Systemic Barriers to Use of Medications in Addiction Treatment

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Why Is MAT An Issue?

- Epidemic of overdose deaths from opioid pain relievers; comparable to deaths from motor vehicle crashes involving persons under age 65;
- Higher death rates in states with high rates of poverty, non-Hispanic whites, rural areas; and among Medicaid populations;
- Non-medical use of opioid pain relievers costs health insurers ~73 billion annually in health care costs.
- Among adolescents aged 12-17, the highest non-medical use of prescription drugs in the past year or month occurred in suburban counties.
Why Is MAT An issue? (con’t)

- Under-utilization of effective medications in comprehensive treatment prevents using medications to help stem the growth of overdose;
- Medicaid is growing in importance as a public payer for addiction treatment and parity coverage and benefits can support both public and private insurance coverage;
- Lack of Medicaid eligible and enrolled practitioners that can provide MAT is significant.
- Non-quantitative treatment limitations (NQTLs) are frequent among private insurers despite the passage of the parity act (MHPAEA).

Why is MAT an issue? (con’t)

- State legislatures and governors are limiting access, duration, and dosages for medications that are used to treat substance use disorders
- Overdose deaths are increasing at an alarming rate
Number of drug overdose deaths involving opioid pain relievers and other drugs
US, 1999-2010

Rates of opioid overdose deaths, sales and treatment admissions increased in parallel in the United States
Medications for Alcohol Dependence

- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable
- Acamprosate
- Disulfiram

Medications for Opioid Dependence

- Methadone
- Buprenorphine
- Naltrexone – oral
- Naltrexone (Vivitrol) – long-acting, injectable
Effectiveness of Medications in Treatment

All medications for treatment of moderate and severe addiction to opioids have shown clear clinical evidence of effectiveness in:

• reducing opioid use and opioid-use related symptoms of withdrawal and craving and,
• risk of infectious diseases and crime when used as part of a comprehensive approach in appropriate doses.

Similar effectiveness exists for medications to treat alcohol dependence but adherence to oral medications are often a problem.

Effectiveness (con’t)

• Effectiveness of these medications is true only when used as maintenance treatments.

• There is NO evidence of enduring benefits from any medications when used in any type of “detoxification only” regimen that does not include continuing treatment and recovery supports.
Cost-Effectiveness

- All medications are cost-effective
  - Use of medications reduces inpatient hospital admissions for both alcohol- and drug-related issues and for other health issues including admissions to emergency departments
  - Use of medications increases use of outpatient psychotherapy – we speculate because patients are more stable and able to participate in outpatient treatment

Any vs. No Medication:
TOTAL Cost per patient (inpatient + outpatient + pharmacy costs)
Medicaid Coverage of Medications for the Treatment of Opioid Dependence

• Based on a recent survey conducted by TRI and the Avisa Group for ASAM---
  – Every state Medicaid program covers at least one of the four FDA-approved medications for the treatment of opioid dependence
  – Different Medicaid programs have implemented either flexible or rigid authorization requirements which must be met in order for payment for these medications to be approved.
  – Requirements for approval can range from limited to severe, and may include “fail first” policies or a history of frequent service utilization.
  – Actual implementation of written criteria may vary from what is stated.
Private Sector Coverage

• Inclusion in a plans’ formulary does not imply that there is easy access to medications.
• Patients often are required to have medical, pharmacy, and behavioral health benefits in the same plan to access medication during treatment.
• Utilization management (UM) techniques often reduce access:
  – Prior authorization
  – Quantity and dosage limits
  – Step therapy or “fail first” requirements
    • Lower doses before higher doses is not unusual

Public and Private Sector Utilization

• Only about 30% of treatment programs in the US use medications as part of comprehensive treatment
• Under-utilization of medications for treatment of opioid disorders has been driven by:
  – State licensing requirements that restrict hiring of physicians in substance use treatment programs
  – Restrictions on use of some medications in specific treatment settings, e.g. residential treatment
  – Cultural and ideological issues in the workforce
Levels of Systemic Barriers

Multi-level barriers:
• Policy - Federal and State regulations
• Financing – Public and private coverage and benefits
• Organizational – Substance use specialty treatment programs, primary care, hospitals
• Clinicians – medical and non-medical staff

Policy Issues

• Policy - Federal
  – Federal regulation and accreditation of methadone treatment programs
  – Federal regulation of training and practitioner limitations for buprenorphine
  – DEA prescription requirements
Policy Issues

- Policy – State
  - Medicaid
    - Eligible and enrolled providers
    - Eligible patients - offenders
    - Preauthorization and reauthorization processes that take weeks or months
    - “Fail first” or “Step therapy” criteria
  - State Agency regulation
    - Limitations on hiring of physicians by specialty treatment programs

Financing Issues

- Financing - Medicaid
  - Coverage limitations – in most States one or two of the approved medications are not on the formulary
  - Limits on dosages prescribed (recently being defined in statute by State legislatures)
  - Complex initial authorization and reauthorization processes
  - Prescription refill limits that do not reflect a chronic disease understanding
  - Requiring that a program pre-purchase the medication but only charge Medicaid following use, a policy which makes the medications unaffordable to most programs that lack the cash flow for such expenditures
Financing Issues

• Financing – All insurances
  – Covering medications as a medical benefit only and not as a pharmacy benefit
  – Covering medications only in certain settings
  – Costs of medication that must be borne by the treatment programs unless prescribed, purchased, and administered by CHCs or FQHCs under the 340b program

Organizational and Clinician Barriers?

• Lack of institutional support
  – No access to an addiction specialist on site or by telephone
  – Insufficient office staff support for dealing with insurers and pre- and re-authorization requirements to access medications
  – Insufficient nursing and other necessary staff to support use of medications
  – Difficulty coordinating treatment, pharmacy, and medical benefits
  – Lack of training required by staff
Organizational and Clinician Barriers

• ATTITUDES, ATTITUDES, ATTITUDES – the “I did it this way so you should too” and “if you’re using medications you’re not in recovery”

• USE OF MEDICATIONS IS AN “INNOVATION” and a BEST PRACTICE and barriers to adoption of innovations and best practices also apply to use of medications