioid epidemic in an effort to ensure that all Georgians have access to MAT." DBHDD also stated it is "ready to implement any new programs or services upon new available funding."*

DCH Response: *DCH agreed with the finding.*

DHS Response: *DHS stated DFCS "will work with DPH and other stakeholders to develop a statewide plan. DHS agreed that additional funding is needed to improve capacity and access to treatment."*

***DPH Response**: DPH stated it is currently developing the strategic plan and arranging meetings to obtain input from multiple agencies and organizations that are part of the Attorney General's State Opioid Task Force. DPH stated the report was "very helpful in identifying critical areas that need to be addressed" and that it will use the audit "extensively as a guide for much of what will be included in the medication-assisted treatment portion of the strategic plan."*

While most Georgians live within 20 miles of both an NTP and a buprenorphine prescriber, the state likely does not have an adequate supply to meet current need.

Due to the geographic distribution of NTPs and active buprenorphine prescribers, most Georgians can travel fewer than 20 miles to reach an MAT provider. However, individuals in certain rural areas of the state travel further than 20 miles to reach an NTP, which can be burdensome for the required daily visits. Additionally, while buprenorphine prescribers are located throughout the state, they generally do not serve the number of patients allowed, leading to less treatment capacity than may be anticipated.

Best practice literature states that individuals with opioid use disorder need access to all forms of MAT medications since patients' treatment needs depend on the severity of their addiction. Only 41 Georgia counties (26%) have both methadone and buprenorphine prescribers within their borders; generally these are the most populous counties with higher numbers and rates of opioid-related deaths and opioid reversals using naloxone. However, some counties that do not have either an NTP or a buprenorphine prescriber also have overdose rates higher than the statewide average. See Appendix D for data related to counties and DBHDD treatment regions.

While available data have been used to generally describe opioid utilization and overdose deaths, no state entity has evaluated the capacity of MAT providers in Georgia to determine whether it is sufficient. Identifying areas of need based on overdose deaths, naloxone administrations, and other metrics may prompt new state activity such as recruiting physicians to become buprenorphine prescribers. Likewise, an awareness of high-need areas may help influence decisions to license NTPs seeking to operate in the area.

In acknowledging the need for more providers, other states have worked to increase the number of buprenorphine prescribers in particular by

- promoting the waiver through the state medical board;
- increasing reimbursement rates for treatment activities to ensure buprenorphine prescribers join the Medicaid network; and
- allowing advanced nurse practitioners or physicians' assistants to prescribe buprenorphine or, alternatively, encouraging registered nurses to manage office visits, assessments, and paperwork while their waivered physician prescribes the buprenorphine.

Effective MAT requires more than medication

We interviewed multiple stakeholders—including DBHDD staff, adult felony drug court judges, and DCS management—who expressed concern that individuals receiving methadone and buprenorphine do not always obtain the proper counseling and behavioral therapy to assist in their recovery. Stakeholders and NTP staff indicated there were NTPs that only dispensed medication despite federal and state requirements to provide sufficient individual and group therapy to their patients. Additionally, in reviewing State Health Benefit Plan claims for 131 individuals receiving buprenorphine or naltrexone medications for opioid use disorder during all of calendar year 2016, we noted only about half (70) had a claim for counseling during the year. Less than 25 appeared to attend counseling approximately once a month. Finally, while labs may be necessary to ensure the individual is using the medication properly and is experiencing no adverse effects, approximately 60% (78) of SHBP members receiving medication had not obtained a lab test in 2016.

To better ensure MAT (i.e., medication plus counseling and lab work) is properly administered in NTPs, the state recently overhauled its process for approving and regulating NTPs. State law now codifies minimum standards of quality and services, requires a more rigorous enrollment process, and requires annual on-site inspections. Physicians prescribing buprenorphine receive their waiver from the federal government and are not regulated by the state. However, state entities such as the Georgia Composite Medical Board and the Department of Public Health can educate these providers on how to create an infrastructure to provide sufficient counseling and perform lab work or refer to appropriate outside providers.

As described below, while providers are located across the state, more NTPs and buprenorphine prescribers are likely needed to increase access to and capacity for treatment.

Methadone

Georgia has more NTPs than most contiguous states, and nearly 90% of Georgians are within 20 miles of at least one NTP. However, individuals in 63 counties likely travel further than 20 miles to reach the closest NTP, which can create a burden given the requirement to visit the NTP six days a week. Some of these counties have high rates of overdose deaths and reversals, which may indicate a need for an NTP.

As shown on **Exhibit 6**, Georgia's 72 NTPs are dispersed throughout the state, generally located in relatively populous counties that also have a high number of overdose deaths and reversals. This is expected because NTPs are for-profit entities that would locate in areas where the number of patients would generate the level of activity needed to successfully operate.

An NTP's capacity is not restricted as long as it meets counselor-to-patient ratios outlined in DCH's rules. NTPs we interviewed stated they typically do not turn patients away due to capacity issues. In February 2017, the number of patients served at each NTP ranged from less than 10 to nearly 1,000. We did not determine whether the capacity of NTPs was sufficient to meet demand in the surrounding area, though the gaps in NTP distribution indicate more may be needed to increase geographic access to methadone.

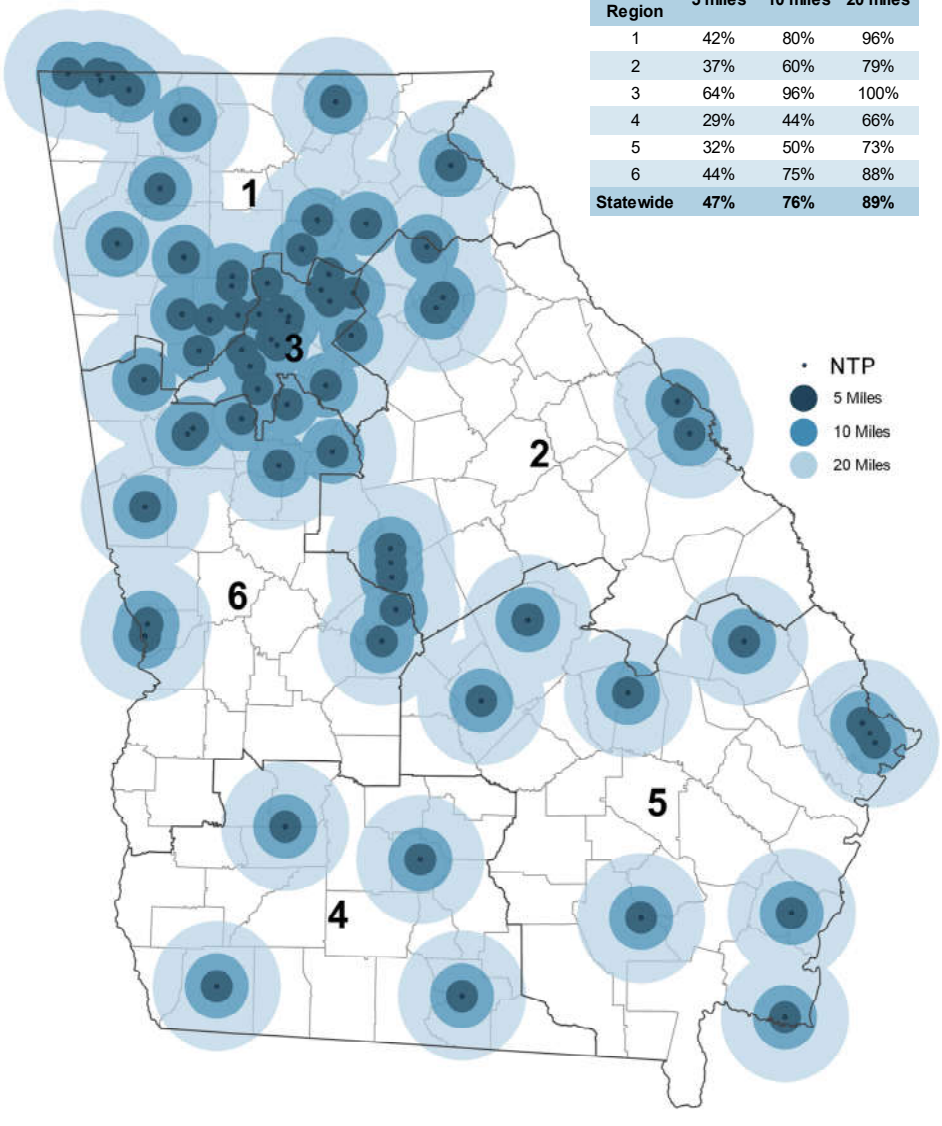
Legislation passed during the 2017 session designated a specific enrollment period for NTPs and created a more robust process for obtaining a license from DCH. Applicants must now present information about the prospective NTP and its staff, surrounding NTPs' patient levels, evidence of community input, and proof of intent to file with

nearby law enforcement and drug courts. It is unclear the extent to which the application's content would contribute to the licensure decision.

The new law also restricts the number of NTPs by regions that mirror judicial circuits, which may range from one county to eight counties. Four NTPs may operate in each of the 49 regions (this is already the case in four regions), though the law allows exceptions. DCH is finalizing rules that would pertain to this exception, and it appears the decision would be based on the applicant's description of need and community stakeholder support.

Exhibit 6
Individuals in Many East and South Georgia Counties Are More Than 20 Miles from an NTP, July 2017

DBHDD Region	5 miles	10 miles	20 miles
1	42%	80%	96%
2	37%	60%	79%
3	64%	96%	100%
4	29%	44%	66%
5	32%	50%	73%
6	44%	75%	88%
Statewide	**47%**	**76%**	**89%**



Source: DCH, U.S. Census Bureau

Some best practice states we reviewed have loosened licensure requirements to facilitate more NTPs opening; however, three contiguous states require NTPs to undergo a certificate of need process that is more rigorous (and thus limits the number of NTPs) than Georgia's new process.[9] DBHDD staff indicated Georgia's new process was modeled after North Carolina, which has 59 NTPs.

Buprenorphine

Based on SAMHSA's complete list of physicians who have obtained a waiver to prescribe buprenorphine, approximately half of Georgia's counties have at least one physician who can prescribe this medication. Approximately 70% of Georgians are within five miles of a physician that prescribed to at least one patient in fiscal year 2017, and nearly all are within 20 miles. However, the actual activity of these physicians suggests that patients seeking MAT with buprenorphine are not necessarily able to access this treatment.

Georgia's capacity to serve individuals with buprenorphine is likely less than the need. Based on a SAMHSA survey, we estimate approximately 180,000 Georgians have an opioid use disorder. While the portion of those individuals needing buprenorphine is unknown (some receive methadone or naltrexone; others may find counseling sufficient), Georgia's capacity to treat these individuals is lower than the contiguous states. Georgia's buprenorphine prescribers are able to serve as much as 22% of the population, while other states' prescribers can serve a maximum of 25% to 60%.

Examining maximum capacity to treat based on patient caps overestimates actual treatment levels. As shown in **Exhibit 7**, Georgia's buprenorphine prescribers serve approximately 34% of their patient capacity, which is still significantly less than the estimated number of Georgians who may need the treatment. In fiscal year 2017, approximately 16,800 individuals received at least one prescription for a buprenorphine-based medication approved for addiction treatment, compared to the nearly 50,000 that would be served if all physicians with the waiver were serving the maximum number their cap allows.

Such a gap in capacity and number served is not unique to Georgia. Studies on the impact of the federal waiver to prescribe buprenorphine have pointed to similar issues related to physician participation. Based on our review of literature, as well as Georgia prescription data and responses[10] to our physician survey, we identified several reasons why buprenorphine may not be accessible to individuals.

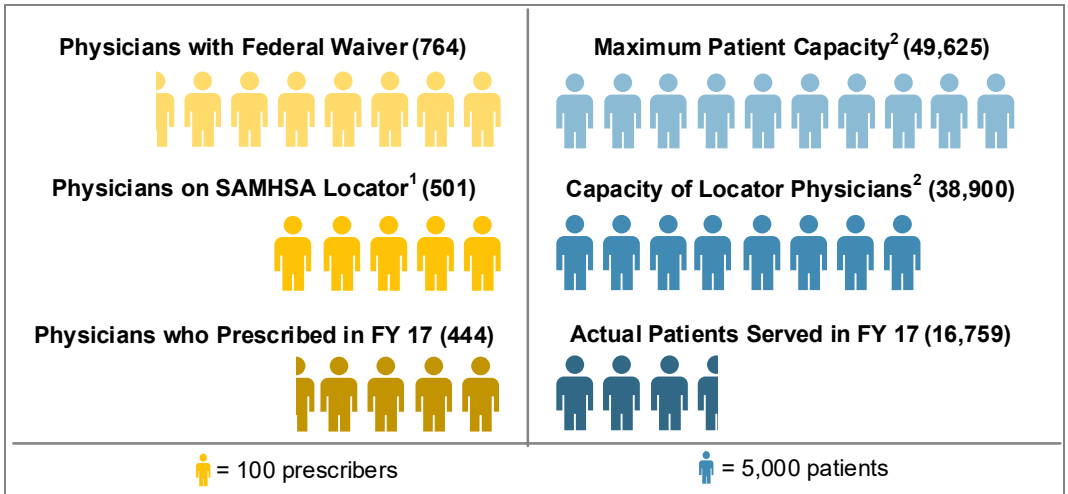
- **A small percentage of physicians obtain the waiver** – According to SAMHSA, 764 Georgia physicians have obtained the waiver as of February 2017. This comprises approximately 3% of the estimated 25,000 active physicians in Georgia, which is a lower proportion than other states that may have as much as 6% of their physician population. Certain specialties are more prominently represented than others, though only a small proportion of physicians with these specialties obtain the waiver. For example, psychiatrists make up nearly 40% of all buprenorphine prescribers; however, only 25% of psychiatrists have the waiver. Family practice and internal

[9] Alabama, South Carolina, and Tennessee require certificate of need.

[10] Surveys were successfully delivered to 413 physicians who indicated a willingness to be included on SAMHSA's physician locator. We received 155 responses—a response rate of 38%.

medicine specialists each comprise 14% of buprenorphine prescribers but less than 5% of all physicians in their respective specialty.

Exhibit 7
Sixty Percent of Georgia Buprenorphine Prescribers Serve One-Third of Allowed Capacity, Feb. 2017



[1] Number of physicians who agreed to be included in the SAMHSA physician locator, which individuals can access on SAMHSA's website to determine nearby providers.
[2] Calculated based on the total number of physicians with each patient cap (30, 100, or 275).
Source: SAMHSA, Prescription Drug Monitoring Program

- **Physicians may not advertise their ability to provide treatment** – SAMHSA's website[11] directs potential patients to providers in their area through a physician locator. Physicians may opt not to be included on this locator, which may indicate an unwillingness to serve new patients. Approximately two-thirds (501) of Georgia's buprenorphine prescribers allow SAMHSA to publish their contact information. While the distribution of these providers is not significantly different than the comprehensive list of physicians, individuals' knowledge of who can provide buprenorphine treatment is limited.

- **Physicians with the waiver may not actually provide the treatment** – Approximately 40% of physicians with the waiver did not prescribe a medication approved for addiction treatment in fiscal year 2017 (see **Exhibit 7**). Survey respondents who stated they were not prescribing buprenorphine (despite being on SAMHSA's locator) indicated it was because providing the treatment was time-consuming, it was never their intention to serve a large number, and/or opioid use disorder was generally not a problem among their patients.

- **Physicians treat fewer patients than their caps allow** – Of the 456 physicians that prescribed for addiction treatment in fiscal year 2017, approximately 60% served fewer than half the number of patients allowed;

[11] https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-locator

nearly 25% treated fewer than five patients for the year. Our survey of buprenorphine prescribers indicates that most treat fewer than 80% of their patient cap because they did not intend to treat a large number of patients when they obtained the waiver. Other reasons mentioned included a low demand, a low number of referrals, and lack of insurance coverage.

- **PAs and APRNs have not obtained the waiver** – The federal Comprehensive Addiction and Recovery Act of 2016 permits physicians' assistants (PAs) and qualifying nurse practitioners to obtain the waiver to prescribe buprenorphine.[12] Under Georgia law, PAs and advanced practice registered nurses (APRNs) can prescribe buprenorphine (as a Scheduled III controlled substance) if they are authorized by a job description (PAs) or a nurse protocol (APRNs). According to the Georgia Composite Medical Board and the Board of Nursing, Georgia law and regulation do not restrict these practitioners from obtaining the waiver. However, in the first six months following the act, only two of the approximately 4,300 PAs and none of the nearly 13,000 APRNs had done so.

Naltrexone

As previously described, naltrexone is not a controlled substance and does not require special certification to prescribe. As such, individuals seeking this type of medication are able to obtain it from any physician. However, naltrexone can only be utilized if the individual has completely detoxed from opioids, which would typically occur in a residential facility. Additionally, naltrexone would likely only be prescribed by physicians knowledgeable about addiction.

Data is not available on how many individuals have utilized naltrexone or who has prescribed it.

RECOMMENDATIONS

1. DPH should use available datasets to evaluate the need for and capacity to provide treatment (using all three medications) to individuals with an opioid use disorder.

2. DCH should ensure its new application process and rules are not overly burdensome so as to prevent NTPs from opening in identified areas of need.

3. DPH should ensure the state strategic plan identifies the entities that can encourage providers to obtain the waiver to prescribe buprenorphine through education and outreach. Certain specialties may be targeted, including psychiatrists, pain management specialists, and general practitioners, who may have the infrastructure to provide counseling and/or lab work in-house. PAs and APRNs could also be encouraged to obtain the waiver when their supervising physicians prescribe buprenorphine for MAT.

***DCH Response**: DCH agreed with the finding and recommendation.*

[12] The provision, effective until October 1, 2021, requires that nurse practitioners and physicians' assistants complete 24 hours of training to obtain the waiver.

DHS Response: *DHS emphasized the large number of counties that do not have an NTP (110) or a buprenorphine prescriber (74). DHS also noted that the majority of buprenorphine prescribers are "grouped together leaving some large gaps for services across the state." DHS cited DBHDD regions 2, 4, and 6 as examples of areas of the state in which few counties have either an NTP or a buprenorphine prescriber, noting that those counties that do have a buprenorphine prescriber often only have between one and four. DHS stated "the lack of prescribers creates a barrier for services needed. There are some areas of the state where the closest provider is three counties away and where almost half of the state does not have any prescribers."*

DPH Response: *DPH agreed with the finding and recommendations.*

Training and resources are needed to improve practitioner knowledge of MAT and where to refer individuals identified as having an opioid use disorder.

Practitioners are frequently not trained to identify individuals with an opioid use disorder and have limited knowledge of MAT resources for referrals. Often health practitioners refer patients to treatment options that do not offer MAT. Other states have developed resources and training for practitioners to increase the likelihood of referrals to an MAT provider when appropriate.

Recent health and public policy research has called attention to practitioners' lack of training in how to identify and refer individuals to addiction treatment. In a 2011 report on prescription painkiller abuse, the Government Accountability Office noted that medical schools provide limited education regarding the identification of substance use disorder. Subsequent reports from the Surgeon General and the American Society of Addiction Medicine have raised similar concerns, suggesting that efforts are needed to better prepare physicians to identify and refer patients to treatment.

Interviews and survey results collected from Georgia health practitioners indicate that action is needed to increase referrals to MAT. For example, NTP and CSB staff we interviewed reported physicians generally do not know where to refer patients for opioid treatment. Additionally, hospitals and county health nurses indicated they refer patients to CSBs for substance abuse treatment, even though CSBs generally do not provide MAT. The sections below describe limitations to treatment referrals for three types of healthcare practitioners/settings that may encounter an increasing number of individuals with an opioid use disorder: physicians, hospitals, and county health departments.

- **Physicians** – According to a 2016 Surgeon General report, since many individuals with a substance use disorder visit primary care physicians, these physicians must be prepared to identify the disorder and connect the patient to proper treatment. Physicians may spot signs of an opioid use disorder, for example, when noting multiple prescriptions for oxycodone from multiple physicians in the Prescription Drug Monitoring Program.[13] However, instead

[13] A 2017 law requires Georgia physicians to check the Prescription Drug Monitoring Program when prescribing certain types of medications (including prescription opioids). This requirement should increase instances in which opioid use disorder is identified.

of only refusing to provide a new prescription, physicians should be able to provide the patient with a list of treatment resources, including MAT providers.

NTP staff we interviewed indicated they rarely receive patients based on physician referral (patient referral is more likely), and CSB staff frequently reported that practitioners generally do not know where to refer individuals for opioid addiction treatment. Similarly, nearly two-thirds of buprenorphine prescribers who responded to our survey reported that practitioners do not know where to send patients when they identify opioid use disorder.

- **Hospitals/Emergency Departments** – According to EMS staff, individuals administered naloxone after an opioid overdose are transported to the emergency department. Often these individuals are admitted to the hospital, and, during their stay or upon discharge, they typically receive counseling or referrals to treatment. This has become more common in recent years with the increase of naloxone administrations (see page 2).

  Hospital discharge coordinators we interviewed indicated they often refer these individuals to a nearby CSB, where MAT is generally not an option. Overall, discharge coordinators had limited knowledge of nearby NTPs or buprenorphine prescribers. Coordinators at some of the larger hospitals mentioned efforts to compile treatment resources, but they were either not specific to opioid addiction or did not include all MAT options.

  DBHDD intends to improve hospital treatment referrals using nearly $300,000 from a recent federal grant, but this investment affects only a small part of the state and is time-limited. The grant will fund peer specialists in two Gwinnett County hospitals who will work to connect individuals who are unable to pay for treatment themselves to DBHDD providers that are offering MAT through the grant.

- **County Health Departments** – According to DPH officials, county health nurses may encounter individuals with opioid use disorder and thus should be able to identify and refer to treatment. This role is consistent with the DPH essential service of linking the public to needed healthcare.

  Survey results showed that generally county nurse managers are not prepared to identify opioid use disorder and are unsure of local treatment options.[14] Only 11% of county nurse manager respondents indicated that they can both identify and address opioid use disorder. In addition, one-half to three-quarters of county nurse managers were unsure whether providers that could offer the various forms of MAT were in their area. Most nurses that do provide referrals send individuals with opioid use disorder to CSBs, which do not offer MAT.

While other states have taken action to increase awareness of MAT and providers, Georgia entities have taken limited steps to increase referrals to this best practice

[14] Surveys were successfully delivered to 158 county nurse managers and 133 responses were received — a response rate of 84%.

treatment. Specifically, we noted a lack of training and information on MAT providers, as described below.

- **Lack of training** – A 2017 report from the Georgia Prevention Project's Substance Abuse Research Alliance highlighted the current gap in physician training. Overall, medical schools dedicate little time to teaching pain management and some physicians receive no training in substance abuse identification. Professional associations such as Medical Association of Georgia and the Georgia Hospital Association also do not train their members about opioid use disorder identification and treatment referral. Finally, approximately 90% of county nurse managers indicated that training would further prepare them to identify and address opioid use disorder.

  While state entities have not historically made an effort to ensure physicians are trained to identify patients in need of MAT and make referrals, two actions have been taken in 2017. The Georgia Composite Medical Board approved a rule that requires physicians to complete one-time training on controlled substance prescribing, which includes the identification of prescription drug misuse and abuse. Additionally, a DBHDD grant has dedicated federal funds for MAT training on a variety of topics including identifying substance use disorder and making treatment referrals. Target audiences include healthcare practitioners such as physicians, counselors, and first responders.

- **Lack of resource guide** – Neither DPH nor DBHDD has disseminated a complete list of Georgia MAT providers, which practitioners could use to determine treatment availability in their area. DBHDD includes a list of NTPs in the toolkit it publishes online; however, this resource has not been updated since January 2016 and does not include buprenorphine prescribers. Similarly, the Georgia Crisis & Access Line's online provider search contains incomplete information about NTPs and does not include buprenorphine providers.

  The websites of nearly all states we reviewed contained a list of methadone providers and a link to SAMHSA's buprenorphine provider locator, which, as described in the box below, would benefit individuals seeking treatment as well as practitioners. Additionally, North Carolina's medical board has been working with the university system and the Governor's Institute on Substance Abuse to increase awareness of MAT among physicians and publicize the availability of current providers.

MAT resource guide would benefit the public

Without clinical guidance from a physician referral, patients must attempt to find treatment on their own. According to the Surgeon General, individuals may not seek addiction treatment because they do not know where to go. Nearly half of buprenorphine prescribers who responded to our survey reported that a lack of patient awareness of buprenorphine treatment poses a barrier to access. A publically available list of MAT providers—including state-licensed NTPs and a link to SAMHSA's list of buprenorphine prescribers—would help individuals with opioid use disorder or their family members with researching potential providers without the assistance of a primary care physician.

RECOMMENDATIONS

1. DPH should ensure public health practitioners, such as county health nurses, are trained to identify opioid use disorder and refer patients to treatment, specifically MAT.

2. DPH should ensure the statewide strategic plan identifies a state entity responsible for ensuring practitioners and the public can easily obtain a comprehensive list of NTPs and buprenorphine prescribers. This can be accomplished through a website and other communication with providers.

3. DPH should ensure the statewide strategic plan identifies state entities to coordinate with the various stakeholders that work with practitioners (e.g., Georgia Composite Medical Board, Medical Association of Georgia) to ensure they know where to obtain information on MAT and what providers offer such treatment.

***DBHDD Response**: DBHDD agreed with the finding and recommendations. As part of its federal grant, DBHDD plans to develop and implement statewide training programs focusing on improving stakeholders' knowledge of MAT. DBHDD will also review its website to ensure opioid MAT and other substance use disorder resources are more prominently displayed.*

***DPH Response**: DPH agreed with the finding and recommendations.*

State entities have inconsistent practices related to whether those they supervise are allowed to obtain MAT.

Supervising entities reviewed include:

Adult Felony Drug Courts

Department of Community Supervision (Field Offices and Day Reporting Centers)

Division of Family and Children Services

Juvenile Courts

State entities that supervise individuals with opioid use disorder have not developed policies that address MAT as an appropriate form of treatment. Additionally, DFCS caseworkers, DCS officers, and accountability court judges have not received sufficient training regarding the effectiveness of MAT when properly administered. As a result, some may restrict individuals from obtaining or continuing the treatment.

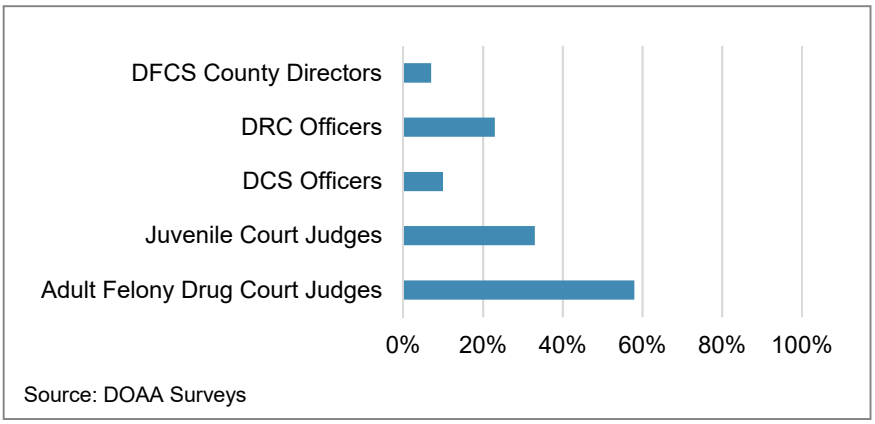
As previously described, best practice literature states that individuals should not be restricted from utilizing any form of MAT when a healthcare provider has deemed such treatment beneficial or appropriate. Studies on MAT in the criminal justice system have found that the use of all three medications has significantly reduced the use of unauthorized opioids in probationers, parolees, and others when compared to counseling without medication. In recent years, best practice entities including the National Governors' Association, the National Association of Drug Court Professionals, and the National Drug Court Institute have encouraged states to incorporate MAT into accountability court programs in particular.

When under the purview of state entities, individuals' ability to obtain or continue MAT—even when providers are available—is inconsistent across the state, as described in the sections below. Given the unique effect of opioid use disorder on the brain, such individuals (depending on the severity of their disorder) may not succeed

in settings that focus on abstinence and provide only behavioral health therapies,[15] leading to lengthy separations from their children or violations of probation or parole.

Vague or nonexistent state policies leave decisions regarding MAT allowance or restriction to individual judges, caseworkers, and officers who have generally not been trained on this form of treatment. As shown on **Exhibit 8**, less than 60% of respondents in each state position surveyed indicated they had received training on MAT. This includes almost no DFCS county directors and only 15% of all community supervision officers.

Exhibit 8
Few Positions Supervising Individuals with Opioid Use Disorder Have Received Training on MAT



Source: DOAA Surveys

During fiscal year 2018, DBHDD will dedicate $500,000 of federal grant funds to conduct trainings across the state that will describe MAT and its benefits. DBHDD plans to target various groups, including judges, DFCS caseworkers, and community supervision officers, as well as practitioners and state agencies.

Adult Felony Drug Courts

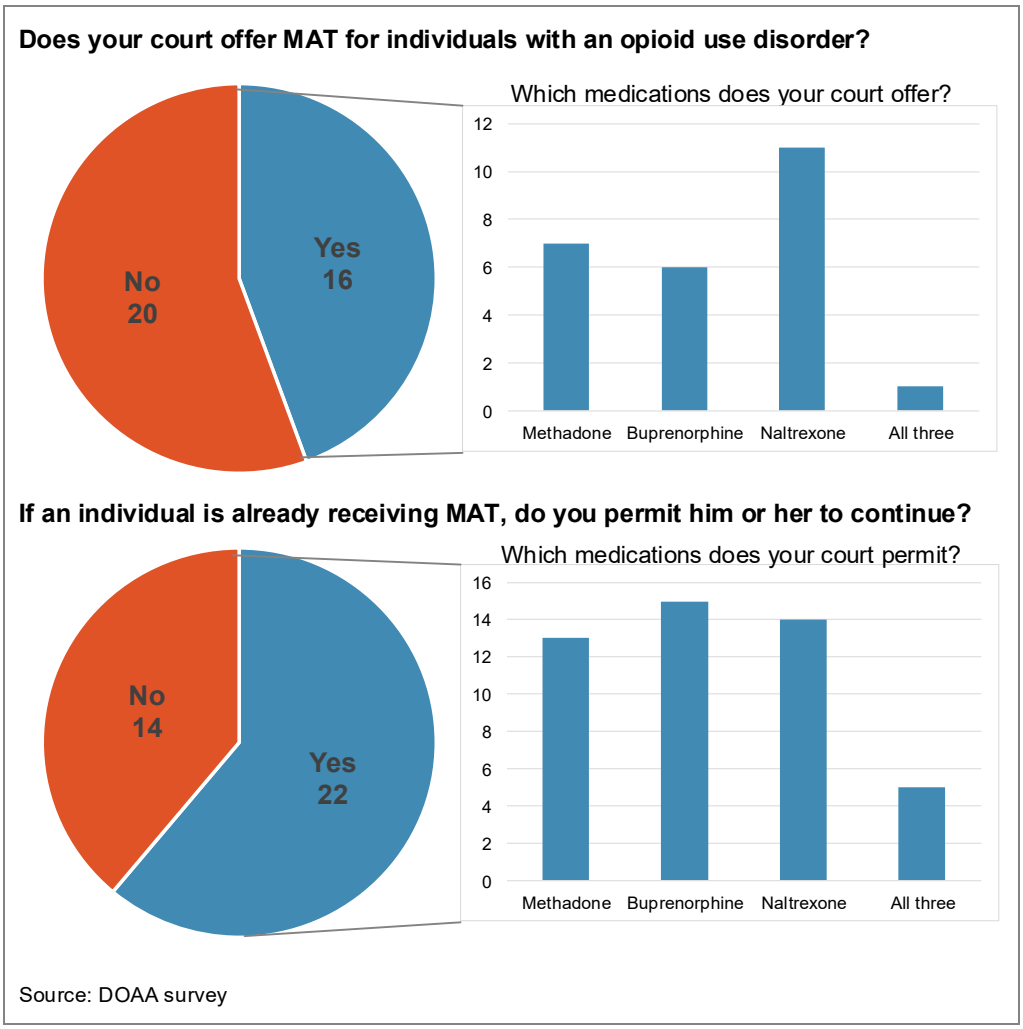
Allowance of MAT in adult felony drug court varies depending on the court. Despite a relatively large proportion of judges indicating they had received training on MAT, the majority of judges held negative perceptions of MAT medications, particularly methadone and buprenorphine.

As shown on **Exhibit 9**, approximately 44% of the 36 respondents[16] (16) indicated their court has incorporated MAT into their program, predominantly allowing naltrexone (which any physician can prescribe). Methadone and buprenorphine, which are less commonly offered, require an arrangement with a certified provider. Additionally, while some individuals enrolling in an adult felony drug court may already be receiving MAT, approximately 40% of respondents (14) indicated they would not permit them to continue that treatment. Courts rarely offer or permit all three medications.

[15] MAT should not replace the traditional counseling and any evidence-based programming used by courts or probation and parole offices. It is a supplement to the behavioral therapies already occurring.

[16] Surveys were successfully delivered to 51 judges who operate an adult felony drug court. We received 36 responses — a response rate of 71%.

Exhibit 9
Adult Felony Drug Court Judges Do Not Consistently Offer or Allow MAT



Source: DOAA survey

MAT allowance appears to depend at least partially on judges' perceptions of the various medications, which survey results (see Appendix G) indicate is more favorable toward naltrexone than methadone or buprenorphine. For example, approximately 40% of judges familiar with naltrexone indicated it was more effective than counseling only programs, compared to 10% for methadone and buprenorphine. It should be noted that methadone and buprenorphine have been studied extensively and found to be more effective than counseling only or no treatment.

Accountability court judges we interviewed and surveyed indicated past experiences have influenced their perceptions of MAT, citing instances of diversion, abuse, and uncooperative providers when they have supervised an individual on MAT. Additionally, judges were unfamiliar with providers in their area. Finally, some judges stated MAT may not be compatible with current programming, which requires drug screens and group counseling with other participants who are often abstinent.

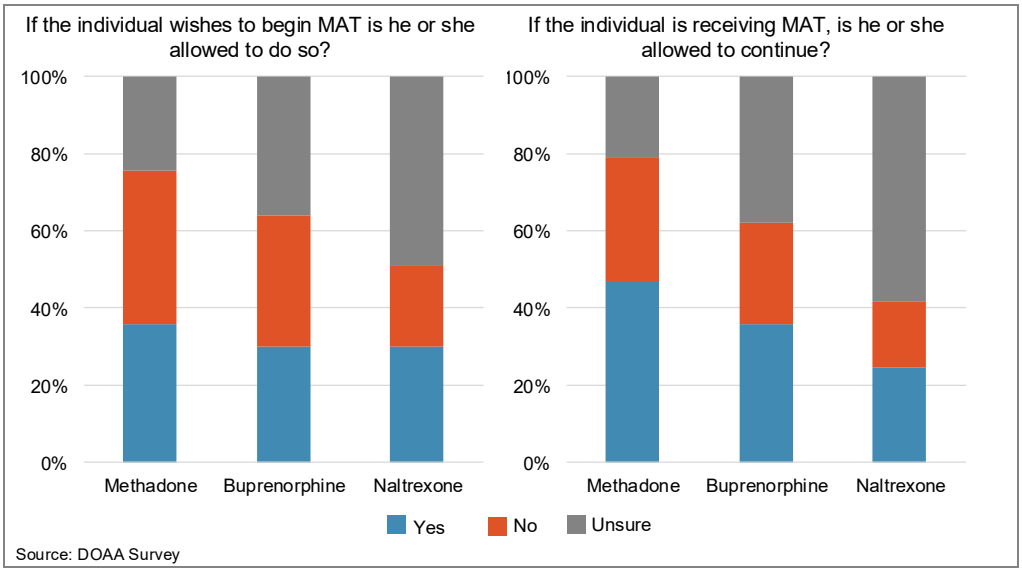
While the Council of Accountability Court Judges has not specifically addressed MAT in its standards related to accountability courts (which focus on abstinence-only practices), the National Drug Court Institute provided MAT training during the 2016

and 2017 State Accountability Courts Training Conference, which included adult felony drug court and other accountability court judges. The council has also created a pilot program using injectable naltrexone (Vivitrol) in two judicial districts and is working to expand to additional districts.

Department of Community Supervision

As shown in **Exhibit 10**, there is inconsistency within DCS regarding whether those on probation or parole are allowed to begin or continue existing MAT. There is also variation between the district chiefs who supervise the field offices and those that supervise the day reporting centers (DRCs) that specifically target substance abuse.[17] At least half of DRC supervisors would not allow individuals to begin or continue MAT with methadone and buprenorphine (most were unsure about naltrexone). DCS district chiefs were more likely to allow MAT to be continued or initiated.

Exhibit 10
Allowance of New or Existing MAT Varies Among DCS Officers



Source: DOAA Survey

DCS management staff indicated officers should allow probationers and parolees to continue any form of medication (including methadone and buprenorphine) that a physician has deemed medically necessary. While we identified this in DCS policies related to drug screening for probationers and parolees, DCS has not officially addressed MAT for opioid use disorder, which has likely contributed to uncertainty among officers as to whether such a treatment is permissible. Depending on the medication, between 20% and 60% of DCS respondents were unsure of whether they can allow an individual to initiate or continue MAT while on probation or parole.

Many DCS officers responding to our survey reported limited familiarity with MAT or had negative perceptions of the medications. While nearly all officers were familiar with methadone, the majority were not aware of buprenorphine or naltrexone for MAT. A large proportion of respondents expressed similar perceptions of the

[17] Surveys were successfully delivered to 47 DCS district coordinating chiefs, which oversee supervision in each judicial circuit, and 31 responses were received—a response rate of 66%. Additionally, surveys were successfully delivered to 33 supervisors at the DRCs and DRC-Lites, and 22 responses were received—a response rate of 67%.

medications as adult felony drug courts, which are often contrary to research findings (see Appendix H). For example, only 4 of the 51 DCS officers familiar with methadone indicated it was more effective than counseling only programs. Nearly all DCS respondents indicated they had not received training on MAT.

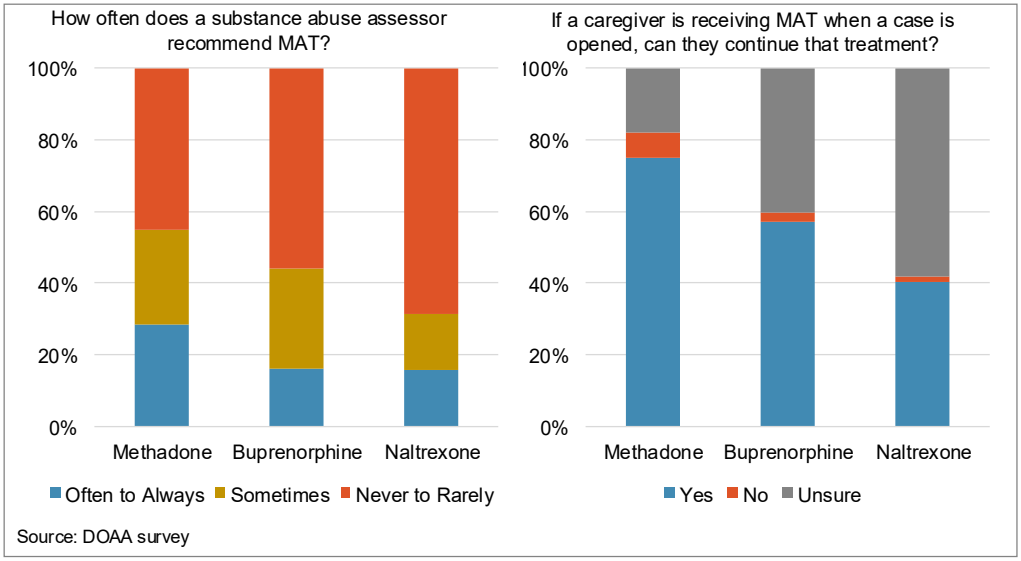
Over the next two years, approximately $20,000 of DBHDD's recent federal grant will provide Vivitrol to an expected 20 individuals who will be released from state prison. The Department of Corrections will begin administering the Vivitrol prior to their release, and then DCS will coordinate follow-up services and care for these individuals, who will receive subsequent injections in the community.

Division of Family & Children Services

Though DFCS policies have not explicitly addressed opioid use disorder, caregivers placed under DFCS supervision are typically not restricted from continuing existing MAT. However, if caregivers are not participating in MAT when they are assessed, the treatment is typically not a recommended part of their case plan. As a result, DFCS county directors we surveyed[18] indicated caregivers rarely obtain MAT while under DFCS supervision.

When DFCS observes that a caregiver has a substance use disorder, a substance abuse assessor will recommend a treatment plan, which is generally accepted by the caseworker and caregiver. As shown in **Exhibit 11**, these assessors[19] do not often recommend any form of MAT for individuals with opioid use disorder. If caregivers are already receiving MAT when the case is opened, they are more likely to be able to continue; however, this is not consistent across all counties or all medications.

Exhibit 11
DFCS Generally Allows Existing MAT to Continue but May Not Recommend MAT in Caregivers' Treatment Plans



Source: DOAA survey

[18] Surveys were successfully delivered to 96 DFCS county directors (some are in charge of multiple county offices). We received 72 responses — a response rate of 75%.

[19] Substance abuse assessors—which also provide the treatment services—are frequently CSBs or other providers licensed for counseling services. While it is possible some providers may have a physician with the waiver to prescribe buprenorphine, CSBs generally do not have the funding to offer MAT.

Similar to DCS, DFCS management indicated that medically necessary MAT is not prohibited. However, DFCS policies do not specifically address MAT for opioid use disorder, particularly with regard to the potential impact on drug screens that are typically required to regain custody of a child. Depending on the medication, up to 58% of DFCS directors were unsure whether caregivers would be allowed to continue their MAT. [20]

When a caregiver's case goes before the juvenile courts (because the child has been removed from the home), DFCS directors indicated the plans presented to juvenile judges typically do not include MAT recommendations. When they do, DFCS directors indicated variation in whether juvenile judges would overrule a treatment plan with MAT, with approximately half indicating it occurs sometimes or often. Of the 56 juvenile judges that responded to our survey,[21] approximately 18% (10) indicated they would not allow caregivers to participate in MAT; approximately half of the 46 judges who allow MAT permit all three medication types. Juvenile judges had similar perceptions of the MAT medications as DCS officers and drug court judges (see Appendix I).

It should be noted that some juvenile courts operate a family treatment court to provide additional supervision and services to caregivers. Nearly all of the 14 family treatment court respondents indicated they allow individuals to continue existing MAT, and seven offer at least one MAT medication in their program.[22]

RECOMMENDATIONS

1. All state entities should permit individuals with opioid use disorder under their purview to utilize any of the three types of MAT medications, according to identified need. Entities should put controls in place to ensure the individual is using the medication appropriately and obtaining necessary counseling.

2. State entities should ensure those supervising individuals with opioid use disorder (including DFCS caseworkers, DCS officers, accountability court judges, and juvenile court judges) are trained on MAT. This may include sending representatives to upcoming DBHDD trainings and disseminating information to the broader population.

3. DCS and DFCS should clarify policies related to drug screens to more explicitly indicate that MAT medications (methadone and buprenorphine) are permitted when they are prescribed and monitored by a certified provider (i.e., an NTP or a buprenorphine prescriber).

4. DFCS should consider partnering with substance abuse treatment providers that can offer MAT themselves or can refer caregivers with opioid use disorder to outside providers.

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[20] Approximately 18% of DFCS county directors were unsure about whether methadone was allowed, compared to 40% for buprenorphine and 58% for naltrexone.

[21] Surveys were successfully delivered to 90 juvenile court judges. We received 60 responses — a response rate of 67%.

[22] All seven family treatment courts that offer MAT provide injectable naltrexone (Vivitrol), and two offer all three medication types.

DBHDD Response: *DBHDD agreed with the finding and recommendations and stated it "will participate in a coordinated effort with other state agencies to ensure that consistent and standard practices are established and included in the statewide strategic plan." DBHDD will also target the stakeholder groups mentioned in the finding in the statewide MAT training that will be implemented through the federal grant.*

DCS Response: *DCS acknowledged that "MAT is one of the many pathways to recovery. We also agree that this is an evidenced based, research driven best practice and we are committed to supporting this best practice within DCS." In addition to its pilot project using Vivitrol, DCS is developing an online training module that will include information about opioids as well as research and outcomes related to MAT. DCS will also begin reviewing its policies that address DRC admission criteria, drug screening processes, and offenders under general supervision "to ensure that individuals who have not been successful with recovery using other treatment modalities have the option to participate in MAT."*

DCS stated it has worked to "spread awareness and ensure preventable measures are in place to combat [opioid use disorder]." This includes providing training to 1,850 staff on the effects of opioids and the use of naloxone to counter the effects of an opioid overdose (more than 1,500 received kits). Additionally, DCS developed an informational pamphlet to distribute statewide to educate staff and offenders about opioid use disorder.

DCS noted that "while DCS policies and procedures can be overridden by a court and/or board order, we are committed to doing our part to minimize the misconceptions and stigmas surrounding the use of MAT while eliminating policy barriers that are restrictive in nature. We also commit to providing further training to educate ourselves and our stakeholders on the opioid crisis."

DHS Response: *DHS stated it "agrees with the need for consistency" within the practice of allowing any of the three MAT medications and will partner with juvenile courts and other state agencies to encourage consistent practices.*

DHS noted DFCS currently conducts mandatory training on substance abuse for all social services employees, which covers the various types of opioids and their impact on the body and brain, addiction, treatment options, and relapse planning. MAT is mentioned as a treatment option, but DHS noted that "training could be enhanced to add additional emphasis on MAT." DFCS staff will also participate in the upcoming DBHDD trainings.

DHS stated DFCS is in the process of clarifying and enhancing its policy regarding drug screens and will include information and guidance regarding MAT services. The policy will be released in January 2018.

Finally, DHS stated DFCS will research the recommendation to partner with substance abuse treatment providers that can offer MAT themselves or refer to outside providers.

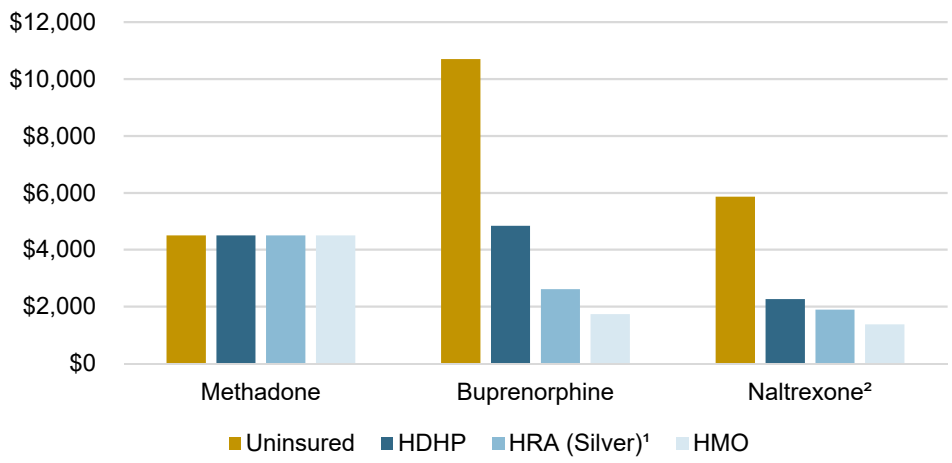
Cost is a barrier to many individuals seeking to obtain or maintain MAT.

Cost is frequently cited as a barrier for individuals who need MAT. An individual may pay thousands per year for the medication, counseling, and lab work that comprise the treatment. Methadone is the least expensive form of MAT but is generally not covered by private insurance in Georgia. Buprenorphine and naltrexone have higher costs but are more affordable for the privately insured.

Literature on MAT access notes cost as a prominent barrier for individuals with opioid use disorder seeking treatment. In a 2015 national survey, SAMHSA found nearly one-third of individuals who sought treatment reported that lack of insurance coverage and inability to pay prevented them from receiving treatment. While access to private insurance can help reduce treatment costs, insured individuals may still pay thousands out of pocket based on their deductibles, required copayments, or overall coverage. Interviewed and surveyed Georgia stakeholders also noted that cost often prohibits an individual from starting or continuing MAT.

As shown in **Exhibit 12**, methadone maintenance is the cheapest form of MAT for uninsured individuals, with naltrexone slightly higher and buprenorphine costing almost twice as much.[23] If an individual has insurance, buprenorphine and naltrexone-based MAT (ranging from $1,400 to $4,900) are cheaper because private insurance generally does not cover NTPs in Georgia, resulting in the same total out-of-pocket costs for methadone as the uninsured. These estimates were based on State Health Benefit Plan claims data and insurance plans, as described below.

Exhibit 12
Annual Out-Of-Pocket Costs Vary Based on Access to Insurance



¹"Silver" HRA plan is the middle of the three HRA plans available to SHBP members. For more information on plan benefits, see Appendix J.
²Naltrexone costs do not include costs related to required detoxification prior to naltrexone treatment.

Source: SHBP, NTPs

[23] For our analyses, we evaluated the cost of the most commonly prescribed form of buprenorphine (Suboxone) and naltrexone (oral generic form).

Total out-of-pocket costs can be prohibitive for uninsured individuals seeking MAT. Research shows these individuals are more likely to be living below the federal poverty line (approximately $12,000 for an individual and $25,000 for a family of four) and thus lack the resources to pay for treatment. In some cases, MAT costs could comprise more than half of an uninsured patient's annual earnings.

Medicaid members have few to no expenses for MAT. All medication types are covered, and most members do not have a copay, which range from $0.50 to $3 for each prescription. Members also do not pay a copay for counseling or lab work. As such, our discussion focuses on out-of-pocket costs for the uninsured or privately insured.

Methadone

According to NTPs we interviewed, methadone maintenance costs average approximately $12 per day (which includes the medication, lab work, and counseling), or an estimated $4,500 per year. Private insurance providers in Georgia generally do not include NTPs in their networks; therefore, insured individuals seeking methadone maintenance also pay the full cost out of pocket.

Depending on the NTP, individuals may incur additional charges such as admission or transfer fees. Seven of the 25 NTPs we examined charge between $30 and $100 in admission fees; four also charge a transfer fee ($30). For some NTP patients, traveling long distances on a required daily basis may increase treatment costs further.

According to NTP staff we interviewed, while finances were the most commonly cited barrier for potential patients, NTP treatment is cheaper than maintaining an illicit drug habit. To assist with treatment costs, five NTPs we examined provide eligible patients (i.e. indigent, disabled) reduced rates of approximately $10 a day (or about $3,100 a year), while others indicated they may negotiate costs on a case-by-case basis. Additionally, two programs that operate four locations receive state funding to provide reduced rates to low-income clients who do not have Medicaid.

Buprenorphine

For the uninsured, buprenorphine-based MAT can cost twice as much as methadone (almost $11,000 per year), primarily due to the cost of the medication as well as separate billing for counseling and lab work (which is bundled into the all-inclusive NTP daily rate). Insurance coverage can decrease out-of-pocket costs significantly, with costs totaling an estimated $1,700 to $5,000, depending on the plan.

We used State Health Benefit Plan (SHBP) claims data[24] to estimate how much someone would pay to obtain buprenorphine-based treatment for the first year. Based on our literature review, stakeholder interviews, and the claims data, we assumed that under a typical treatment plan the individual would receive a 30-day supply of medication, one counseling session per month by the prescribing physician, and four lab procedures per year.[25] Our cost estimates are described below.

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[24] SHBP is one of the largest insurance providers in the state and, according to America's Health Insurance Plans (an insurance professionals organization), is generally representative of other private plans.

[25] Federal entities and stakeholders encourage increased counseling in the early phases of treatment, when patients are more susceptible to relapse. As such, we assumed four counseling sessions per month in the first two months of the year. The type and frequency of lab procedures for opioid-related diagnoses varied; however, about 80% of individuals in our sample received fewer than six lab claims in a year.

- **Uninsured** – We estimated costs for uninsured individuals based on the charges providers submitted to SHBP. Charges submitted for medications vary by strength and type, but a 30-day supply of the most commonly prescribed buprenorphine medication (Suboxone) was approximately $530 per prescription, or $6,400 per year. Physicians charged approximately $145 for each visit related to counseling and other psychiatric services, which would equate to approximately $2,600 per year. Finally, the median total lab cost for individuals receiving MAT was approximately $1,700. In total, we estimate an uninsured individual may pay nearly $11,000 a year for buprenorphine-based MAT.

  It should be noted that providers may offer special rates for uninsured patients or allow individuals to negotiate charges submitted on a case-by-case basis.

- **Privately Insured** – We estimated insured individuals' costs using data from three SHBP plans that, according to DCH staff, are comparable to other private insurers' options. These plans vary by standard monthly payments (known as premiums), deductibles (established out-of-pocket amount prior to insurance coverage), and the percentage insurance will pay, all of which influence a member's out-of-pocket costs for MAT (see Appendix J for plan descriptions).

  Private insurers negotiate with providers to obtain a lower charge for services, which becomes the total amount individuals may be responsible for before reaching their deductible. SHBP's negotiated amount for Suboxone was approximately $450 per prescription, while the median amount for counseling was approximately $85 per visit. Lab costs were estimated to be approximately $315 per year. We incorporated these amounts into each insurance plan's model to estimate annual out-of-pocket costs, which ranged from approximately $1,700 (Health Management Organization plan) to nearly $5,000 per year (High Deductible Health Plan).

Naltrexone

Office-based MAT using oral naltrexone costs significantly less than buprenorphine, primarily due to the price of the medication. Pharmacists submitted charges of approximately $130 per prescription for the most commonly prescribed form of naltrexone (a generic), and SHBP negotiated a rate of nearly $30 for the same medication.

Using the same costs for counseling and lab work, we estimate the uninsured could pay nearly $6,000 for their first year of naltrexone-based MAT, while insured individuals may pay between $1,400 and $2,300. This estimate, however, does not include the costs for detoxification, which is required prior to using naltrexone medications and may consist of a stay at a residential treatment facility.

It should be noted that the injectable form of naltrexone, Vivitrol, is significantly more expensive—estimated at nearly $1,300 per administration. Few SHBP members had utilized this form of MAT in the fiscal years we reviewed.

Private insurance may not cover all forms of MAT. While Medicaid does cover all medication types, members may not have access to network providers.

While Medicaid will pay for all MAT medications, members in certain areas of the state—particularly those with managed care—do not have access to methadone and/or buprenorphine because providers have not joined the Medicaid provider networks. National studies indicate that private insurance may cover both methadone and buprenorphine; however, Georgia providers indicated there are frequently limitations to coverage.

Numerous agencies in the fields of health and medicine advocate for access to a range of addiction treatment options, including all three medication types. Effective treatment principles outlined by the National Institute on Drug Abuse and reported by the Surgeon General state that no single treatment is appropriate for everyone. Since patients' treatment needs differ depending on the extent of their addiction, a variety of medications, services, and settings should be available to ensure the greatest likelihood of success. Furthermore, the American Medical Association's opioid task force advocates for public and private insurers to cover all services that comprise MAT, including all three medications.

As described below, Georgians with Medicaid or private insurance may have limited access to methadone and buprenorphine due to a lack of network providers or plan limitations. Naltrexone is often covered and, since any physician can prescribe it, we did not evaluate the provider network. However, addiction specialists are more likely to prescribe naltrexone than more common provider specialties.

Medicaid

Medicaid Networks

A provider must be in the FFS network before it is eligible to join the CMO networks. Therefore, CMOs have a smaller recruitment pool than the full provider population.

While the fee-for-service (FFS) Medicaid and the Care Management Organization (CMO) plans cover at least one form of all three types of MAT medication, as well as necessary counseling and lab work, insufficient provider networks limit access to methadone and buprenorphine.[26] This network limitation likely results in members being unable to obtain the needed treatment. DCH recently estimated that only 12% of Medicaid's 11,000 members with an opioid use disorder were obtaining some form of MAT in calendar year 2016.

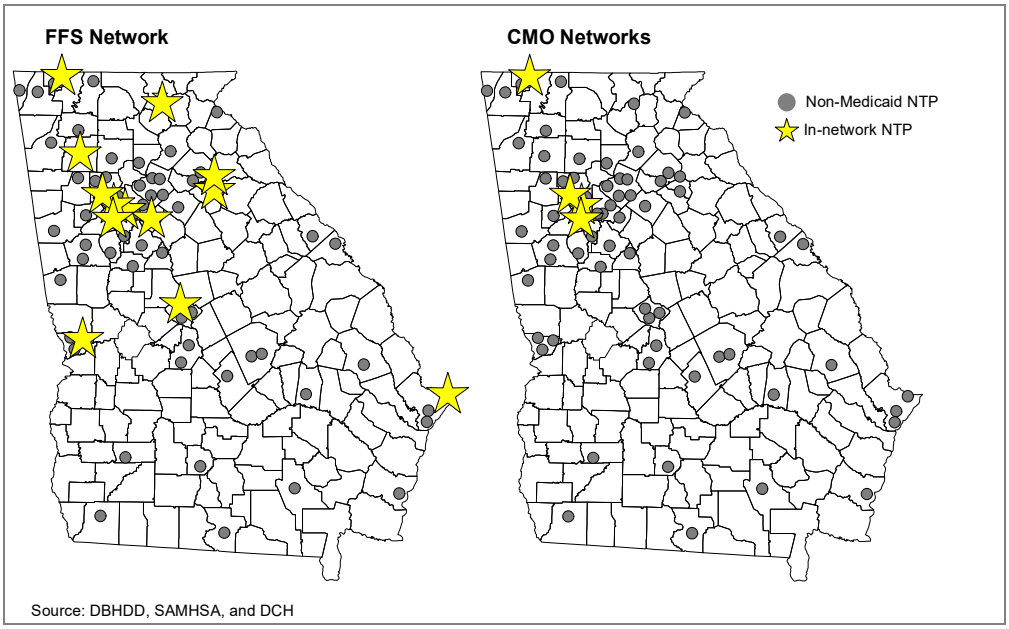
Medicaid members can obtain coverage for at least one form of all three MAT medications, though actual drugs covered or preferred vary by plan. For example, one CMO plan lists Suboxone and its generic form as the preferred buprenorphine medications, while another opts for only Zubsolv. The generic oral naltrexone is preferred in all plans, while the injectable form (Vivitrol) is often covered as a medical benefit (because it is physician administered). Methadone is bundled as a medical benefit with other NTP services.

NTPs are located throughout the state, but few become Medicaid providers and fewer join CMO networks. As a result, Medicaid members in most of the state have no access to methadone. Prior to a DBHDD policy change in 2016, only two NTPs—both in Metro Atlanta—were able to accept Medicaid because they provided a broader range

[26] FFS Medicaid primarily serves aged, blind, and disabled Georgians, while managed care members are generally pregnant women as well as low-income children and their families.

of required behavioral health services.[27] At the beginning of fiscal year 2018, 13 of the 72 NTPs (18%) had become FFS providers. As shown in **Exhibit 13**, FFS providers are located primarily in Metro Atlanta and North Georgia, with some coverage in urban areas in Central and Coastal Georgia. Notable gaps exist in South and East Georgia even though there are NTPs in many of these areas.

Exhibit 13
Few NTPs Join Medicaid FFS Network and Fewer Join CMOs, July 2017



While the DBHDD policy change increased the number of NTPs in the FFS network, it has had limited impact on managed care. At the beginning of fiscal year 2018, three of four CMOs had a single NTP in their provider network (Peach State included three).[28] As a result, only managed care members in Metro Atlanta and Northwest Georgia are able to access methadone treatment (see **Exhibit 13**).[29]

Buprenorphine prescribers are included in the FFS network at a higher rate than the NTPs, with 325 of the 456 active[30] prescribers (71%) accepting Medicaid. The provider distribution in the FFS network mirrors the overall availability of active prescribers (which, as described on page 18 is already limited in some regions).

CMOs have added 55% to 60% (180 to 196) of the 325 buprenorphine prescribers from the FFS network. These prescribers may operate in multiple offices, increasing members' access to MAT; however, fewer overall prescribers in managed care has created gaps in certain parts of the state. As shown in **Exhibit 14**, CMOs have fewer

[27] The new policy allowed NTPs to join the Medicaid network without expanding their scope of services.

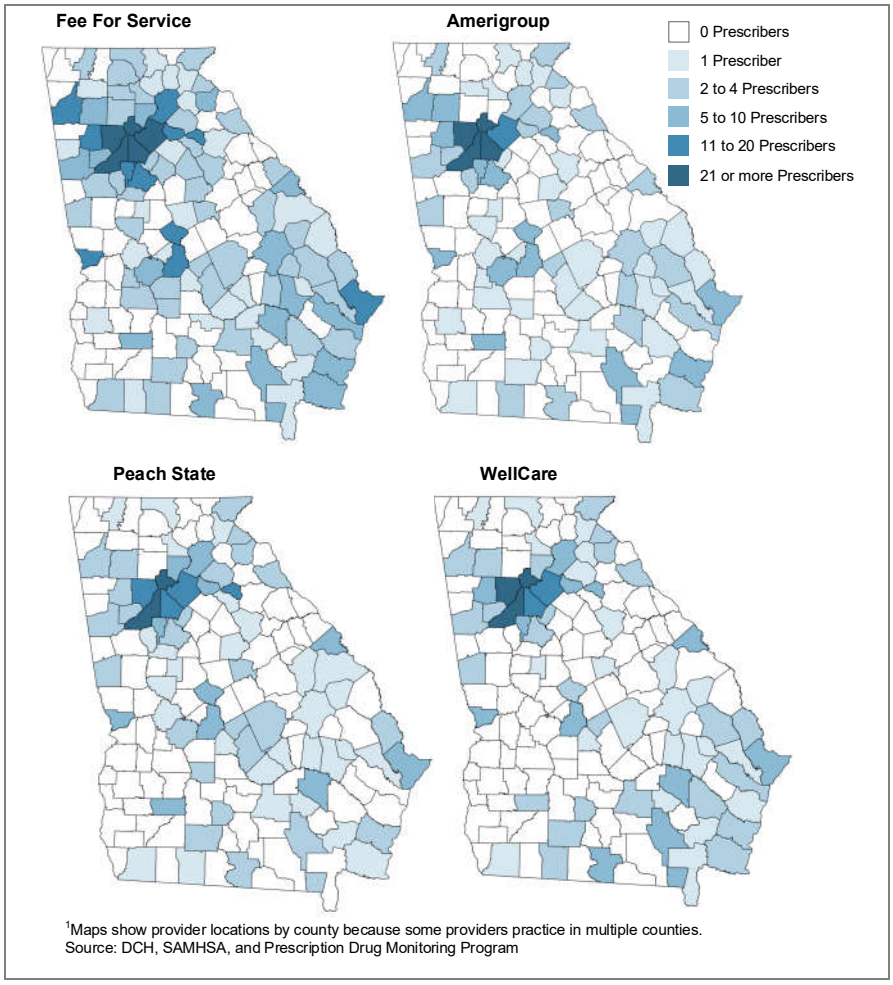
[28] CMO staff indicated they were in discussions to include other NTPs in their networks. For example, WellCare is recruiting two NTPs, which operate in Metro Atlanta and Augusta.

[29] CMOs may arrange single-case agreements with NTPs that accept Medicaid but are outside their provider network. However, this did not appear to be a common practice.

[30] Active prescribers wrote a prescription for a SAMHSA-approved buprenorphine medication for at least one patient in fiscal year 2017. This likely overestimates access, however, because some physicians do not intend to serve a large number of patients and thus may not accept new patients for MAT (see page 17).

prescribers per county compared to FFS. Prescriber coverage disappears in some areas, notably in central and eastern counties.

Exhibit 14
CMOs Have Fewer Active Buprenorphine Prescribers per County Compared to FFS, June 2017[1]



[1]Maps show provider locations by county because some providers practice in multiple counties.
Source: DCH, SAMHSA, and Prescription Drug Monitoring Program

Though the access gap can be partially attributed to providers opting not to accept Medicaid, DCH has not taken steps to ensure its members have access to methadone or buprenorphine, despite the documented need for MAT. These factors are discussed below.

- **Providers unwilling to join Medicaid** – Interviews and survey responses from MAT providers suggest that the enrollment process and reimbursement rates discourage providers from joining Medicaid. We spoke with methadone providers who described the enrollment process as time consuming and complicated, leading one provider to give up after several attempts. Another NTP indicated that reimbursement rates could not compensate for the additional work required to enroll, such as developing policies and acquiring billing expertise. It should be noted that NTPs must first enroll as a behavioral health provider with DBHDD before obtaining final approval from DCH.

DBHDD contracted with a new vendor for provider enrollment last year, and both agencies stated that their enrollment processes have improved over time.

In addition, half of buprenorphine prescribers who responded to our survey indicated they did not accept Medicaid, frequently citing insufficient reimbursement rates and their perception of a burdensome enrollment process.

- **DCH policies do not require CMOs to include specific behavioral health provider types** – DCH's network access standards for behavioral health do not require CMOs to include NTPs in their networks. Access standards require CMOs to have one behavioral health provider within 30 or 45 minutes/miles of a Medicaid member (depending on whether the location is urban or rural). Despite variability in behavioral health providers' specialties, DCH assesses behavioral health facility access as one group. Therefore, if a CMO has a clinic serving adolescents with behavioral issues in one area, for example, it has met the DCH access requirement for behavioral health services. The CMO has little incentive to add an NTP to its network.

  Changes to the CMOs' fiscal year 2018 contract may better assure that CMOs add NTPs to their networks. A new provision requires the CMOs to cover three tiers[31] of behavioral health providers: comprehensive community providers, community Medicaid providers, and specialty providers. However, its potential effect is unknown because DCH has yet to determine how to interpret or implement this provision.

- **DCH did not communicate network changes to CMOs** – DCH did not announce the DBHDD policy change that expanded the number of NTPs eligible for CMO networks. Without notification from DCH, CMOs were unaware of new Medicaid providers that could offer their members a form of MAT they could not previously access. As noted above, CMO networks include three or fewer NTPs, almost all of which practice in the Atlanta area, though other NTPs have joined Medicaid. As such, managed care members in much of the state do not have access to a service that FFS members can obtain. Following discussions with the audit team and receiving a list of NTPs accepting Medicaid, Peach State and CareSource indicated they would begin actively recruiting NTPs to their networks.

- **DCH has not recruited buprenorphine prescribers** – DCH recently commissioned a study that included a geographic analysis of MAT providers and Medicaid members who may need MAT. However, at this point, the presence of buprenorphine prescribers in FFS and managed care networks has been left to chance rather than the result of intentional action by the agency or CMOs, leaving gaps in the CMO networks in particular. In areas where there are few buprenorphine prescribers, efforts to include them in Medicaid networks could make a notable difference in treatment access. One state we reviewed is working to recruit prescribers by increasing reimbursement rates.

[31] Services offered by these providers vary by tier. Comprehensive community providers offer a wide range of behavioral health services, while specialty providers, like NTPs, may target specific needs.

Without access to a MAT network provider, Medicaid members would have to pay out-of-pocket costs even though Medicaid covers the medications. As previously noted, methadone treatment costs approximately $4,500 annually, and buprenorphine costs even more. Such amounts would be cost-prohibitive for someone on Medicaid. As a result, these members would likely have to seek treatment options without medication (e.g., outpatient counseling at a CSB) that are often less effective.

Private Insurance

Private insurance coverage of MAT varies among insurers and plans. Under the federal Affordable Care Act, insurers must cover addiction treatment but can determine what medications and treatments are covered. For example, SHBP covers MAT using buprenorphine and naltrexone, but NTPs are carved out of the provider network, removing methadone maintenance as a treatment option.[32]

While one national study of private insurance treatment options found that many insurers covered both NTPs and buprenorphine, interviews with SHBP and NTP staff suggest that private insurance's lack of coverage for NTPs is common in Georgia. According to SHBP staff, insurers may not cover methadone providers and other similar treatment centers due to cost. Moreover, insurers are inclined to exclude treatments for which there is no determined end date.

Recent studies indicate that it is common for private insurance to cover the necessary components of office-based buprenorphine treatment (including the prescription and outpatient counseling). Survey responses from physicians with the waiver to prescribe buprenorphine suggest that coverage for buprenorphine and counseling in Georgia may be limited in some private insurance plans. Our review of SHBP coverage did not show these limitations.

RECOMMENDATIONS

1. DCH should ensure that both FFS and managed care members have access to NTPs.

2. DCH should notify CMOs of NTPs in the Medicaid provider network and encourage/require them to work to include them in their provider network.

3. DCH should use its recently commissioned report to evaluate network access to buprenorphine prescribers to ensure adequate access throughout the state. If gaps are identified, DCH should consider methods to recruit additional prescribers, such as increasing reimbursement rates.

DCH Response: *DCH agreed with the finding and recommendations. It also noted that the provider enrollment and credentialing process, implemented in August 2015, has "significantly reduced the processing time for Medicaid applications" by allowing providers to submit enrollment applications through a single point of entry. DCH stated that although it "has made great strides in streamlining the enrollment process," it is engaging the provider community to identify additional improvements.*

[32] As a non-federal, self-funded insurance plan, SHBP opted out of the Mental Health Parity and Addiction Equity Act, which enacts certain requirements to ensure coverage of mental health and addiction services is comparable to that of general medical coverage.

Certain administrative requirements implemented by Medicaid or private insurers may delay or deny members' access to MAT.

While Georgia Medicaid meets some of the best practice recommendations regarding MAT benefits, policies related to prior authorization, time limits, and step therapy (i.e., trial and failure) may delay or restrict individuals seeking to obtain or maintain treatment. Private insurers use similar requirements but may be moving away from applying some restrictions to treatment medications.

Insurance plans use benefit design requirements, such as prior authorization, to contain costs and promote appropriate use of medications and services. Health agencies and professional organizations such as SAMHSA and the American Society of Addiction Medicine (ASAM) have examined treatment barriers and determined that some requirements hamper individuals' ability to obtain or maintain treatment and thus should either be eliminated or revised.

Georgia plans we reviewed are more likely to apply administrative requirements to buprenorphine (likely due to its potential for abuse and diversion) and Vivitrol (because of its cost) than other treatment medications, with the exception of FFS Medicaid. Public and private insurance plans often cover oral naltrexone without any restrictions. Due to its bundling with other NTP services, Medicaid covers methadone as a medical benefit and has few administrative restrictions. SHBP and private insurance companies in Georgia typically do not cover methadone treatment.

We reviewed the following benefit design requirements to determine whether they posed a barrier to treatment access in Georgia: prior authorization, time limits, dose limits, and step therapy. As shown in **Exhibit 15**, Medicaid managed care providers and our private insurance example (SBHP) lacked real-time prior authorization. CMOs also implemented step therapy policies, but other best practice recommendations were evident in nearly all plans.

Exhibit 15
Prior Authorization and Step Therapy Are Barriers in Georgia

Benefit Best Practices	Medicaid[1]					Private Insurance
	FFS	WellCare	Amerigroup	Peach State	CareSource	SHBP
Real-time prior authorization or No prior authorization	✓	✗	✗	✗	✗	✗
No time limits	✓	✗	✓	✓	✓	✓
No arbitrary dose limits	✓	✓	✓	✓	✓	✓
No step therapy	✓	✗	✗	✗	✗	✓

[1] Fee-for-Service (FFS) Medicaid primarily serves approximately 600,000 aged, blind, and disabled Georgians, while the four care management organizations serve approximately 1.4 million low-income children and their families, as well as pregnant women.

Source: DCH, CMO policies

It should be noted that insurance plans have broad discretion in creating policies and benefit design requirements related to MAT. Medicaid CMOs also have discretion in applying benefit design requirements; however, DCH has the authority to establish baseline coverage and issue directives within its contract to ensure individuals can obtain the services they need.

Prior Authorization

Prior authorization requires physicians to request permission for coverage of certain prescriptions and services. The benefit plan approves coverage if the patient and/or prescriber meets certain criteria (e.g., proper diagnosis or sufficient provider credentials). While prior authorization is an effective cost containment measure, it can delay or deny treatment. The National Institute on Drug Abuse states that addiction treatment should be readily accessible since early and quick treatment access ensures that patients begin treatment the moment they are willing to accept help. Moreover, SAMHSA recommends that prior authorization should be electronic and real-time to avoid delays that can result in patients abandoning treatment or relapsing.

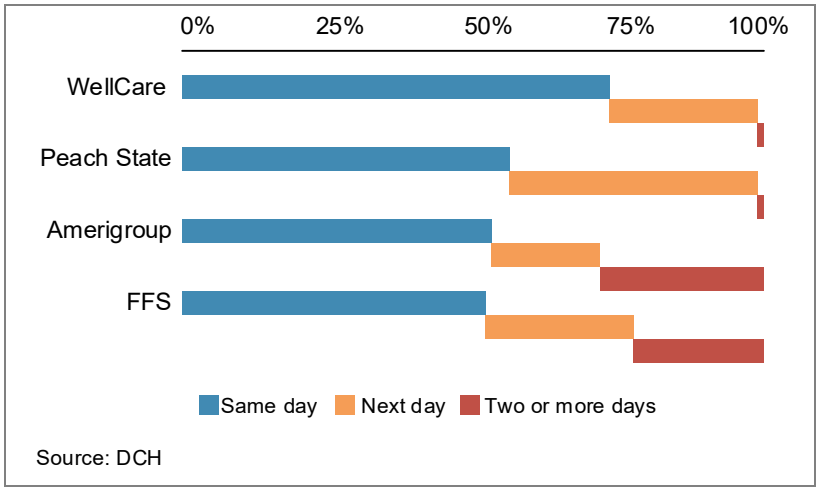
Effective November 2017, FFS Medicaid removed the prior authorization requirement for preferred buprenorphine products and Vivitrol. However, the four CMOs require prior authorization for buprenorphine prescriptions, even when the medication is on the preferred drug list (typically medications with preferred status do not require prior authorization). Three of the four CMOs also require prior authorization for Vivitrol. These prior authorizations last between three and twelve months depending on the dose, at which point the provider must make another request to continue treatment.

As discussed below, our review of prior authorization requests for FFS and CMO coverage in fiscal year 2017 shows that prior authorization may result in individuals waiting for treatment or unable to obtain the medication at all.[33] This review is limited to buprenorphine medications due to the low incidence of requests for Vivitrol (less than 15 across all plans).

- **Treatment Delayed** – In fiscal year 2017, the majority of Georgia Medicaid members requesting prior authorization for buprenorphine were approved or denied the same day, but many members waited until the following day or longer for a final determination. As shown in **Exhibit 16**, two CMOs completed almost all buprenorphine requests by the following day, but approximately 20% of requests to FFS and the remaining CMO were unresolved after two days. Of those prior authorizations that were completed same-day, the time required to process the requests ranged from under an hour to more than eight hours. This means it is likely that many patients left the doctor's office without knowing whether they would be approved for treatment coverage.

[33] This analysis is limited to the three CMOs with historical data: WellCare, Peach State Health Plan, and Amerigroup. The fourth CMO (CareSource) began operating in fiscal year 2018.

Exhibit 16
At Least Half of Buprenorphine Prior Authorizations Were Complete Same Day in FY 2017



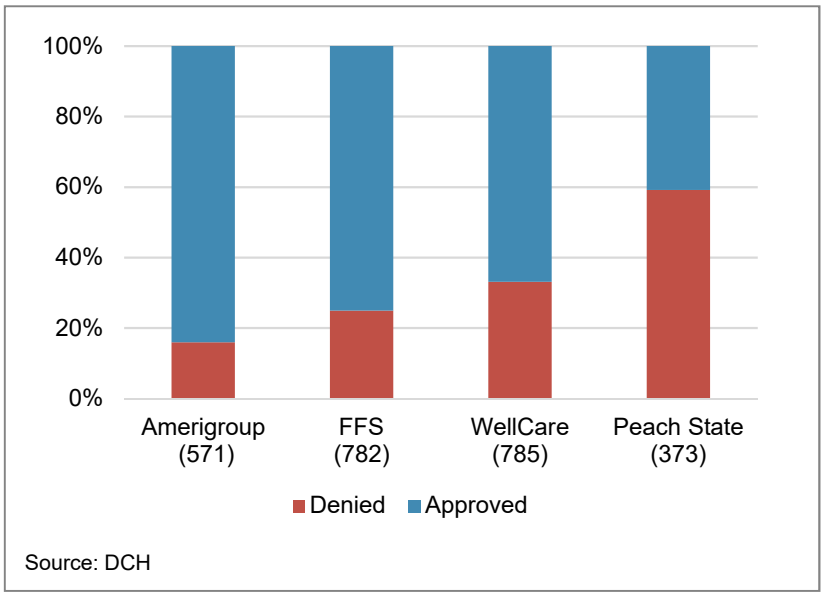
Previous DCH contracts with the CMOs did not explicitly require pharmacy PAs to be completed within a specified time period, and CMO staff we spoke with had varying interpretations of whether such a standard existed.[34] However, the fiscal year 2018 contract includes a 24-hour turnaround time for pharmacy prior authorizations and allows up to 72 hours for resolution if the provider does not submit all required information. While this provision attempts to promote expedient authorizations, it does not ensure that patients seeking treatment experience no delay.

- **Treatment Denied** – As shown in **Exhibit 17**, three of four Georgia Medicaid plans approved the majority of buprenorphine prior authorizations in fiscal year 2017. When requests were denied, CMOs commonly cited criteria not being met as the reason. While this appears to have included some instances in which the patient did not meet eligibility requirements (e.g., depression diagnosis), a large proportion of denials were because the physician did not submit all required documentation. The CMO with the highest denial rate, Peach State, denied nearly 60% of requests. Peach State staff stated physicians did not always submit sufficient documentation but also acknowledged that they use a generic prior authorization request form and were likely unaware of specific requirements for buprenorphine requests. More than half of WellCare's denials also appear to be due to insufficient documentation.

  Providers can appeal prior authorization denials, but this initiates another waiting period that runs contrary to the recommendation of immediate treatment access.

[34] The Centers for Medicare and Medicaid Services requires that responses to prior authorization requests be made within 24 hours for outpatient drugs. According to DCH, CMOs should be aware of this federal requirement.

Exhibit 17
One CMO Denied More than Half of Buprenorphine Prior Authorizations in FY 2017



While some private insurers, including SHBP, require prior authorization for buprenorphine, recent trends suggest private insurance is moving away from this requirement. Beginning in 2016, several large private insurers, including Aetna, Anthem, and Cigna, eliminated prior authorization for buprenorphine treatment products under commercial plans. This movement was spurred in part by lawsuits suggesting that prior authorization unfairly barred patients from addiction treatment. The American Medical Association and attorneys general in several other states have called on health insurers to remove prior authorization from treatment medications, therein expediting access to opioid addiction treatment.

Prior authorization did not appear to be a barrier for obtaining counseling for Georgia Medicaid members. Per the CMO contract, CMOs must provide members with at least 12 counseling sessions prior to requiring prior authorization. Some CMOs had more lenient policies, with one allowing 20 sessions before prior authorization and another forgoing the process altogether. FFS approves service bundles that allow a certain number of counseling sessions per authorization period (from 90 days up to one year). For example, the opioid maintenance package allows 36 counseling sessions under a one-year authorization.

While SHBP does not require prior authorization for non-intensive outpatient counseling, a recent study of private marketplace plans in large cities suggests that it might be required for substance abuse counseling. This was corroborated by our own review of select Georgia plans offered under the Affordable Care Act Health Insurance Marketplace. Additionally, approximately one-third of buprenorphine prescribers who responded to our survey provided feedback indicating that some private insurance plans apply prior authorization to substance abuse counseling.

Dose Limits

Insurers often limit medication strength by establishing a maximum dose or restricting the amount of medication issued per copay or per prescription. In an effort to move toward treating addiction as a chronic disease, ASAM advocates against arbitrary medication limits that prevent providers from tailoring treatments to meet patient needs.

Buprenorphine limitations identified under SHBP, FFS, and all CMOs align with the pharmaceutical manufacturers' prescribing guidance that is intended to ensure safe and effective use of their medications. For example, prescribing information provided by the manufacturer for Suboxone (the most commonly prescribed buprenorphine medication) recommends a maintenance dose of 16 mg and states that doses above 24 mg have not demonstrated any clinical advantage. Buprenorphine dosage limitations under SHBP, FFS, and all but one CMO align with the manufacturer's maximum effective dose. The remaining CMO, Amerigroup, permits 24 mg for the first three months of treatment (known as the induction phase) and then requires the patient to lower the dose to the recommended maintenance dose of 16 mg. FFS and CMOs allow providers to appeal to obtain a higher dose upon proof of medical necessity.

Time Limits

Time limits restrict the total amount of time one can receive coverage for a medication or service. This can be problematic for an individual with an opioid use disorder because, as NIDA asserts, remaining in treatment for a sufficient amount of time (often more than a year) is a critical part of effective recovery. A SAMHSA report echoed this statement, noting that limiting treatment time can have damaging consequences for addiction recovery; since addiction is a chronic disease, relapse is a persistent threat even after long periods of abstinence.

Some CMO members receiving the recommended dose[35] of buprenorphine may experience barriers to continuing treatment after one year. One CMO (WellCare) has a strict exclusion policy, while another (CareSource) reserves the right to request documentation of the treatment's effectiveness and any tapering attempts in order to continue treatment. These policies assume that a patient at a certain dosage should attempt to taper within the first year of MAT. Survey responses from buprenorphine prescribers suggest that tapering within one year might not be possible for some patients. Nearly three-quarters of respondents reported that typical buprenorphine treatment lasts longer than one year, with nearly 40% indicating more than two years.

SHBP does not impose these limits for its covered medications.

Step Therapy/Trial and Failure

Step therapy requires patients to document trial and failure of a preferred, more cost-effective medication before trying non-preferred medications. Documentation must show the preferred medication was ineffective or caused an adverse reaction. ASAM advocates against step therapy policies because they hinder providers' efforts to match patients with the most effective medications. Similarly, in a 2014 bulletin about MAT, the Centers for Medicaid and Medicare Services noted that it does not advocate for a

[35] The recommended dose, established by the manufacturer, indicates the target maintenance dosage that should be taken daily.

stepped approach to opioid treatment medications because providers should match the medication to the patient's needs at the time of the assessment.

FFS does not require documented trial and failure for buprenorphine medications, but providers must explain in writing why the preferred product is not medically appropriate. By contrast, though the four CMOs do not list buprenorphine as a product that requires step therapy, providers must submit written documentation of a patient's use of and intolerance to the preferred medication (e.g., allergy, therapeutic failure) before the plan will authorize the requested medication. Amerigroup requires the trial and failure to be within the past 180 days, but the requirement is waived if the patient was receiving the non-preferred medication within the prior 180 days.

Additionally, WellCare requires patients to document trial and failure of the preferred buprenorphine product, Zubsolv, before it will cover Vivitrol (injectable naltrexone). As a result, a patient who has detoxed from all opioids (which is necessary for all naltrexone medications) is required to take an opioid-based treatment and, if later approved, detox a second time before beginning Vivitrol. While step therapy is not required for oral naltrexone, this medication form may not be suitable for all patients. For example, patients who have difficulty adhering to a treatment regimen of daily tablets may have greater success with a monthly injection.

Results from a national study of addiction medication restrictions suggest that private insurers rarely require step therapy for buprenorphine, but often do so for Vivitrol coverage. SHBP does not require step therapy for buprenorphine or Vivitrol.

RECOMMENDATIONS

1. DCH should encourage the CMOs to eliminate prior authorization for treatment medications. In lieu of removing prior authorization entirely, decisions should be real-time to avoid any treatment delays.

2. DCH should continually evaluate FFS and CMO policies as they pertain to MAT to ensure there are no unnecessary barriers for individuals seeking treatment for opioid use disorder. DCH should specifically evaluate current CMO practices related to step therapy and time limits for treatment medication coverage.

***DCH Response**: DCH agreed with the finding and recommendations.*

When unable to obtain MAT, individuals frequently rely on community service boards and other DBHDD network providers for treatment.

Georgians who cannot access MAT due to location or ability to pay appear to rely on community service boards (CSBs) to provide detoxification, residential, and outpatient services to treat their disorder. CSBs have historically not offered MAT because of limited funding; however, DBHDD has recently begun to implement MAT at eight new provider locations through a two-year federal grant.

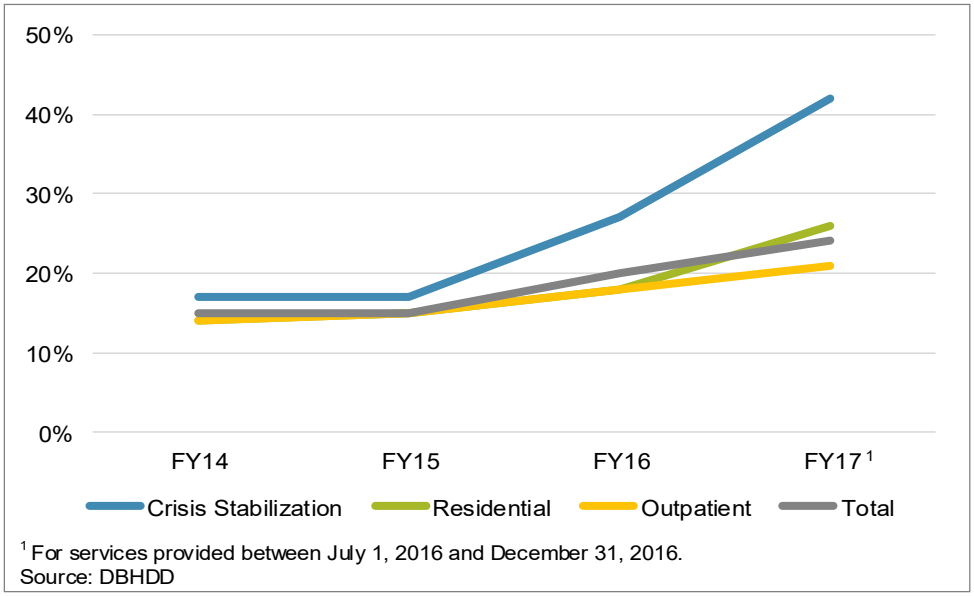
Individuals with opioid use disorder may seek treatment from one of the state's 430 licensed Drug Abuse Treatment and Education Providers. DCH certifies these

facilities to offer primarily residential and outpatient counseling services to individuals with substance use disorders. We were unable to determine the extent to which these providers are treating opioid use disorder, though it is likely some employ physicians who have obtained the waiver to prescribe buprenorphine.[36]

Some Drug Abuse Treatment and Education Providers contract with DBHDD to serve individuals who are unable to pay for their treatment. These providers include the 26 CSBs, which are statutorily created public corporations that provide mental health, developmental disability, and addictive disease services. All CSBs provide a range of outpatient care, including behavioral health assessments, crisis intervention, and psychiatric treatment. The majority of CSBs also provide crisis stabilization and residential services. CSB services have generally not included MAT because DBHDD has not funded the medications.

For each of the past four fiscal years, approximately 50 providers in DBHDD's network—predominantly CSBs—have served approximately 3,000 individuals with opioid use disorder.[37] As shown in **Exhibit 18**, the proportion of patients served for opioid-related diagnoses compared to other addictive diseases has increased from 15% in fiscal year 2014 to 24% in the first half of fiscal year 2017. The most notable increase occurred within the providers' crisis stabilization (i.e., detoxification) services—from 17% to 42%.

Exhibit 18
Proportion of DBHDD Addictive Disease Patients Seeking Treatment for Opioid Use Disorder Has Increased, FY 2014-2017



[1] For services provided between July 1, 2016 and December 31, 2016.
Source: DBHDD

[36] The state only collects data for individuals that qualify for state-funded services; therefore, the total number of individuals receiving treatment for opioid use disorder from non-MAT providers is not known. Drug Abuse Treatment and Education Providers, including CSBs, serve an unknown number of private pay patients with opioid use disorder.

[37] The claims described here are those for which an opioid related diagnosis was the primary reason for the service. Providers submit claims to DBHDD for reimbursement based on their contracted amount or on a fee-for-service basis when the individual is uninsured and cannot pay for the services. Providers may also submit claims to Medicaid; however, those claims are not included in this analysis.

The value of these services averaged an estimated $7.4 million per year from fiscal year 2014 through fiscal year 2016. Fiscal year 2017 services were valued at an estimated $4.7 million for the first six months (compared to approximately $3.6 million over the same period in previous fiscal years) and are projected to total nearly $9.5 million.

While some individuals may benefit from non-MAT services offered by CSBs, it is likely that others' addiction requires medication as well. According to DBHDD staff, individuals will typically spend several days at a crisis stabilization unit to detoxify and then receive residential or outpatient therapeutic services depending on the extent of their addiction. However, CSB staff noted it is difficult to get individuals to return for outpatient services after leaving the crisis stabilization unit. As a result, they may repeatedly return to detox. We noted that of the 2,300 individuals who visited a crisis stabilization unit in fiscal years 2016 and 2017, approximately 480 (20%) received additional detoxification services primarily related to opioids in subsequent months, indicating a relapse. Relapses are common among those with an opioid use disorder, but they are less likely with MAT.

DBHDD staff acknowledged that MAT would be a beneficial addition to their network services; however, limited funding has prohibited the agency from paying for the medication. DBHDD's recent federal grant devotes approximately $2.6 million per year to funding buprenorphine and/or naltrexone at eight new provider locations.[38] This will be achieved in a variety of ways, with some providers adding residential beds and others implementing a traditional outpatient MAT program. DBHDD expects to provide MAT to nearly 2,500 individuals with the two-year grant.

[38] A ninth provider is one of the NTPs that has historically contracted with DBHDD. Southside Medical will receive approximately $38,000 to provide methadone to uninsured individuals.

Appendix A: Table of Recommendations

The state does not have a comprehensive strategy to address the opioid epidemic, which would include ensuring Georgians have access to MAT. (p. 10)
1. In creating the statewide strategic plan, DPH should involve key stakeholders, including state officers in behavioral health, public health, Medicaid, public safety, corrections, and social services. The state plan should include activities related to preventing, monitoring, and treating opioid use disorder; define lead entities for specific tasks; and create evaluation metrics.
2. The General Assembly should consider directing funds to MAT-related activities within DBHDD, as well as adult felony drug courts and DCS day reporting centers, to ensure access to this best practice treatment among individuals unable to pay for it themselves.
While most Georgians live within 20 miles of both an NTP and a buprenorphine prescriber, the state likely does not have an adequate supply to meet current need. (p. 14)
3. DPH should use available datasets to evaluate the need for and capacity to provide treatment (using all three medications) to individuals with an opioid use disorder.
4. DCH should ensure its new application process and rules are not overly burdensome so as to prevent NTPs from opening in identified areas of need.
5. DPH should ensure the statewide strategic plan identifies the entities that can encourage providers to obtain the waiver to prescribe buprenorphine through education and outreach. Certain specialties may be targeted, including psychiatrists, pain management specialists, and general practitioners, who may have the infrastructure to provide counseling and/or lab work in-house. PAs and APRNs could also be encouraged to obtain the waiver when their supervising physicians prescribe buprenorphine for MAT.
Training and resources are needed to improve practitioner knowledge of where to refer individuals identified as having an opioid use disorder. (p. 20)
6. DPH should ensure public health practitioners, such as county health nurses, are trained to identify opioid use disorder and refer patients to treatment, specifically MAT.
7. DPH should ensure the statewide strategic plan identifies a state entity responsible for ensuring practitioners and the public can easily obtain a comprehensive list of NTPs and buprenorphine prescribers. This can be accomplished through a website and other communication with providers.
8. DPH should ensure the statewide strategic plan identifies state entities to coordinate with the various stakeholders that work with practitioners (e.g., Georgia Composite Medical Board, Medical Association of Georgia) to ensure they know where to obtain information on MAT and what providers offer such treatment.
State entities have inconsistent practices related to whether those they supervise are allowed to obtain MAT. (p.23)
9. All state entities should permit individuals with opioid use disorder under their purview to utilize any of the three types of MAT medications, according to identified need. Entities should put controls in place to ensure the individual is using the medication appropriately and obtaining necessary counseling.
10. State entities should ensure those supervising individuals with opioid use disorder (including DFCS caseworkers, DCS officers, accountability court judges, and juvenile court judges) are trained on MAT. This may include sending representatives to upcoming DBHDD trainings and disseminating information to the broader population.
11. DCS and DFCS should clarify policies related to drug screens to more explicitly indicate that MAT medications (methadone and buprenorphine) are permitted when they are prescribed and monitored by a certified provider (i.e., an NTP or a buprenorphine prescriber).
12. DFCS should consider partnering with substance abuse treatment providers that can offer MAT themselves or can refer caregivers with opioid use disorder to outside providers.

Appendix A (Continued)

Individuals with Medicaid or private insurance may not receive coverage for all forms of MAT due to plan limitations or lack of network providers. (p.33)
13. DCH should ensure that both FFS and managed care members have access to NTPs.
14. DCH should notify CMOs of NTPs in the Medicaid provider network and encourage/require them to work to include them in their provider network.
15. DCH should use its recently commissioned report to evaluate network access to buprenorphine prescribers to ensure adequate access throughout the state. If gaps are identified, DCH should consider methods to recruit additional prescribers, such as increasing reimbursement rates.
Certain administrative requirements implemented by Medicaid or private insurers may delay or deny members' access to MAT. (p. 38)
16. DCH should encourage the CMOs to eliminate prior authorization for treatment medications. In lieu of removing prior authorization entirely, decisions should be real-time to avoid any treatment delays.
17. DCH should continually evaluate FFS and CMO policies as they pertain to MAT to ensure there are no unnecessary barriers for individuals seeking treatment for opioid use disorder. DCH should specifically evaluate current CMO practices related to step therapy and time limits for treatment medication coverage.

Appendix B: Objectives, Scope, and Methodology

Objectives

This report examines the extent to which Georgians with an opioid use disorder have access to medication-assisted treatment (MAT). Specifically, our audit set out to answer the following questions:

1. Is there a sufficient number and distribution of MAT providers able to treat individuals with opioid use disorder?
2. Do practitioners and state agencies direct individuals with an opioid use disorder to available MAT?
3. Are individuals able to pay for the treatment they need for opioid use disorder?
4. Where do individuals go when they are unable to access MAT providers?

Scope

This audit generally covered activity related to multiple state entities that are involved in the treatment of opioid use disorder, including the Department of Behavioral Health and Developmental Disabilities (DBHDD), the Department of Community Health (DCH), the Department of Community Supervision (DCS), the Department of Public Health (DPH), the Division of Family and Children Services (DFCS) within the Department of Human Services, and adult felony drug courts. We generally reviewed activity that occurred from fiscal year 2015 through the first half of fiscal year 2017, with consideration of earlier or later periods when relevant.

The scope was restricted to MAT for opioid use disorder based on its demonstrated effectiveness in treating this population. To determine this, we primarily relied on a literature review sponsored by the American Society of Addiction Medicine and the National Institute of Drug Abuse. In the evaluation, 75 research articles that examined the effectiveness of methadone, buprenorphine, and naltrexone were reviewed and summarized, with special emphasis on studies from 2008 to 2013. Common outcome measures included reductions in use or abstinence. We also used other studies identified when relevant.

Information used in this report was generally obtained by reviewing relevant laws, rules, and regulations; interviewing state entity officials and staff; reviewing literature and reports related to MAT; interviewing staff from contiguous and best practice states (Ohio, Massachusetts, and Washington, as identified by national organizations); and conducting surveys of multiple stakeholders, which are described in their corresponding objective. We also interviewed staff from a sample of NTPs and DBHDD providers and surveyed buprenorphine prescribers, which informed multiple objectives and are describe below:

- **NTP Interviews** – We interviewed staff representing 25 of the 71 NTPs that had an active population in February 2017 (34%). Sites were selected primarily based on the size of the patient population and DBHDD treatment region to ensure an adequate distribution across the state, as well as representation based on size and rural versus non-rural locations.

- **DBHDD Provider Interviews** – We interviewed staff from seven DBHDD providers that represented approximately 26% of the 27 providers that were either community service boards or served more than 100 individuals with opioid-related diagnoses in 2015, based on DBHDD's Treatment Episode Dataset. These providers were selected based on patient size and location.

- **Buprenorphine Prescriber Survey** – We sent surveys to 413 physicians with the federal waiver who also allowed SAMHSA to include them on its online physician locator. We received 155 responses, a response rate of 38%. Given our purposeful selection of physicians visible via online locator and our small sample size, we are not able to apply our findings to the full population.

Government auditing standards require that we also report the scope of our work on internal control that is significant within the context of the audit objectives. Our audit did not assess agencies' internal controls. We compared agency policies and procedures to best practices and other states only to ensure that they did not restrict access to MAT. We did not review agencies' policies and procedures to ensure that they were accomplishing the agency objectives.

Methodology

To determine whether there is a sufficient number and distribution of MAT providers, we obtained a list of narcotic treatment programs (NTPs) and their location from DCH (as of July 1, 2017). The percentage of Georgians within a 5-, 10-, or 20-mile radius from these locations was determined using Geographic Information System (GIS) software and 2015 United States Census Bureau population data. We used DBHDD's Central Registry—to which all NTPs are federally required to report to ensure individuals are not concurrently enrolled—to estimate the number of patients NTPs served as of February 2017.

We obtained a list of physicians who had received the waiver to prescribe buprenorphine from the Substance Abuse and Mental Health Services Administration (SAMHSA) in February 2017. Information included the physician's location, patient cap (30, 100, 275), and whether the physicians allowed SAMHSA to include their contact information in its online physician locator. The capacity to treat with buprenorphine was calculated by multiplying the patient cap by the number of physicians with that cap. We used GIS to calculate the percentage of Georgians within 5, 10, or 20 miles of each prescriber.

We used Georgia's Prescription Drug Monitoring Program (PDMP) to estimate the number of Georgia physicians with the waiver who wrote a prescription for buprenorphine medications[39] approved for treatment in fiscal years 2016 and 2017 (the only years available). We also identified the number of Georgia patients who had filled a prescription. While we did not independently verify the data, we assessed the

[39] These medications included Bunavail, generic buprenorphine and buprenorphine-naloxone, Suboxone, and Zubsolv. Physicians with the federal waiver, which comprise only 3% of Georgia's licensed physicians, wrote approximately 97% of prescriptions for Suboxone (the most commonly prescribed buprenorphine treatment medication), compared to only 12% for the common prescription painkiller Oxycodone. Therefore, it is unlikely Suboxone is used for purposes other than addiction treatment. As such, all prescriptions written for these approved medications by physicians with the waiver were included in our estimates.

controls over the PDMP and determined the data used were sufficiently reliable for our analysis.

To estimate the need for treatment in Georgia, we applied percentages derived from SAMHSA's National Survey on Drug Use and Health (based on 2012-2014 averages), to the 2016 population over 12 years of age. We also used mortality data from DPH's online statistical information system to determine the number of individuals who had died from an overdose of opioid pain relievers and/or heroin. Finally, we used self-reported data collected by DPH's Office of EMS and Trauma to determine how often EMS technicians administered naloxone to an individual who had overdosed.

To determine whether practitioners and state agencies direct individuals with an opioid use disorder to available MAT, we reviewed literature and state policies and interviewed various stakeholders, including NTPs and DBHDD providers, state entity staff, and representatives from professional organizations. In particular, we interviewed five emergency department discharge planners from urban and rural hospitals, as recommended by the Georgia Hospital Association. We also sent surveys to several positions in state entities that encounter individuals with opioid use disorder, including:

- **County Health Department Nurse Managers** – We emailed surveys to the 153 county nurse managers (seven were undelivered) and received 133 responses, a response rate of 91%. Based on this sample size, we are able to apply our results to the full population with a 99% confidence level.

- **DCS Officers** – We emailed surveys to the 49 DCS coordinating chiefs (two were undelivered) and received 31 responses, a response rate of 66%. Based on this sample size, we not are able to apply our results to the full population. We also emailed surveys to the 36 DRC and DRC-Lite administrators (three were undelivered) and received 22 responses for a 67% response rate. Again, this sample size did not allow us to apply our results to the full population.

- **Adult Felony Drug Court Judges** – We emailed surveys to the 53 AFDC judges (two were undelivered) and received 36 responses, a response rate of 71%. Based on this sample size, we not are able to apply our results to the full population.

- **DFCS County Directors** – We emailed surveys to the 96 DFCS county directors and received 72 responses, a response rate of 75%. Based on this sample size, we not are able to apply our results to the full population.

- **Juvenile Court Judges** – We emailed surveys to the 93 juvenile court judges (three were undelivered) and received 60 responses, a response rate of 67%. Based on this sample size, we not are able to apply our results to the full population.

To determine whether individuals are able to pay for MAT, we estimated costs for buprenorphine- and naltrexone-based treatment using State Health Benefit Plan (SHBP) pharmacy and professional claims data from 2014 to 2016. We selected a

sample of SHBP members who were undergoing maintenance therapy in 2016[40] and examined pharmacy and professional claims data for those members. We estimated median monthly costs of medications, median cost for each counseling/doctor's visit, and median annual lab work cost.

To estimate out-of-pocket costs for privately insured and uninsured Georgians, we created a treatment model based on federal and treatment professional recommendations. In this model, a patient visited the same physician once a month[41] to receive counseling and their prescription for a 30-day supply of the most commonly prescribed buprenorphine or naltrexone medication. We also assumed the patient would receive lab work every three months, which was which was consistent with SHBP claims data, though variances were noted. Inputs used for the model include benefit information from SHBP plans that SHBP staff indicated were comparable to other private insurance plans, and treatment cost (e.g., medication cost, counseling/doctor's visit cost, and cost of lab work) from claims data.

To estimate the annual cost of methadone treatment, we interviewed staff representing 25 NTPs of the 71 NTPs that were serving patients in February 2017. We averaged the daily rates these NTPs charged to patients (which ranged from $11 to $14) and estimated the annual cost.

To determine coverage of MAT under Medicaid, we reviewed Medicaid policies, care management organization policies and contracts, and conducted interviews with staff. As a proxy for private insurance, we reviewed MAT coverage under SHBP by examining plan documents and interviewing DCH staff.

To determine where individuals go when they cannot access MAT, we obtained a list of Drug Abuse Treatment and Education Programs (DATEPs) from DCH (as of November 2016). To estimate the number of individuals treated at DATEPs that serve in DBHDD's provider network, we obtained DBHDD claims data for services rendered between July 1, 2013 and December 31, 2016 (the most recent data reliably available) for which an opioid-related diagnosis was the primary reason. We assessed the reliability of this data and found it be sufficient for the purposes of our analysis. To determine the value of the services provided, we used claim amounts for services paid under the fee-for-service arrangement. For services provided under contract, we allocated a proportion of contracted amounts based on the units of service for opioid-related diagnoses and all other addictive diseases.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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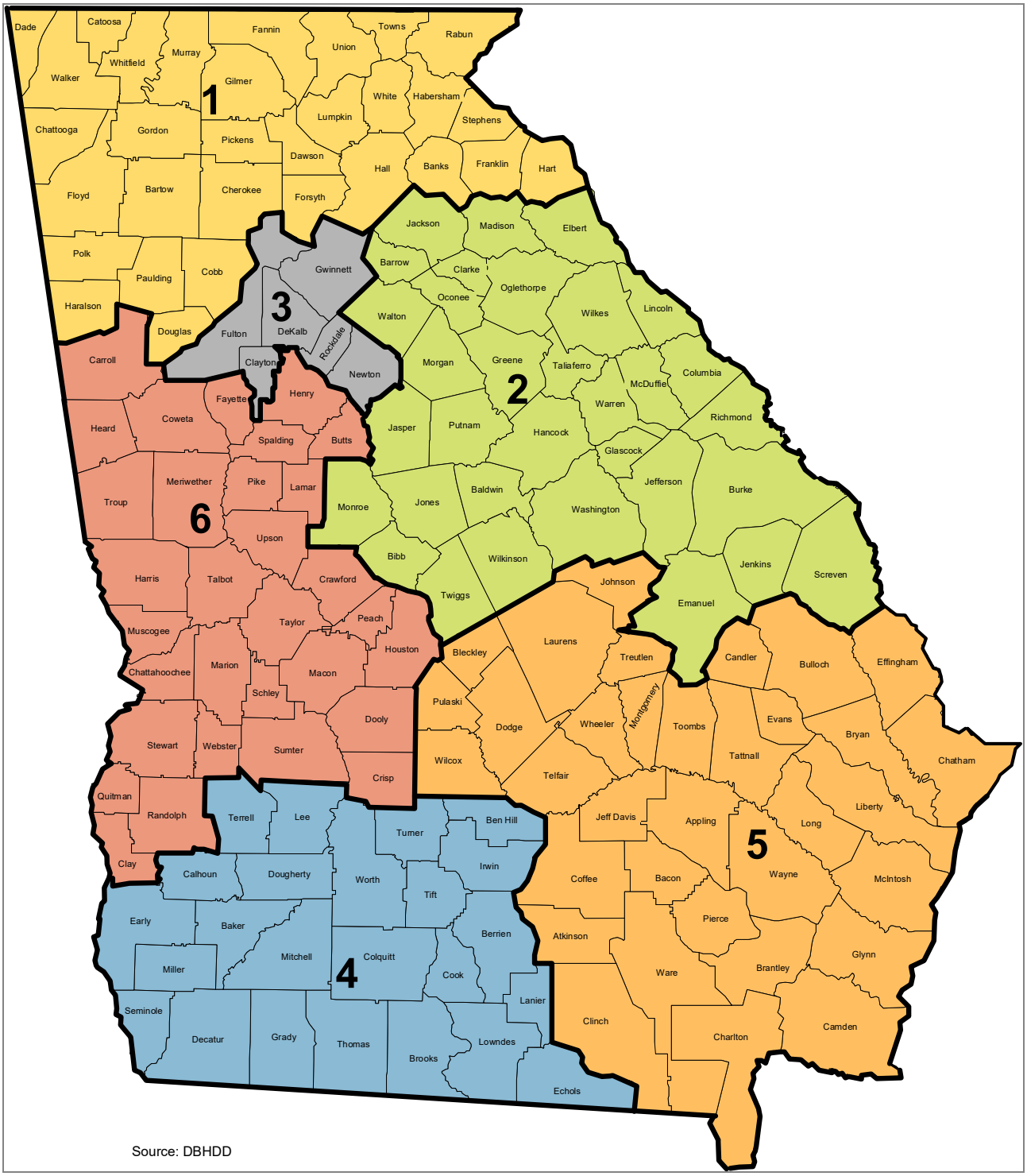
[40] SHBP members were identified as being on maintenance therapy if they received a 30-day supply of either buprenorphine or naltrexone each month in 2016.

[41] Federal and treatment professional recommendations note that during the early months of treatment individuals are most susceptible to relapse and potential overdose, and treatment providers should monitor patients closely. In the model, patients visit their treatment providers weekly during the first two months of treatment (eight visits) and see them once a month for subsequent months.

Appendix C: DBHDD Treatment Regions



Source: DBHDD

Appendix D: Need for and Availability of MAT

County	Population (CY16)	# of Deaths (CY16)	Death Rate[1] (CY16)	# of Overdose Reversals (CY16)	Overdose Reversal Rate[1] (CY16)	# of NTPs (FY18)	Miles to Closest NTP	# Active Buprenorphine Prescribers (Feb. 2017)
Region 1	**2,164,113**	**345**	**12.7**	**2,931**	**135.4**	**18**	**10**	**106**
Banks	15,030	3	*	15	99.8	0	8	0
Bartow	82,713	16	15.0	156	188.6	1	1	3
Catoosa	53,838	12	19.2	20	37.1	1	1	2
Chattooga	20,274	4	*	53	261.4	0	21	0
Cherokee	191,670	34	14.6	282	147.1	1	11	6
Cobb	597,729	108	14.0	1,014	169.6	3	4	58
Dade	13,677	0	0	0	0	1	9	0
Dawson	19,640	3	*	27	137.5	1	6	1
Douglas	111,707	27	18.8	179	160.2	1	1	4
Fannin	21,399	5	11.3	28	130.8	0	22	1
Floyd	77,780	10	10.3	163	209.6	1	4	4
Forsyth	170,172	13	6.1	22	12.9	1	1	5
Franklin	18,348	3	*	35	190.8	0	17	0
Gilmer	24,912	5	22.0	47	188.7	0	19	0
Gordon	45,284	7	13.4	28	61.8	1	1	0
Habersham	35,996	5	9.4	42	116.7	0	10	0
Hall	154,515	12	6.1	134	86.7	1	3	8
Haralson	23,358	9	28.4	50	214.1	0	17	0
Hart	21,093	2	*	24	113.8	0	30	0
Lumpkin	26,767	3	*	25	93.4	0	12	0
Murray	31,269	3	*	22	70.4	1	1	0
Paulding	121,689	25	15.4	198	162.7	1	3	3
Pickens	25,709	4	*	47	182.8	0	23	0
Polk	32,853	4	*	97	295.3	0	15	0
Rabun	14,283	1	*	22	154.0	0	19	2
Stephens	20,992	2	*	33	157.2	1	2	2
Towns	10,175	2	*	24	235.9	0	12	0
Union	20,011	3	*	31	154.9	1	1	0
Walker	55,617	10	16.4	1	*	1	17	0
White	24,080	5	13.0	37	153.7	0	19	3
Whitfield	81,533	5	5.1	75	92.0	0	10	4
Region 2	**1,055,271**	**124**	**9.4**	**970**	**91.9**	**9**	**22**	**55**
Baldwin	37,870	0	0	35	92.4	0	29	1
Barrow	59,909	10	11.9	56	93.5	1	7	2
Bibb	120,893	9	6.6	279	230.8	3	2	14
Burke	17,742	3	*	7	39.5	0	20	0
Clarke	105,949	14	11.0	78	73.6	2	3	6
Columbia	116,402	17	11.0	22	18.9	1	12	7
Elbert	15,687	1	*	14	89.2	0	30	2
Emanuel	17,887	1	*	4	*	0	26	0
Glascock	2,462	0	0	5	203.1	0	33	0
Greene	14,272	1	*	13	91.1	0	30	1
Hancock	7,476	0	0	11	147.1	0	49	0
Jackson	50,828	7	10.1	84	165.3	1	10	2
Jasper	10,946	1	*	6	54.8	0	17	0
Jefferson	12,817	0	0	3	*	0	33	0
Jenkins	7,319	1	*	1	*	0	27	1
Jones	23,208	3	*	27	116.3	0	11	2
Lincoln	6,583	1	*	11	167.1	0	28	0
Madison	23,361	3	*	46	196.9	0	13	0
McDuffie	16,962	0	*	16	94.3	0	22	0
Monroe	22,801	1	*	13	57.0	0	19	0
Morgan	14,830	0	0	13	87.7	0	26	0
Oconee	28,973	0	0	7	24.2	0	6	5
Oglethorpe	12,316	0	0	14	113.7	0	18	1

Appendix D (cont.)

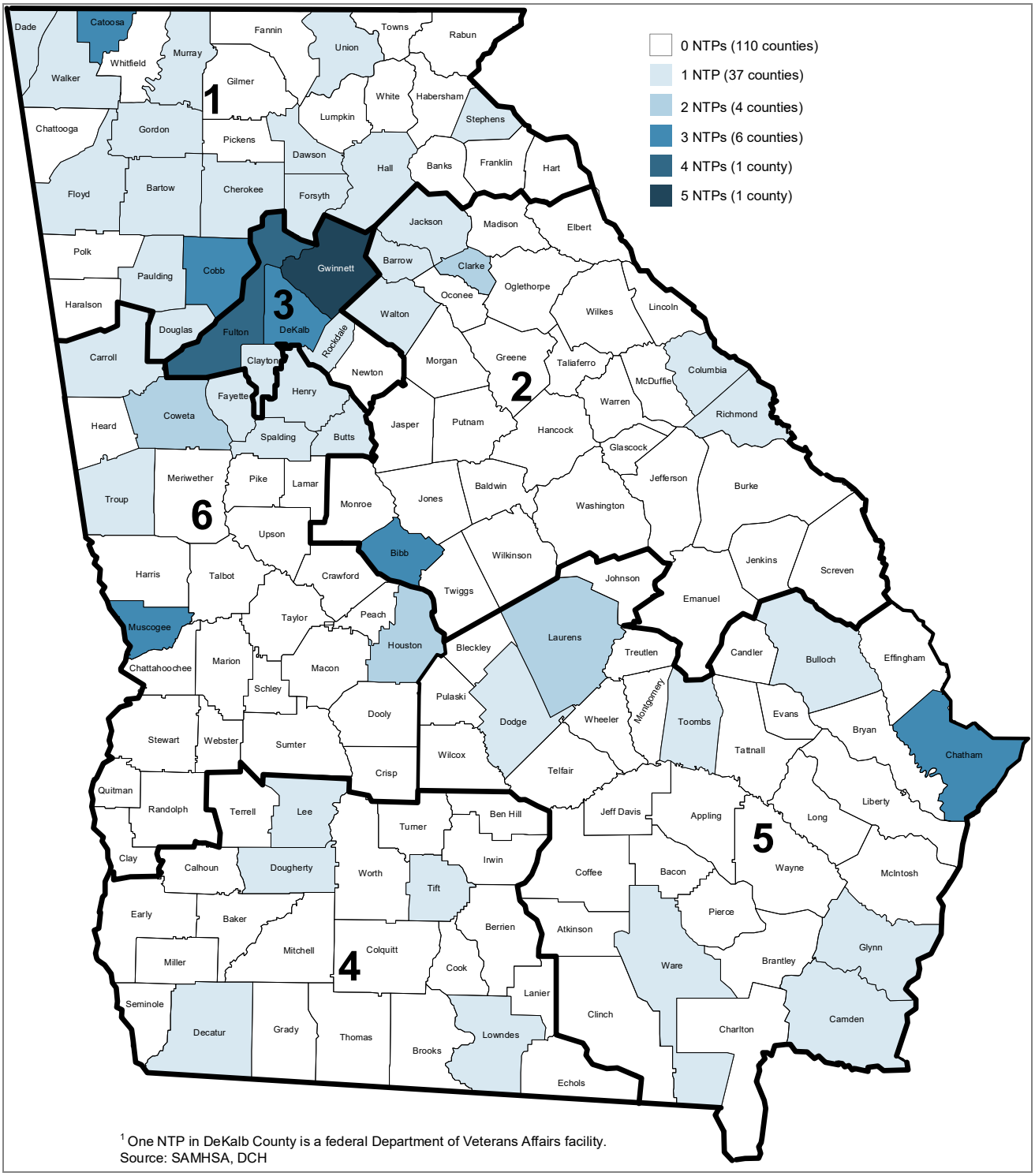
County	Population (CY16)	# of Deaths (CY16)	Death Rate[1] (CY16)	# of Overdose Reversals (CY16)	Overdose Reversal Rate[1] (CY16)	# of NTPs (FY18)	Miles to Closest NTP	# Active Buprenorphine Prescribers (Feb. 2017)
Putnam	17,807	1	*	10	56.2	0	34	2
Richmond	161,990	34	15.0	54	33.3	1	2	7
Screven	11,583	0	0	5	43.2	0	22	0
Taliaferro	1,356	0	0	0	0	0	40	0
Twiggs	6,823	2	*	17	249.2	0	18	0
Walton	71,630	12	13.8	82	114.5	1	9	2
Warren	4,474	0	0	8	178.8	0	33	0
Washington	16,672	2	*	21	126.0	0	31	0
Wilkes	8,081	0	0	1	*	0	39	0
Wilkinson	7,362	0	0	7	95.1	0	23	0
Region 3	**2,493,641**	**282**	**8.6**	**3,381**	**135.6**	**14**	**4**	**146**
Clayton	213,459	21	7.6	314	147.1	1	4	18
DeKalb	591,308	54	6.7	822	139.0	3	1	52
Fulton	831,153	130	12.0	1,679	202.0	4	3	46
Gwinnett	702,787	61	6.7	417	59.3	5	2	27
Newton	83,715	7	6.6	73	87.2	0	10	0
Rockdale	71,219	9	9.5	76	106.7	1	4	3
Region 4	**481,507**	**22**	**3.9**	**418**	**86.8**	**4**	**19**	**18**
Baker	2,633	0	0	2	*	0	23	0
Ben Hill	13,516	1	*	4	*	0	22	0
Berrien	15,155	0	0	10	66.0	0	24	0
Brooks	12,811	0	0	23	179.5	0	17	0
Calhoun	5,373	1	*	3	*	0	24	0
Colquitt	35,405	0	0	12	33.9	0	27	2
Cook	13,421	0	0	14	104.3	0	20	0
Decatur	21,435	0	0	16	74.6	1	1	0
Dougherty	71,500	5	5.7	116	162.2	0	3	6
Early	8,201	0	0	6	73.2	0	39	0
Echols	3,046	0	0	0	0	0	19	0
Grady	19,596	0	0	20	102.1	0	22	0
Irwin	7,782	1	*	4	*	0	17	0
Lanier	8,126	0	0	3	*	0	17	0
Lee	22,992	1	*	20	87.0	1	8	0
Lowndes	91,466	5	4.7	51	55.8	1	1	7
Miller	4,789	0	0	6	125.3	0	21	0
Mitchell	18,169	0	0	15	82.6	0	27	0
Seminole	7,004	0	0	6	85.7	0	21	0
Terrell	7,228	0	0	4	*	0	18	0
Thomas	36,231	3	*	48	132.5	0	36	3
Tift	32,372	2	*	28	86.5	1	1	0
Turner	6,420	1	*	6	93.5	0	18	0
Worth	16,836	2	*	1	*	0	20	0
Region 5	**911,788**	**91**	**8.2**	**888**	**97.4**	**14**	**18**	**75**
Appling	14,571	3	*	13	89.2	0	31	5
Atkinson	6,330	1	*	4	*	0	31	0
Bacon	8,916	0	0	5	56.1	0	25	1
Bleckley	10,840	0	0	2	*	0	17	1
Brantley	14,752	6	34.1	40	271.1	0	21	0
Bryan	27,467	0	0	17	61.9	0	23	2
Bulloch	62,277	3	*	5	8.0	1	0	7
Camden	42,149	4	*	47	111.5	1	15	3
Candler	8,638	1	*	12	138.9	0	17	0
Charlton	10,534	1	*	35	332.3	3	24	0
Chatham	235,354	22	8.5	262	111.3	3	3	20
Clinch	5,369	0	0	7	130.4	0	27	0
Coffee	34,212	6	12.3	27	78.9	0	37	4

Appendix D (cont.)

County	Population (CY16)	# of Deaths (CY16)	Death Rate[1] (CY16)	# of Overdose Reversals (CY16)	Overdose Reversal Rate[1] (CY16)	# of NTPs (FY18)	Miles to Closest NTP	# Active Buprenorphine Prescribers (Feb, 2017)
Dodge	17,145	3	*	22	128.3	1	1	1
Effingham	45,890	5	8.6	36	78.4	0	23	0
Evans	8,281	1	*	7	84.5	0	21	0
Glynn	68,649	6	6.6	80	116.5	1	8	17
Jeff Davis	11,550	4	*	11	95.2	0	27	0
Johnson	8,059	0	0	10	124.1	0	17	0
Laurens	37,866	3	*	38	100.4	2	1	1
Liberty	47,229	4	*	43	91.0	0	32	5
Long	14,044	1	*	8	57.0	0	35	0
McIntosh	11,957	1	*	9	75.3	0	10	0
Montgomery	7,505	0	0	0	0	0	12	0
Pierce	15,221	3	*	14	92.0	0	9	0
Pulaski	9,493	3	*	5	52.7	0	17	1
Tattnall	20,682	1	*	27	130.5	0	18	0
Telfair	13,714	1	*	14	102.1	0	19	0
Toombs	21,114	1	*	3	*	1	4	3
Treutlen	5,305	0	0	7	132.0	0	16	0
Ware	28,561	1	*	28	98.0	1	1	3
Wayne	23,905	5	16.6	36	150.6	0	32	1
Wheeler	6,850	0	0	3	*	0	23	0
Wilcox	7,359	1	*	11	149.5	0	15	0
Region 6	**1,128,174**	**118**	**8.5**	**1,277**	**113.2**	**13**	**20**	**47**
Butts	19,723	3	*	38	192.7	1	1	0
Carroll	93,093	22	20.0	97	104.2	1	5	4
Chattahoochee	9,002	0	0	3	*	0	13	0
Clay	2,486	0	0	0	0	0	50	0
Coweta	111,445	15	10.8	181	162.4	2	1	2
Crawford	10,226	2	*	11	107.6	0	20	0
Crisp	18,112	0	0	8	44.2	0	34	0
Dooly	11,739	0	0	0	0	0	26	0
Fayette	91,494	6	5.4	90	98.4	1	0	2
Harris	27,808	5	14.9	24	86.3	0	17	0
Heard	9,383	1	*	11	117.2	0	17	0
Henry	175,230	25	11.0	171	97.6	1	6	8
Houston	119,640	5	3	89	74.4	2	1	14
Lamar	15,317	2	*	27	176.3	0	15	1
Macon	11,363	0	0	9	79.2	0	24	0
Marion	7,024	1	0	2	*	0	28	0
Meriwether	17,303	0	0	14	80.9	0	16	0
Muscogee	156,548	10	5.3	189	120.7	3	5	13
Peach	21,789	1	*	36	165.2	0	12	0
Pike	14,638	1	*	11	75.1	0	11	0
Quitman	2,000	0	0	3	*	0	42	0
Randolph	5,919	0	0	6	101.4	0	36	0
Schley	4,045	0	0	3	*	0	38	0
Spalding	51,911	8	12.7	92	177.2	1	1	1
Stewart	5,038	1	*	3	*	0	31	0
Sumter	24,551	0	0	18	73.3	0	31	0
Talbot	5,274	0	0	6	113.8	0	27	0
Taylor	6,878	1	*	18	261.7	0	32	0
Troup	55,512	6	10.3	85	153.1	1	4	2
Upson	21,501	2	*	30	139.5	0	24	0
Webster	2,182	1	*	2	*	0	36	0

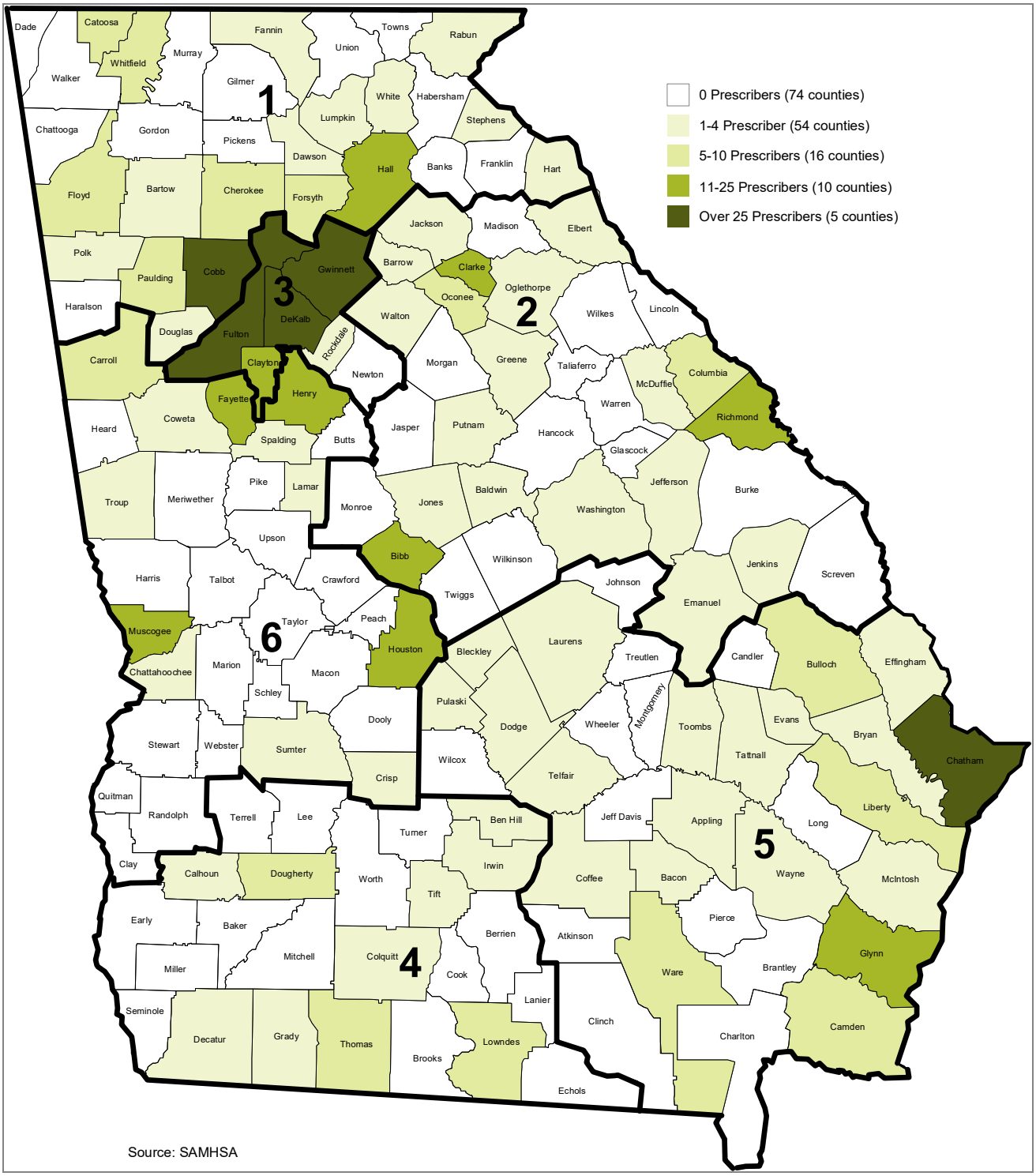
[1] Rates were not calculated for less than five deaths or naloxone administrations (indicated by *).
Source: DBHDD, DCH, DPH, SAMHSA

Appendix E: NTP Distribution

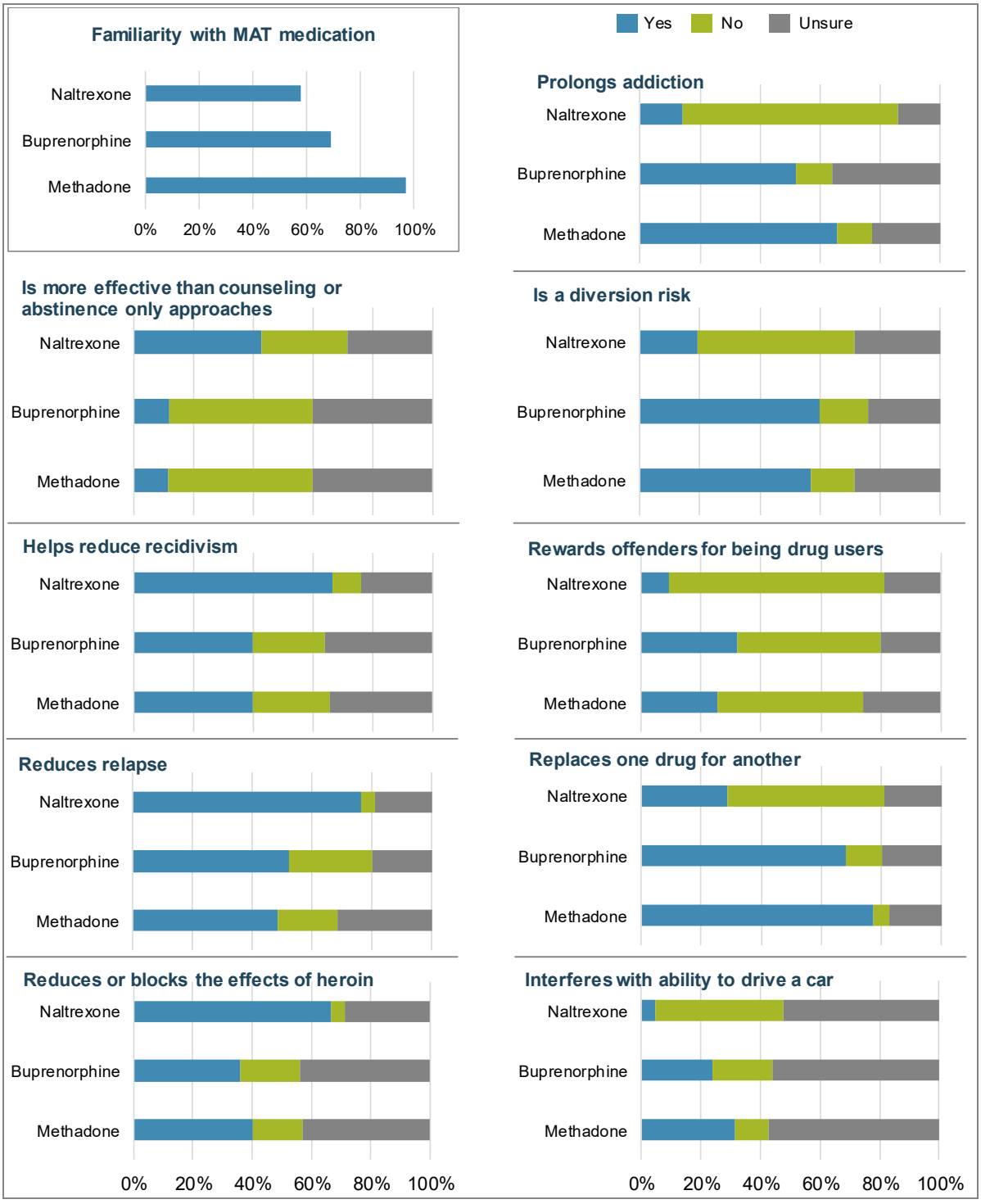


[1] One NTP in DeKalb County is a federal Department of Veterans Affairs facility.
Source: SAMHSA, DCH

Appendix F: Buprenorphine Prescriber Distribution

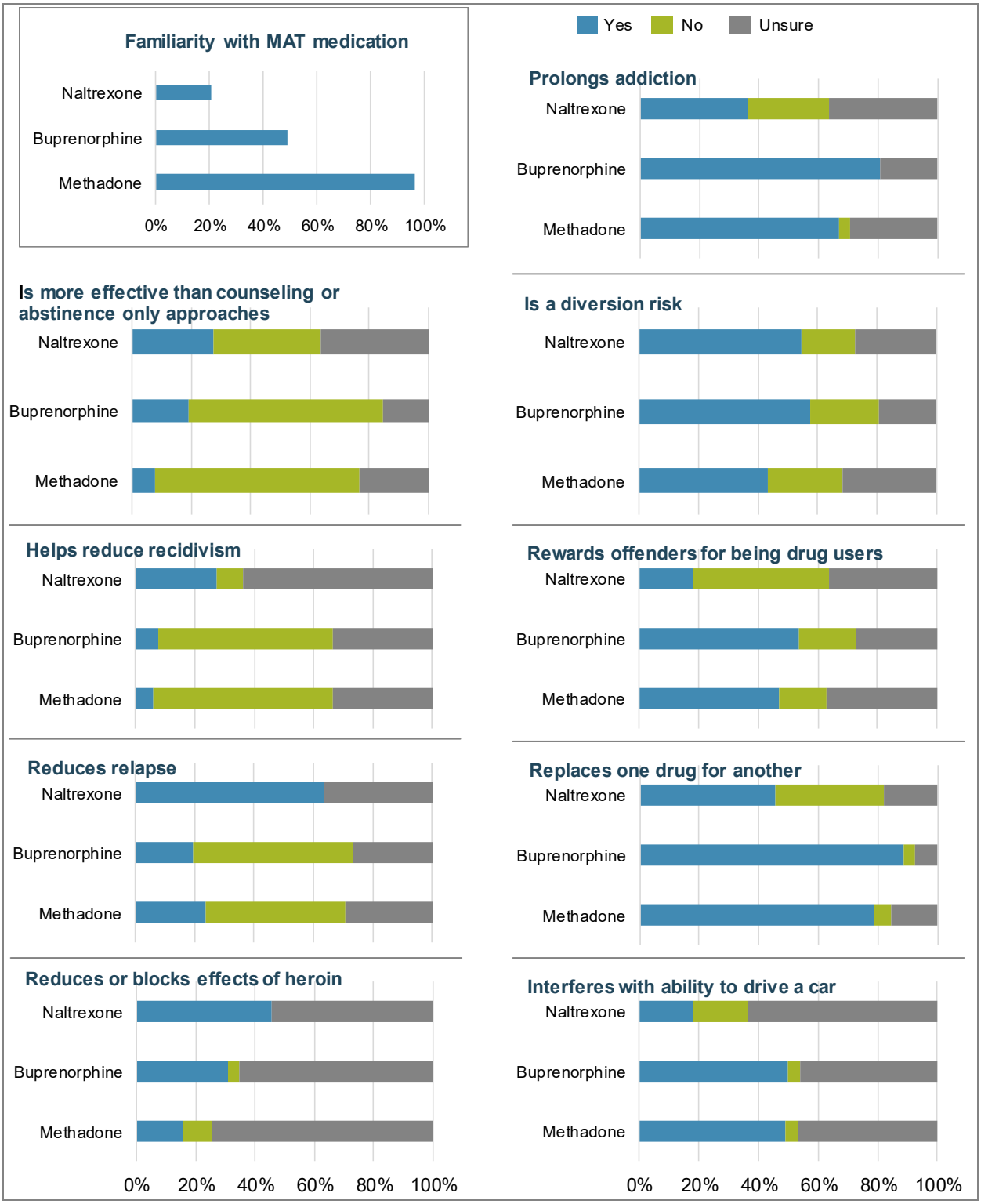


Appendix G: Adult Felony Drug Court Judges' Perceptions of MAT Medications[42]



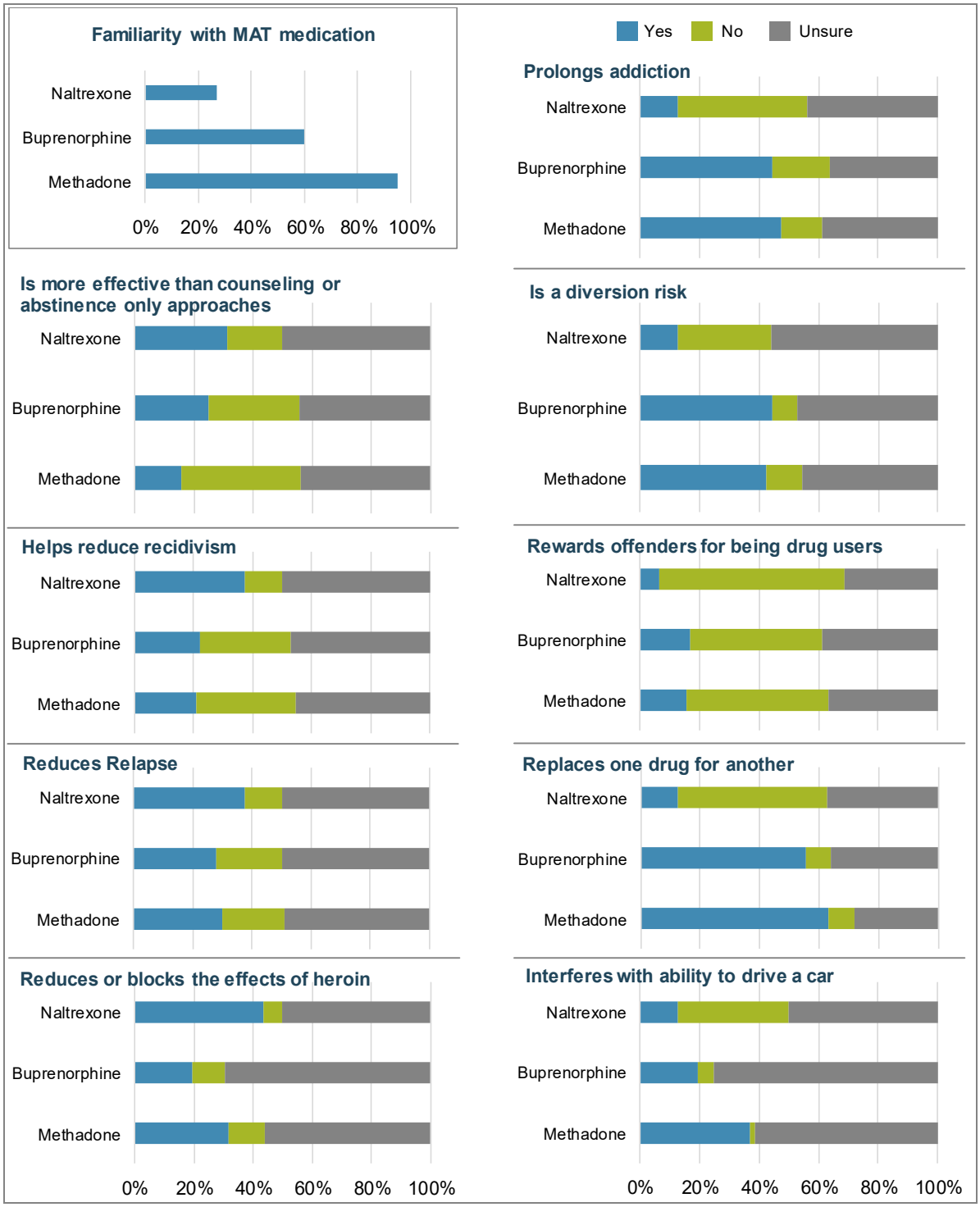
[42] Perception questions were asked only to those who reported familiarity with that particular medication. Of the 36 respondents, 35 were familiar with methadone, 25 with buprenorphine, and 21 with naltrexone.

Appendix H: DCS Supervisors' Perceptions of MAT Medications[43]



[43] Perception questions were asked only to those who reported familiarity with that particular medication. Of the 51 respondents, 51 were familiar with methadone, 26 with buprenorphine, and 11 with naltrexone.

Appendix I: Juvenile Court Judges' Perceptions of MAT Medications[44]



[44] Perception questions were asked only to those who reported familiarity with that particular medication. Of the 60 respondents, 57 were familiar with methadone, 36 with buprenorphine, and 44 with naltrexone.

Appendix J: State Health Benefit Plan Insurance Plans Reviewed and MAT Costs

	Health Reimbursement Arrangement (HRA)[1]			Health Management Organization (HMO)		High Deductible Health Plan (HDHP)
	Bronze	Silver	Gold	BCBS	UHC	UHC
Plan Features						
Monthly Premium[2]	$70	$110	$165	$130	$170	$50
Deductible	$2,500	$2,000	$1,500	$1,300[3]		$3,500
HRA Balance[4]	$100	$250	$400	N/A		N/A
Out-of-Pocket Maximum[5]	$6,000	$5,000	$4,000	$4,000		$6,450
Coverage for Services[6]						
Primary Care Physician	75%	80%	85%	$35		70%
Mental Health/Substance Abuse Outpatient Specialist	75%	80%	85%	$45		70%
Outpatient Testing/Labs	75%	80%	85%	80%		70%
Insured Cost of Treatment Medications						
Buprenorphine	$80	$80	$80	$50		$400
Oral Naltrexone	$20	$20	$20	$20		$35
Estimated Annual Cost of MAT[7]						
Buprenorphine	$2,700	$2,600	$2,100	$1,700		$4,900
Oral Naltrexone[8]	$2,000	$1,900	$1,400	$1,400		$2,300

[1] Blue Cross Blue Shield manages all HRA plans. HRA plan members have to pay all costs out of pocket until they reach their deductible, after which the applicable coinsurance will take effect.

[2] Monthly premium costs reflect 2017 rates for individuals (rounded).

[3] In HMO plans, copays do not apply toward the deductible (i.e., only labs and diagnostic testing would apply toward the deductible).

[4] HRA plan members begin each year with a set amount of funds to use for healthcare costs.

[5] Out-of-pocket maximum is the maximum amount a plan member must pay before insurance covers all healthcare costs.

[6] Percentages listed reflect the percent the insurance will pay. HMO members pay a fixed rate copayment for every visit to a primary care physician or specialist.

[7] Annual treatment costs calculated based on SHBP claims data.

[8] Naltrexone treatment costs do not include the cost of undergoing medically supervised withdrawal.

Source: SHBP

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