PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

Challenge of Working With Payers: What you need to know about payer limitations on medications for opioid addiction

Mark L. Kraus, MD FASAM
Diplomate of ABAM

Richard Soper, MD JD FASAM
Diplomate of ABAM

Disclosures

Mark L. Kraus, MD, FASAM, DABAM

Speaker:

- Reckitt Benckiser, ASAM

Advisory Board:

- Reckitt Benckiser Pharmaceuticals
- BioDelivery Systems Inc.
- ASAM

Physicians Clinical Support System:

- Reckitt Benckiser, CSAT/SAMHSA, PCSS
- Mentor

Disclosures

Richard Soper, MD, JD, MS,FASAM,FACP, ABAM

Speaker:

- Reckitt Benckiser, ASAM, NAADAC, BDSI, TMA

Advisory Board:

- Reckitt Benckiser Pharmaceuticals
- BioDelivery Systems Inc.
- Titan Pharmaceuticals

Physicians Clinical Support System:

- Mentor

ASAM Lead Contributors, CME Committee and Reviewers Disclosure List

Name	Nature of Relevant Financial Relationship		
	Commercial Interest	What was received?	For what role?
Yngvild Olsen, MD, MPH	None		
Adam J. Gordon, MD, MPH, FACP, FASAM, CMRO, Chair, Activity Reviewer	None		
Edwin A. Salsitz, MD, FASAM, Acting Vice Chair	Reckitt-Benckiser	Honorarium	Speaker
James L. Ferguson, DO, FASAM	First Lab	Salary	Medical Director
Dawn Howell, ASAM Staff	None		

ASAM Lead Contributors, CME Committee and Reviewers Disclosure List, Continued

Name	Nature of Relevant Financial Relationship		
	Commercial Interest	What was received?	For what role?
Noel Ilogu, MD, MRCP	None		
Hebert L. Malinoff, MD, FACP, FASAM, Activity Reviewer	Orex Pharmaceuticals	Honorarium	Speaker
Mark P. Schwartz, MD, FASAM, FAAFP	None		
John C. Tanner, DO, FASAM	Reckitt-Benckiser	Honorarium	Speaker and consultant
Jeanette Tetrault, MD, FACP	None		

Accreditation Statement

- The American Society of Addiction Medicine (ASAM) is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

Designation Statement

- The American Society of Addiction Medicine (ASAM) designates this enduring material for a maximum of one (1) *AMA PRA Category 1 Credit*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.
  - Date of Release April 22, 2015
  - Date of Expiration July 31, 2016

System Requirements

- In order to complete this online module you will need Adobe Reader. To install for free click the link below:
  - http://get.adobe.com/reader/

Target Audience

- The overarching goal of PCSS-MAT is to make available the most effective medication-assisted treatments to serve patients in a variety of settings, including primary care, psychiatric care, and pain management settings.

Educational Objectives

At the conclusion of this activity participants should be able to:

- Understand the significant variability across payers for coverage of medications to treat opioid addiction
- Understand the need to be familiar with these differences for optimal patient care
- Understand the need to counsel patients about all of the available medications as part of treatment planning

Medicaid Scenario

- **HPI**: John is a 34 year old white male with active opioid use disorder.
  - Using 2-3 bundles of heroin daily
  - Started with prescription oxycodone at age 24, after a work injury
  - Moved to snorting oxycodone, then intranasal heroin use at age 28 because it was cheaper.
  - Tried Alcoholics Anonymous and Narcotics Anonymous but did not like them.
- **PMH**: Anxiety disorder, hyperlipoproteinemia, nicotine use disorder (2 ppd x20 yrs)
- **FHX**: depression (mother); opioid, cocaine and alcohol use disorders (father).
- **SHX**: Single, has a girlfriend (who does not use), lives alone, unemployed, enrolled in Medicaid.
- **Meds**: None
- **ROS**: unremarkable
- **PE**: VSS, unremarkable
- **Labs**: CBC, Basic Metabolic Panel, Liver Functions all unremarkable. Hep B/C negative. Urine drug screen positive for Benzodiazepines, Opiates, Oxycodone.

- Review of Prescription Monitoring Program revealed two doctors prescribing benzodiazepines and oxycodone.

Medicaid Scenario

- John is interested in buprenorphine/naloxone -- a friend is doing well with it and John needs to return to work.

- John lives in a state where buprenorphine/naloxone is on the Medicaid formulary but requires prior authorization and has a daily dose limit of total 16mg/2mg after 6 months of therapy.

  - Is this an unusual scenario?
  - What are John's options?
  - Does it matter?

Commercial Insurance Scenario

- **HPI**: Mary is a 42 year old employed secretary with mechanical cervical and lumbar pain since age 35 after an MVA.
  - Prescribed Vicodin (hydrocodone/acetaminophen) and Flexeril, a muscle relaxant at the time of injury.
  - Now admits to using and misusing Vicodin
  - PCP continued to prescribe Vicodin until prescription monitoring program identified that 4 doctors across the state all prescribed Vicodin, Percocet (oxycodone/acetaminophen) and benzodiazepines.
  - PCP fired her from his practice.
- **PMH**: depression (no suicidal attempts or ideation), anxiety disorder, h/o cholelithiasis s/p lap cholecystectomy, pre-menopausal, h/o nicotine use since age 18 (1 ppd x7 yrs)
- **SHX**: married and lives with her 2 children, employed as a secretary
- **ROS**: irregular menses; frequent neck and lower back pain.
- **PE**: VSS, unremarkable.
- **Labs**: CBC, Basic Metabolic Panel, Hep B/C negative, HIV negative, Urine Drug Screen positive for opiates and oxycodone.

Commercial Insurance Scenario

- Mary has tried Suboxone but found that she continued to have significant cravings, is now buying Vicodin and Percocets from an acquaintance to use intranasally.
- She is worried about how long she can keep doing this – she has heard about methadone.
- Mary has commercial insurance through her employer but she has had difficulty finding an opioid treatment program that will accept her insurance.

- Is this an unusual scenario?
- What are Mary's options?
- Does it matter?

The Road to Treatment

- Understanding insurance barriers facing practitioners is critical in navigating the road to treatment for our patients with Opioid Use Disorder.

- ASAM commissioned Treatment Research Institute/AVISA Group to study the resistance from public (Medicaid) and commercial insurance industry to expanding access to medication assisted treatment (MAT) and to review the literature on medication effectiveness.

- This resulted in a 3-part report: http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final

The American Society of Addiction Medicine Report

- This module separately reviews the findings from the Medicaid and commercial insurance reports beginning with Medicaid.

AVAILABILITY WITHOUT ACCESSIBILITY?

State Medicaid Coverage And Authorization Requirements For Opioid Use Disorder Medications

Report prepared for the American Society of Addiction Medicine by:

The Avisa Group

June 2013

Medicaid Report Highlight #1: CDC Data

November 2011 report from the Centers for Disease Control and Prevention describes opioid epidemic.

- Opioid overdose death rates have more than tripled since 1990 but vary fivefold by state
- Opioid overdose mortality disparities
  - Higher death rates in states with high rates of poverty
  - Higher death rates among non-Hispanic whites and native Americans/Alaska Natives.
  - Highest death rate among persons aged 45-54 years with the biggest increase from 1999-2010.
  - More rural, impoverished counties tend to have higher prescription opioid overdose death rates.
- Medicaid populations are at greater risk for overdose than other insured groups.

CDC Data

November 2011 report from the Centers for Disease Control and Prevention describes costs of the opioid epidemic.

- Nonmedical use of prescription opioids cost U.S. health insurers about $72.5 billion annually in healthcare costs.
- These include costs paid by Medicaid

Medicaid Report Highlight #2: Background on MAT

- Opioid use disorder is now understood as a chronic disease, not a defect of character.
- As with other diseases, there are medications effective for treatment approved and reviewed by the FDA.
- Three different FDA-approved medications are available to treat opioid use disorder.*
- Research supports their wide application by state Medicaid agencies for treatment of clinically appropriate patients
- Uncertainty exists about comprehensive access to these medications across state Medicaid agencies

*There are also several evidence-based counseling therapies used in Medication-Assisted Treatment

Medicaid Report Highlight #3: Scope and Methods

- Report includes:
  - Surveys of state Medicaid agencies' coverage of medication-assisted treatments (MAT).
  - Reviews of state Medicaid websites
- Data collection conducted in 2013 and updated in 2014
- Concurrently, ASAM independently conducted a national survey of its members to collect additional information from practitioners on the ground.

Medicaid Report Highlight #4: Findings -- Workforce Limitation

- Few treatment programs, addiction medicine and other prescribers offering MAT are enrolled as Medicaid providers
  - In one Southern state, only one opioid treatment program is obtaining state Medicaid reimbursement.

- This scarcity of available practitioners and programs significantly limits geographic access for Medicaid enrollees with opioid use disorder.

Medicaid Report Highlight #5: Findings – Coverage Limits

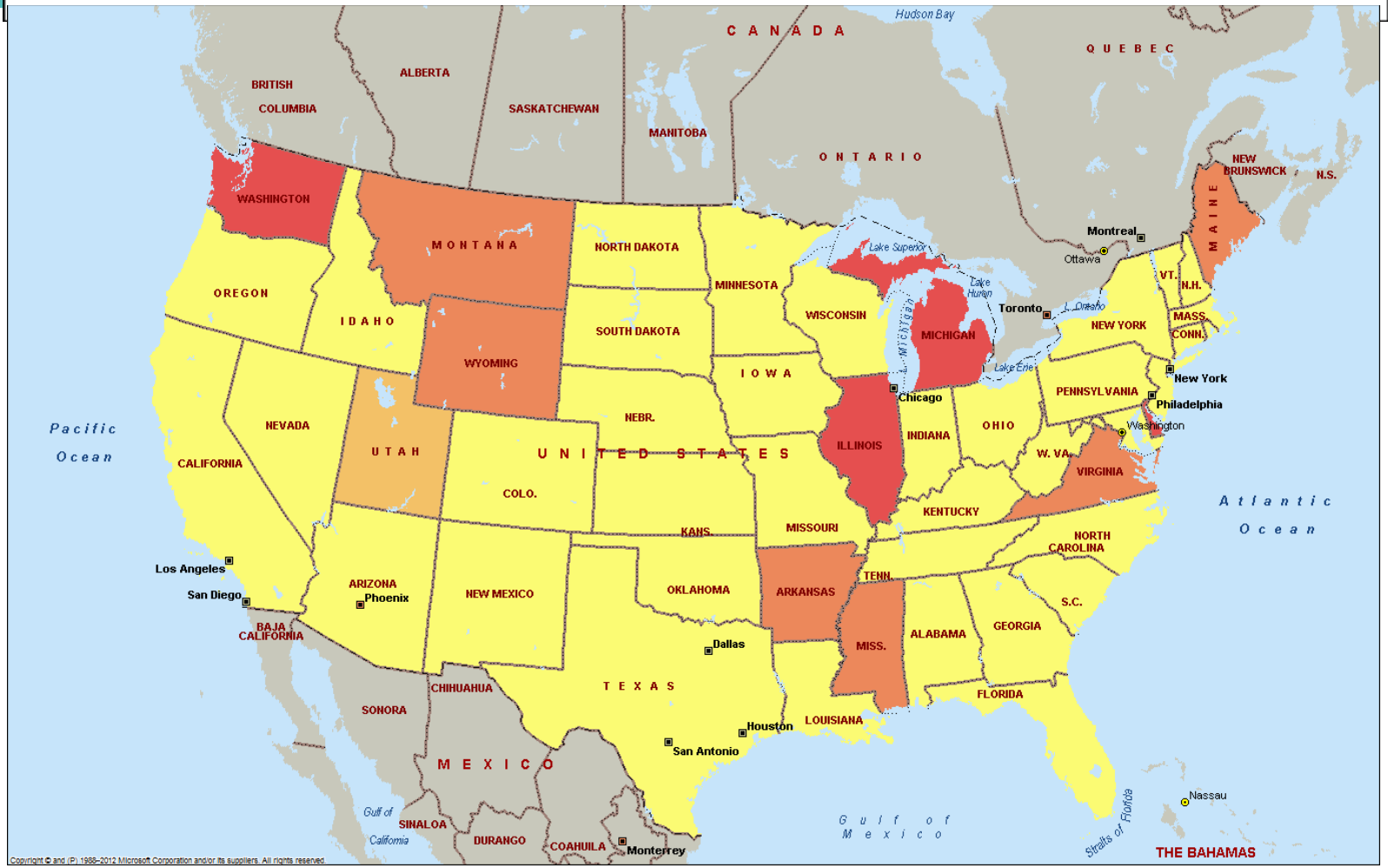
- Coverage limitations on one or more medications is common.
  - Coverage of only one or two of the three approved medications.
  - Limits on dosages prescribed that may not correspond to clinically recommended doses based on scientific evidence
  - Lifetime limits on MAT for methadone and/or buprenorphine, unlike other medications.
    - One New England state limits treatment with methadone to 24 months in a lifetime
  - Prescription refill limits that do not reflect chronic disease expectations

MEDICAID FUNDING OF METHADONE MAINTENANCE BY STATE - MAY 2013

- SAPT / STATE FUNDS KNOWN TO RESPONDENTS
- FFS MEDICAID
- NO MEDICAID FUNDING OF METHADONE MAINTENANCE

LIFETIME LIMITS ON BUPRENORPHINE (MONTHS) - MAY 2013

- 12 MONTHS
- 24 MONTHS
- 36 MONTHS
- UNKNOWN



MAXIMUM DAILY DOSE OF BUPRENORPHINE AFTER SIX MONTHS OF THERAPY - MAY 2013

- 8 MG / DAY
- 16 MG / DAY
- 24 MG / DAY
- 32 MG / DAY
- UNKNOWN

Medicaid Report Highlight #6: Findings – Administrative Barriers

- Preauthorization and reauthorization processes specific to a particular medication that may take days or weeks
-
- Minimal counseling coverage while using counseling as preauthorization/reauthorization requirement
-
- Written utilization management and/or drug utilization review committee notes reported or found on the Internet that show primarily financial, rather than quality management or life-saving concerns, as justification for limitations placed on medication approval

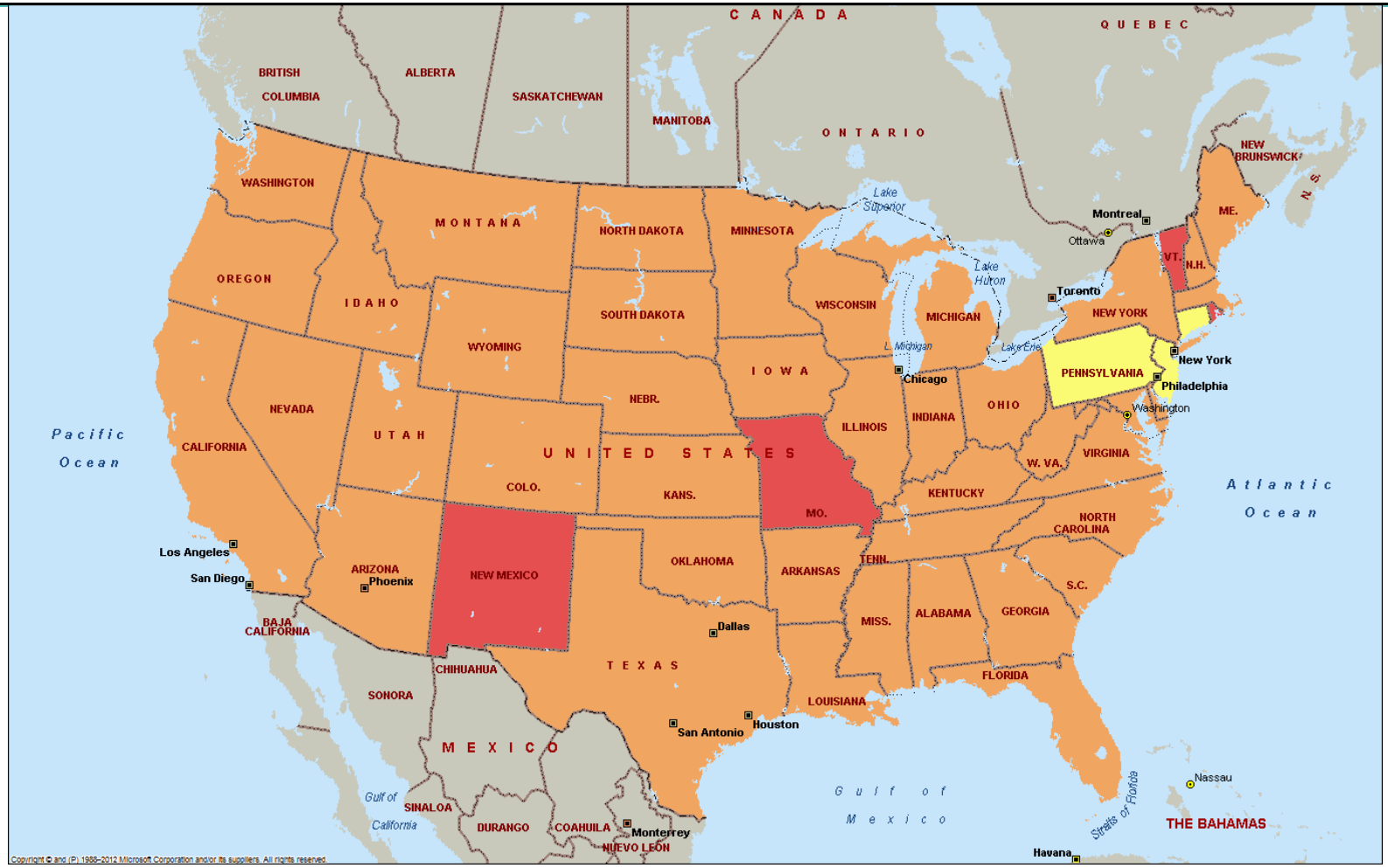
PRIOR AUTHORIZATION REQUIREMENTS FOR INJECTABLE NALTREXONE - MAY 2013

- NONE
- PRIOR AUTHORIZATION REQUIRED
- UNKNOWN

PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

PRIOR AUTHORIZATION REQUIREMENTS FOR BUPRENORPHINE / NALOXONE - MAY 2013

- NO PRIOR AUTHORIZATION REQUIRED
- PRIOR AUTHORIZATION REQUIRED
- UNKNOWN



PCSS MAT TRAINING
PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

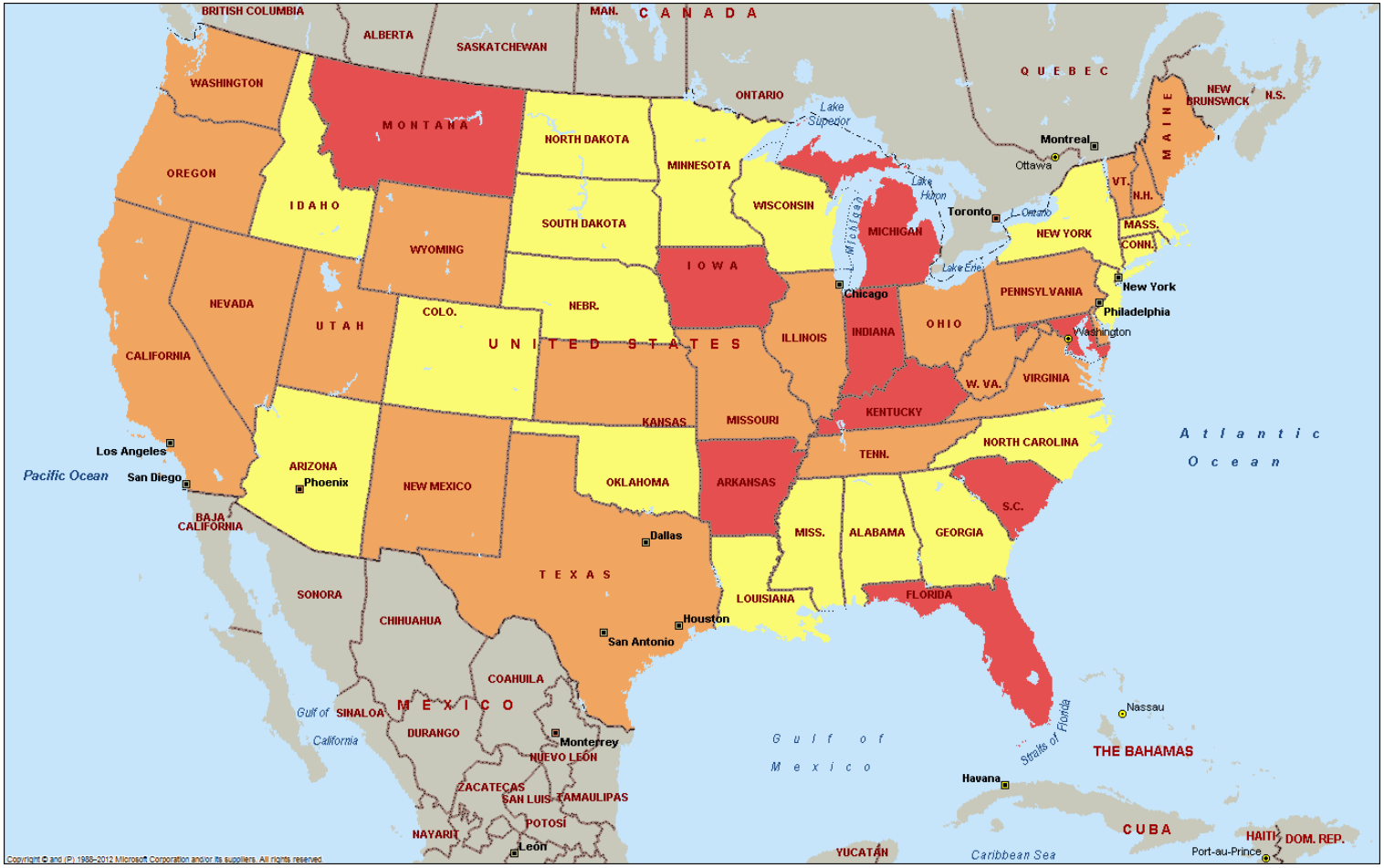
Medicaid Report Highlight #7: Findings – Clinical Barriers

- "Fail First" or "step therapy" criteria that require documentation that other, possibly less costly therapies have been attempted but were ineffective

- Requirements for submission of extensive documentation of counseling before approval granted, with rules sometimes including submission of counselors' treatment notes and patient attendance records

COUNSELING REQUIREMEMENTS IN FFS MEDICAID FOR APPROVAL OF BUPRENORPHINE - MAY 2013

- DOCUMENTATION OF COUNSELING REQUIRED
- COUNSELING REQUIRED
- UNKNOWN



ASAM Member Survey Findings

Survey of ASAM members confirmed the state Medicaid report findings.

- ASAM practitioners reported Medicaid coverage, utilization management, financing, reimbursement and regulatory issues as significant obstacles to treatment
- Highlighted lack of coverage and complex initial prior authorization and reauthorization processes that become more demanding with each reauthorization period
- These findings underscore the real impact of policies on the ground.

The American Society of Addiction Medicine Report

- Similar coverage and access limitations were identified in the survey of commercial insurers

Report of Commercial Health Plan Medication Coverage and Benefits Survey

Report prepared for the American Society of Addiction Medicine by:

Treatment Research Institute

June 2013

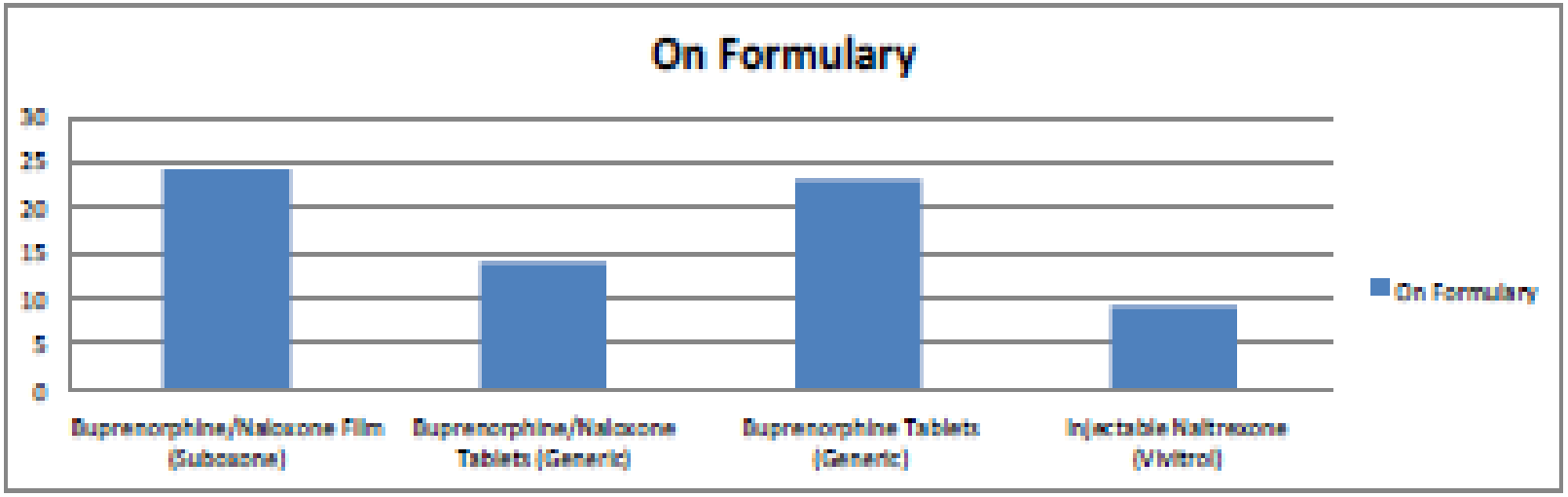
Commercial Insurance Report Highlight #1: Scope and Methods

- A total of 30 plans included
  - The two largest plans, based on enrollment numbers, from each of the 10 most populated states
  - Largest small group plan, based on enrollment numbers, in the 10 most populated states

  - Data collection included:
    - Surveys to identified plans
    - Secondary sources including published formularies, prior authorization documents, preferred drug lists, and other publicly available information

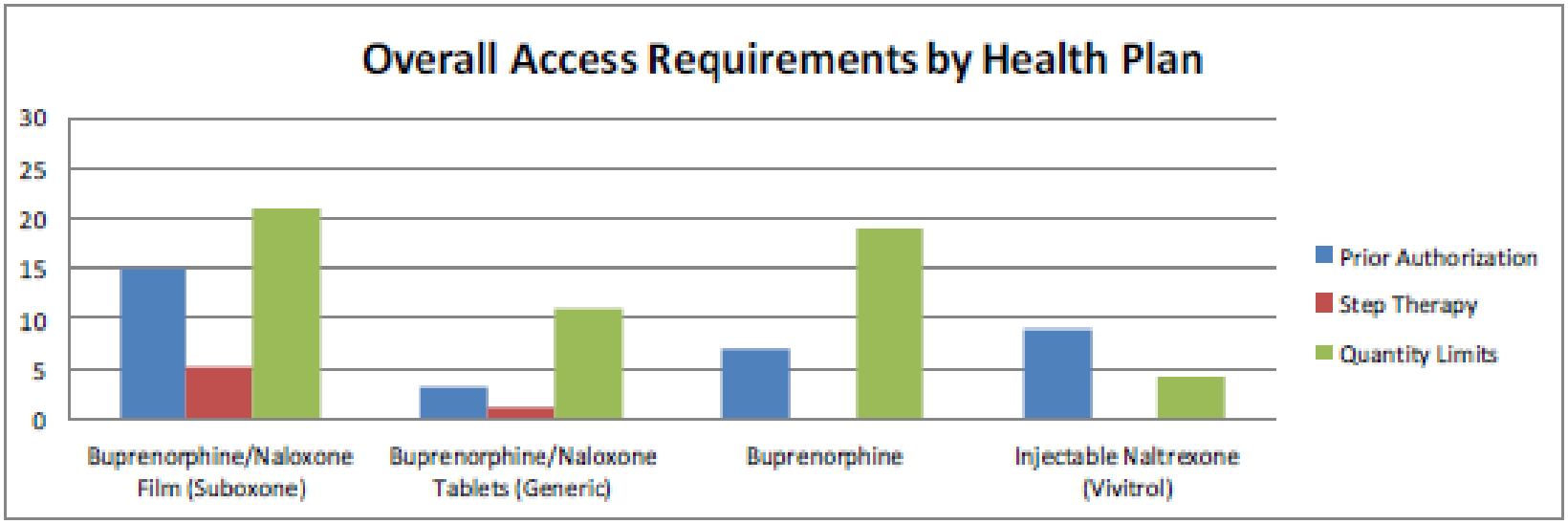
Commercial Insurance Report Highlight #2: Findings – Coverage Limits

- No plan covered all 3 FDA approved medications
- No plan covered treatment with methadone
- Suboxone film and generic monoproduct tablets most common on formularies



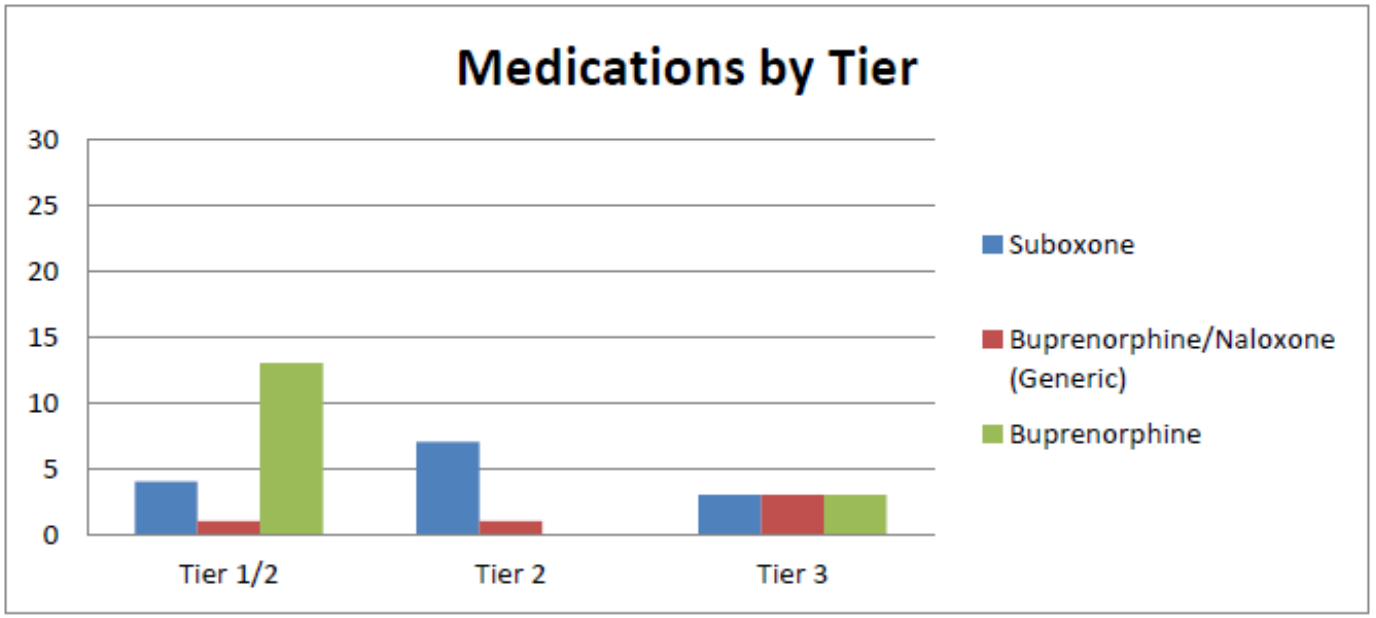
Commercial Insurance Report Highlight #3: Findings – Access Limits

- Prescription refill limits that do not reflect chronic disease expectations
- Limits on dosages prescribed that may not correspond to clinically recommended doses based on scientific evidence
- Prior authorization requirement variable



Additional Access Limits

- Confusing coverage of medications as either pharmacy benefit, medical benefit, or both
- Out-of-pocket costs to patients are higher for medical benefits and higher tier due to higher cost-sharing requirements



The American Society of Addiction Medicine Report: Part 3

- The third part of the ASAM commissioned report from 2013 included a comprehensive literature review of the effectiveness and cost-effectiveness of medication-assisted treatment.

FDA Approved Medications for the Treatment of Opiate Dependence:

Literature Reviews on Effectiveness and Cost-Effectiveness

Report prepared for the American Society of Addiction Medicine by:

Treatment Research Institute

June 2013

Medications Used to Treat Opioid Addiction

Medication	**FDA Approval for Opioid Use Disorder**	**DEA Schedule**	**Treatment Setting**	**Mechanism of action**
Methadone	No official approval date	II	OTP	Long-acting full mu-opioid agonist. Treats withdrawal symptoms, reduces cravings and may block other opioids
Naltrexone oral (ReVia Depade)	1984	Not scheduled	OTP or other healthcare setting	Mu-opioid receptor antagonist. Blocks other opioids
Naltrexone extented release (Vivitrol)	2010	Not scheduled	OTP or other healthcare setting	Mu-opioid recptor antagonist. Blocks other opioids
Buprenorphine (Subutex)	2002	III	OTP or other healthcare setting	Partial mu-opioid agonist and kappa-opioid antagonist. Treats withdrawal symptoms, reduces cravings, and blocks other opioids
Buprenorphone naloxone (suboxone Zubsolv)	2002	III	OTP or other healthcare setting	Partial mu-opioid agonist and kappa-opioid antagonist. Treats withdrawal symptoms, reduces cravings, and blocks other opioids

Key Finding

The three pharmacotherapies [methadone, buprenorphine, and naltrexone] have all shown clear clinical evidence of effectiveness in reducing opioid use and opioid use-related symptoms of withdrawal and craving as well as risk of infectious diseases and crime – when used as part of a comprehensive treatment approach and in appropriate doses. The effectiveness of these medications is true only when used in continuing care, maintenance regimens; there remains almost no evidence of enduring benefits from any of these medications when used only in detoxification regimens.

Medicaid Scenario Follow Up

Recap: John, single, unemployed, 34 year old white male with active opioid use disorder, using intranasal heroin daily. Has been receiving prescriptions from two different doctors for benzodiazepines and oxycodone.

- Is not interested in methadone.
- Brings girlfriend to first visit who agrees to help monitor John's medication adherence -- he will be staying with her for a few weeks
- John signs agreement for weekly visits, urine testing, and film counts.

What happens next?

- You complete the preauthorization form for the initial Suboxone prescription
- Three days later, authorization is approved.
- John returns to office, in opioid withdrawal. Used heroin over the last 2 days but none in the past 24 hours.
- Starts Suboxone but over next few weeks has difficulty managing cravings and completely abstaining from heroin on daily dose of 16mg/4mg. Does well when dose increased to total 24mg/6mg.
- After six months, Medicaid will no longer authorize his daily maintenance dose, despite your appeal.
- On lower dose of Suboxone, John relapses, heavily.
- He eventually leaves care and is lost to follow up.

Commercial Insurance Scenario Follow Up

Recap: Mary, married with 2 kids, 42 year old employed secretary with mechanical cervical and lumbar pain, depression, with opioid use disorder and intranasal use of Vicodin and Percocets, previously prescribed but now purchased illicitly. Has commercial insurance, is interested in methadone as Suboxone has not been effective in helping manage her symptoms.

- Has support of her husband who is willing to drive her to OTP
- Lives in an urban setting
- Has started seeing a therapist for depression and is taking buproprion from a new PCP

What happens next?

- Mary calls the Opioid Treatment Program in her area, but learns that her insurance does not cover treatment with methadone.
- She calls several other OTPs around her state, but each time is told that her insurance will not cover care there.
- Mary calls the insurance company and is told that they will pay for detoxification services at a local hospital.
- Mary checks herself into the local hospital for a 3-day stay as authorized by her insurance.
- About a week after the detox, Mary relapses but cannot find prescription opioids so buys heroin. She overdoses and dies.

"How alcohol or other drug problems are constructed are not merely a theoretical issue debated by academics. Whether we define alcoholism as a sin, a crime, a disease, a social problem, or a product of economic deprivations determines whether this society assigns that problem to the care of the priest, police officer, doctor, addiction counselor, social worker, urban planner, or community activist. The model chosen will determine the fate of untold numbers of alcoholics and addicts and untold numbers of social institutions and professional careers"-Bill White

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC.

- American Society of Addiction Medicine. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (3rd ed.). Chevy Chase, MD.

- Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 (2010).

- Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442.

References

- American Society of Addiction Medicine. (2013). *Medications for the Treatment of Opioid Use Disorder: Public/Private Policies.* http://www.asam.org/docs/default-source/advocacy/asam-impact_barriers4-02-14.pdf?sfvrsn=0

- American Society of Addiction Medicine. (2013). *Proven Clinical and Cost Effectiveness of Medications to Treat Opioid Use Disorder.* http://www.asam.org/docs/default-source/advocacy/asam-impact_cce-4-02-14.pdf?sfvrsn=0

- American Society of Addiction Medicine. (2013). *The full Education and Outreach Toolkit.* http://www.asam.org/advocacy/aaam/education-and-outreach-toolkit

- American Society of Addiction Medicine. (2013). *Advancing Access to Addiction Medications: Implications for Opioid Addiction Treatment.* http://www.asam.org/docs/default-source/advocacy/aaam_implications-for-opioid-addiction-treatment_final

PCSS-MAT Mentoring Program

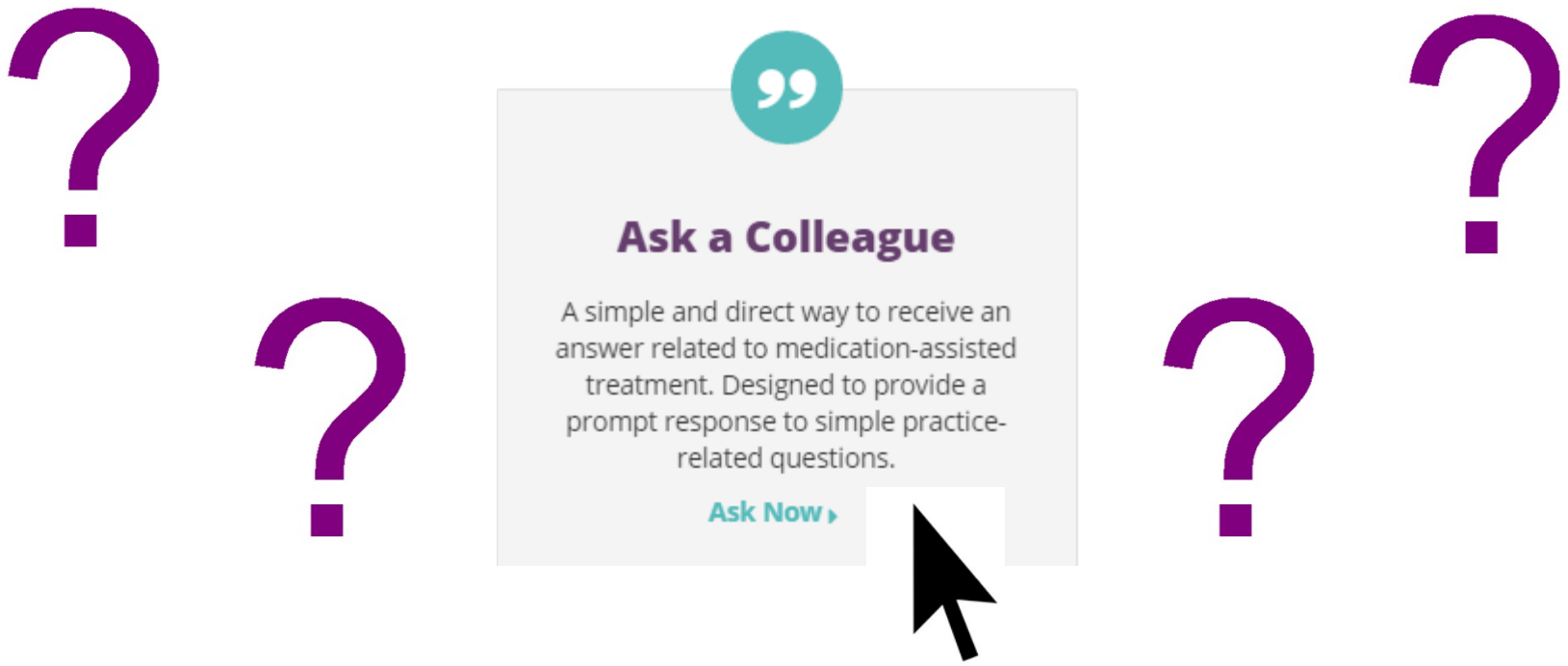
- PCSS-MAT Mentor Program is designed to offer general information to clinicians about evidence-based clinical practices in prescribing medications for opioid addiction.
- PCSS-MAT Mentors comprise a national network of trained providers with expertise in **medication-assisted treatment, addictions** and **clinical education**.
- Our 3-tiered mentoring approach allows every mentor/mentee relationship to be unique and catered to the specific needs of both parties.
- The mentoring program is available, at no cost to providers.

For more information on requesting or becoming a mentor visit:

pcssmat.org/mentoring

PCSS-MAT Listserv

Have a clinical question? Please click the box below!



MAT TRAINING

PROVIDERS' CLINICAL SUPPORT SYSTEM
For Medication Assisted Treatment

PCSSMAT is a collaborative effort led by American Academy of Addiction Psychiatry (AAAP) in partnership with: American Osteopathic Academy of Addiction Medicine (AOAAM), American Psychiatric Association (APA), American Society of Addiction Medicine (ASAM) and Association for Medical Education and Research in Substance Abuse (AMERSA).

For More Information: **www.pcssmat.org**

Twitter: @PCSSProjects

Funding for this initiative was made possible (in part) by Providers' Clinical Support System for Medication Assisted Treatment (5U79TI024697) from SAMHSA. The views expressed in written conference materials or publications and by speakers and moderators do not necessarily reflect the official policies of the Department of Health and Human Services; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. Government.

Please Click the Link Below to Access the Post Test for this Online Module

Click here to take the Module Post Test

Upon completion of the Post Test:

- If you pass the Post Test with a grade of 80% or higher, you will be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

- If you received a grade of 79% or lower on the Post Test, you will be instructed to review the Online Module once more and retake the Post Test. You will then be instructed to click a link which will bring you to the Online Module Evaluation Survey. Upon completion of the Online Module Evaluation Survey, you will receive a CME Credit Certificate or Certificate of Completion via email.

- After successfully passing, you will receive an email detailing correct answers, explanations and references for each question of the Post Test.