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Medicaid Coverage of Medications to Treat Alcohol and Opioid Dependence

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ABSTRACT

Substance use disorders affect 12% of Medicaid beneficiaries. The prescription drug epidemic and growing need for treatment of alcohol and opioid dependence have refocused states' attention on their provision of substance use disorder treatment services, including medications. This study characterized how Medicaid programs cover these treatment medications. Data were from 2013 Medicaid pharmacy documents, 2011 and 2012 Medicaid state drug utilization records, and a 2013 American Society of Addiction Medicine survey. Results showed that only 13 state Medicaid programs included all medications approved for alcohol and opioid dependence on their preferred drug lists. The most commonly excluded were extended-release naltrexone (19 programs), acamprosate (19 programs), and methadone (20 programs). For combined buprenorphine–naloxone, 48 Medicaid programs required prior authorization, and 11 programs used 1- to 3-year lifetime treatment limits. Given the chronic nature of substance use disorders and the overwhelming evidence supporting ongoing coverage for many of these medications, states may want to reexamine substance use disorder benefits.

1. Introduction

Substance use disorders are prevalent among Medicaid beneficiaries, affecting about 12% of adults (Substance Abuse & Mental Health Services Administration [SAMHSA], 2013b). Studies show increasing rates of drug misuse nationwide (Centers for Disease Control & Prevention, 2014), and there has been an increase in opioid prescribing, including Medicaid populations (Desai, Hernandez-Diaz, Bateman, & Huybrechts, 2014; Epstein et al., 2013). Some reports reveal overdose death rates that are much higher among Medicaid enrollees compared with individuals covered by other payers (Kuehn, 2014), yet only 4.4% of Medicaid beneficiaries receive substance use disorder treatment in any given year (SAMHSA, 2013b). Medicaid programs allocate approximately 1.4% of their total expenditures to treating substance use disorders (SAMHSA, 2013a).

The low rates of treatment for substance use disorders and associated cost savings mask the cost impact of substance use disorders and the return on investment from providing treatment. For example, substance use disorder diagnoses are indicated in 2 of the top 10 reasons for Medicaid hospital readmissions (Jiang, 2010). Studies have shown that substance use disorder treatment can pay for itself by reducing the medical consequences of substance use such as drug overdoses, HIV, and hepatitis C (SAMHSA, 2009; Wickizer, Mancuso, & Huber, 2012). Several medications are effective in treating opioid and alcohol dependence. The use of these medications in combination with behavioral therapies can help reestablish normal brain functioning, reduce cravings, and prevent relapse (National Institute on Drug Abuse, 2009).

There currently are no medications approved by the U.S. Food and Drug Administration (FDA) to treat cannabis, cocaine, or methamphetamine dependence. The three FDA-approved medications for opioid dependence are naltrexone, buprenorphine, and methadone. Naltrexone is available in oral and extended-release injectable forms. Buprenorphine is available in oral and sublingual forms alone and combined with naloxone (an opioid antagonist added to deter misuse). Buprenorphine–Naloxone is available in oral and sublingual forms. There are three FDA-approved medications for treating alcohol use disorders: disulfiram, naltrexone, and acamprosate.

At the time of writing, all of the medications available to treat alcohol and opioid dependence are available in generic form except extended release naltrexone (Vivitrol). The ability of Medicaid beneficiaries to obtain these medications is influenced by whether and how medications are included under Medicaid programs' prescription drug benefits, such as whether they are included on a Medicaid program's preferred drug list (PDL) (SAMHSA, 2014).

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Because these medications are critically important for treating substance use disorders, we sought to characterize their coverage within individual state Medicaid programs.

2. Material and methods

2.1. Data

We used various data sources to collect information on coverage. We retrieved the most recent Medicaid pharmacy documents from Medicaid and state government Websites and examined them for information about coverage. If the Medicaid pharmacy documents did not have information on alcohol or opioid dependence medications, we used the 2011 and 2012 Medicaid state drug utilization data to draw inferences about coverage (Centers for Medicare & Medicaid Services, 2011 and 2012). These data include a count of the number of medications for alcohol and opioid use disorders that are paid by Medicaid during one quarter for each year. If the Medicaid programs paid for an alcohol or opioid use disorder medication during the reported quarter of either 2011 or 2012, then we classified the state as covering the drug on their PDL. A third data source was a 2013 report sponsored by the American Society of Addiction Medicine (ASAM, 2013). ASAM surveyed Medicaid directors about coverage of medications for opioid dependence. We used the results of this survey as the main source for determining Medicaid coverage of methadone for opioid dependence, as opposed to coverage as an analgesic. Thus, in ascertaining coverage by Medicaid programs, we looked at medications on the PDL designated for treatment of opioid or alcohol dependence and at whether Medicaid reimburses for methadone dispensed at opioid treatment programs.

2.2. Data analysis

We calculated descriptive statistics on the availability of medications for alcohol and opioid use disorders on Medicaid PDLs in 50 states and the District of Columbia. We also examined Medicaid benefit design elements (prior authorization, behavioral therapy requirement, quantity limits, lifetime treatment limits, step therapy) for these medications.

3. Results

Fig. 1 lists medications used to treat alcohol and opioid use disorders (including methadone dispensed for opioid addiction treatment) and shows their inclusion on PDLs for Medicaid programs in 50 states and the District of Columbia. If a state does not include a medication on the PDL, the prescriber must obtain permission from the member's pharmacy benefit plan before the product can be prescribed; otherwise, the medication is not covered. All 51 Medicaid programs included at least one of the medications listed in the figure, but only 13 state Medicaid programs (Alabama, Arizona, California, Florida, Maine, Maryland, Michigan, New Hampshire, Ohio, Pennsylvania, Vermont, Washington, and Wisconsin) included all of the medications. All 51 Medicaid programs included disulfiram and oral naltrexone, and 50 programs included combined buprenorphine–naloxone (inclusion by the remaining program was unknown). The most commonly excluded medications were extended-release naltrexone (19 programs), acamprosate (19 programs), and methadone (20 programs).

Even if a drug is included on a PDL, states may still impose specific utilization controls. Table 1 describes additional characteristics of each Medicaid program's prescription drug benefits, as discussed below.

3.1. Prior authorization

Prior authorization requires that a prescriber obtain permission from the pharmacy benefit plan prior to prescribing a product to a member. Prior authorization was required by 48 of the 51 programs (94%) for buprenorphine–naloxone, 13 programs (25%) for methadone, 12 programs (24%) for naltrexone, and 5 programs (10%) for acamprosate and disulfiram. Thus, for example, although buprenorphine–naloxone was on the PDL of 50 states, 48 of those states also imposed prior authorization requirements.

3.2. Behavioral therapy

A number of states also required evidence that the patient had a referral to or attended behavioral therapy to be able to fill a prescription. These requirements applied almost exclusively to medications for opioid use disorders. Documentation of behavioral therapy was required

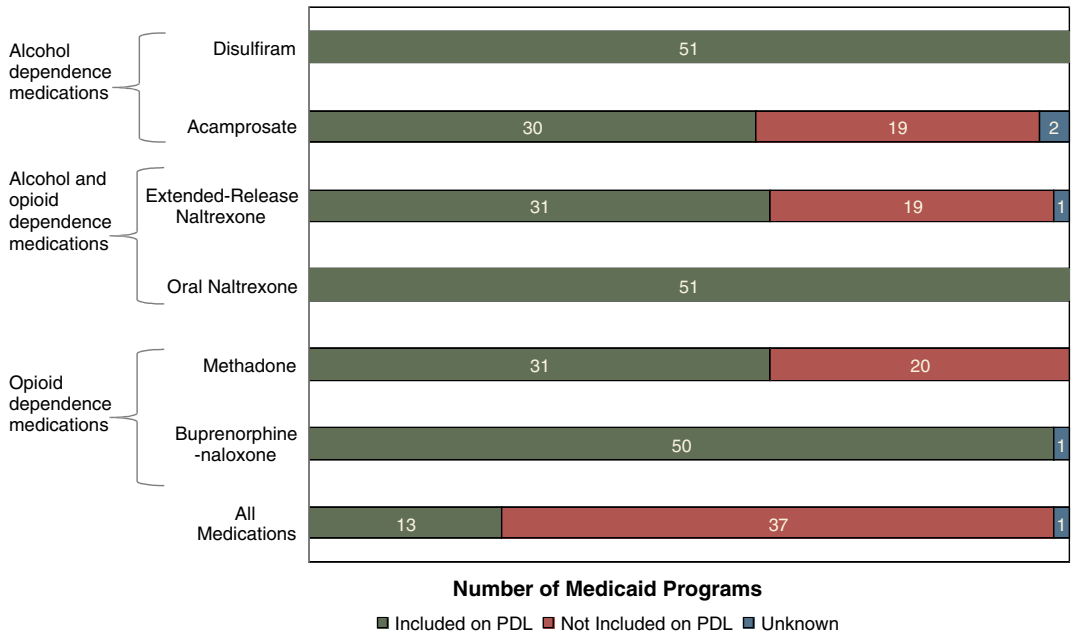

Fig. 1. Availability of medications for alcohol and opioid use disorders on Medicaid Preferred Drug Lists (PDLs) for 50 states and the District of Columbia, 2011–2013. *Sources.* Centers for Medicare & Medicaid Services, 2011 and 2012 Medicaid state drug utilization data, and the American Society of Addiction Medicine, 2013.

Table 1
Medicaid benefit design elements for medications used to treat alcohol and opioid dependence among Medicaid programs in the 50 states and the District of Columbia, 2011–2013.

Medication	Prior authorization required	Behavioral therapy required	Quantity limits[a]	Lifetime treatment limits[b]	Step therapy used
Disulfiram	5	0	3	0	0
Acamprosate	5	1	2	0	0
Naltrexone — oral	12	1	3	0	0
Naltrexone — injectable	12	15	3	0	6
Methadone	13	15	10	0	0
Buprenorphine–Naloxone	48	21	34	11	0

Sources. Centers for Medicare & Medicaid Services, 2011 and 2012 Medicaid state drug utilization data, and the American Society of Addiction Medicine, 2013.
[a] Quantity limits define the maximum quantity of medication that is covered for one prescription or copayment. Typically, a prescription is for a 30-day supply or, in the case of mail-order, a 90-day supply. Lifetime treatment limits are not included.
[b] Lifetime limits are limits on the total length of time that that an individual can receive medications while enrolled in Medicaid.

by 21 programs (41%) for buprenorphine–naloxone and 15 programs (29%) for methadone and injectable extended-release naltrexone. Only 1 program required behavioral therapy for oral naltrexone and acamprosate, and no program required behavioral therapy for disulfiram.

3.3. Quantity limits

Quantity limits define the maximum quantity of medication that will be reimbursed under the prescription drug benefit for one prescription or copayment (e.g., 30 days, 90 days for mail order). Quantity limits were used by 34 programs (67%) for buprenorphine–naloxone, 10 programs (20%) for methadone, and less than 10% of programs for extended release naltrexone, oral naltrexone, disulfiram, and acamprosate.

3.4. Lifetime treatment limits

In addition to quantity limits, 11 Medicaid programs (22%) have established lifetime treatment limits specifically for buprenorphine–naloxone. Four programs (District of Columbia, Illinois, Michigan, and Washington) have a 1-year limit, six programs (Arkansas, Maine, Mississippi, Montana, Virginia, and Wyoming) have a 2-year limit, and one program (Utah) has a 3-year limit.

3.5. Step therapy

Step therapy is a benefit design requiring patients to try a first-line treatment such as a generic or alternative medication before they can receive a second-line treatment such as a brand medication. Step therapy was used only for injectable extended-release naltrexone, which does not have a generic equivalent. Medicaid programs in 6 states (Arizona, Maryland, Massachusetts, Missouri, Oregon, and Vermont) required step therapy for this medication.

4. Discussion

Coverage restrictions on the use of medications to treat alcohol and opioid dependence differ across states and take a variety of forms. To some extent, this disparity in state policies may reflect conflicting concerns, such as the need to stem the increasing use and misuse of opioids balanced against the desire to prevent diversion and misuse of treatment medications. Indeed, third-party payers design pharmaceutical benefits with multiple goals in mind: encouraging cost savings, deterring inappropriate use, and ensuring ease of access to appropriate treatments. Given the growing need for treatment of substance use disorders, however, now may be an important time for Medicaid programs to re-evaluate whether their prescription benefits for dependence medications are designed appropriately to meet these goals. In particular, the following features may warrant evaluation.

4.1. Reassess preferred drug lists

Given the evidence on the effectiveness of medications for treating addiction to opioids and alcohol and the need for treatment, states should re-examine their rationale for excluding dependence medications such as acamprosate, extended-release naltrexone, and methadone from their PDLs. Extended-release naltrexone is not yet available in generic form, so Medicaid programs may choose to substitute similar generic medications: acamprosate, oral naltrexone, or disulfiram. However, this may lead to missed opportunities for effective treatment and ultimate cost savings if the extended-release version is most appropriate for the patient (Hartung et al., 2014; Zarkin et al., 2010). Methadone is a relatively inexpensive medication that has been shown to be an effective treatment (Barnett & Hui, 2000). It reduces heroin use and is well tolerated; at low doses it is better than buprenorphine for retaining people in maintenance treatment and suppressing heroin use and, regardless of dose, better than drug-free alternatives (Mattick, Breen, Kimber, & Davoli, 2009, 2014).

4.2. Re-evaluate lifetime limits

States should re-evaluate lifetime limits on the use of buprenorphine–naloxone. Such limits on addiction medications appear to be inconsistent with best practices. Opioid addiction is considered a chronic disease; individuals remain at risk for relapse with potentially devastating consequences even after long periods of abstinence (McLellan, Lewis, O'Brien, & Kleber, 2000). Thus limiting buprenorphine treatment after a period of between 1 and 3 years is not consistent with medical evidence or likely to be cost-effective (Clark & Baxter, 2013; Clark, Samnaliev, Baxter, & Leung, 2011). Moreover, it is possible that these lifetime limits may violate requirements of parity (Final Rules under the Paul Wellstone and Pete Domenici Mental Health Parity & Addiction Equity Act of 2008, 2013) for mental and substance use disorder treatment if they are more onerous than restrictions placed on comparable treatments for other illnesses.

4.3. Reassess prior authorization and quantity limitations

Prior authorization can be useful for ensuring that lower cost options are tried before more expensive options and that medications are used appropriately. There is, however, a delicate balance between keeping costs low and providing appropriate access to treatment. Depending upon the program design and requirements for prior authorization, some state policies may cause administrative burdens that reduce access to medications. States may need to examine the types of documentation they require (e.g., documentation of access to behavioral health treatment versus documentation of behavioral treatment attendance) to determine how these requirements affect access to medications as well as treatment continuity.

Research on the use of prior authorization with psychiatric medications—including antipsychotics, antidepressants, and medications to treat bipolar disorder—has revealed that although prior

authorization can reduce medication expenditures, it may also have the unintended consequence of creating barriers to access and reducing use of the medication (Lu, Soumerai, Ross-Degnan, Zhang, & Adams, 2010; Mark, Gibson, McGuigan, & Chu, 2010; Vogt et al., 2011). Quantity or dosage limitations can impede effective treatment and run counter to the current scientific literature (Greenwald, Comer, & Fiellin, 2014).

The Massachusetts Medicaid program offers one possible solution for drugs used to treat opioid addiction. This program requires more frequent prior authorization for higher doses of buprenorphine and combined buprenorphine–naloxone. That is, doses above 32 mg/day require prior approval every 30 days, doses between 25 and 32 mg/day require authorization every 90 days, doses between 17 and 24 mg/day require authorization every 180 days, and doses 16 mg/day or less do not require authorization. Investigation into the effects of this program revealed that requiring more frequent prior authorization for higher doses of medication reduces the percentage of patients who use higher doses than FDA-approved dose ranges (for buprenorphine–naloxone 24/6 mg daily) while maintaining access to treatment (Clark et al., 2014). The Massachusetts program is more flexible than rigid tapering schedules in other states, and it does not include a lifetime cap. It may be a model for states wishing to adjust their prior authorization policies to ensure continuous treatment of opioid addiction while maintaining lower costs.

4.4. Promote intra- and interagency coordination

In addition to addressing these specific issues pertaining to formulary designs, Medicaid programs may want to consider more globally how they are creating their formularies and whether their benefits are optimal for meeting the significant needs of people with substance use disorders. As noted in a recent ASAM report, lack of coordination between various parts of the Medicaid program and other agencies within state governments can result in benefits working at cross-purposes (ASAM, 2013). For example, pharmacy and therapeutics committees that decide on formularies may not have data on the prevalence of opioid addiction in a state or enough information on the chronic nature of substance use disorders. These committees also may focus primarily on pharmacy costs rather than total health care costs, thereby undervaluing the benefits of medication-assisted treatment. Single state agencies may not be coordinating with Medicaid agencies to ensure that an adequate number and mix of providers are available to prescribe the medications included on the PDLs. To these ends, Medicaid programs also may want to coordinate with local public health agencies and health care provider and clinician organizations.

4.5. Consider innovative state models

Several states have analyzed barriers to treatment of opioid dependence. They responded to the results by formulating innovative treatment approaches that are both outcome-effective and cost-effective. The Baltimore Buprenorphine Initiative is funded by the Maryland Alcohol and Drug Abuse Administration, Baltimore City, and private foundations (Baltimore Buprenorphine Initiative, n.d.). This program reduced opioid treatment waitlists and heroin overdose deaths by using a team of health care workers to (1) support patients while in short-term treatment at a substance use disorder facility, (2) help them access Medicaid coverage, and (3) refer them to outpatient providers for their continuing care (Schwartz et al., 2013).

In response to long waitlists for outpatient buprenorphine treatment and with funding from the Massachusetts Department of Public Health, Massachusetts has implemented a nurse management program in which the nurse handles much of the initial assessment, referral to treatment, adherence monitoring, paperwork, and communication with prescribing physicians, addiction counselors, and pharmacists. With a nurse taking on these responsibilities, physicians with waivers to prescribe buprenorphine can manage more patients (Alford et al., 2011).

To improve access to opioid use disorder treatment and as part of a Medicaid demonstration project funded under Affordable Care Act Section 2703 (National Academy for State Health Policy, 2014), Vermont developed a regional comprehensive substance use disorder treatment infrastructure known as a Hub and Spoke system. Hubs are centers that provide comprehensive services to Vermont residents with opioid addiction for a given geographic area. Spokes are teams of providers who offer treatment, support, counseling, and case management services for individuals who are less clinically complex.

These innovative models offer ideas and inspiration for other states that are looking for cost-effective ways to reduce alcohol and opioid dependence. New approaches, coupled with modifications to PDLs and benefit designs, offer opportunities for Medicaid programs to enhance treatment options and promote successful outcomes in their efforts to reduce alcohol and opioid addiction.

4.6. Limitations

Most of the limitations of this study are related to our sources of information. Information on which medications were included in each Medicaid program's PDL, and the requirements for accessing those medications (e.g., prior authorization) often were difficult to obtain. In a few instances we were unable to determine whether a medication was included in the PDL. When two different data sources provided conflicting information on whether the medication was included in the PDL or, in the case of methadone, was covered as dispensed at opioid addiction treatment programs, we assumed that it was included. This may have led to an upward bias in the number of programs described as including particular medications in their PDLs. However, because medication costs are often incorporated into an all-inclusive rate for methadone maintenance, which typically is indicated by a service code in outpatient rather than pharmacy claims, the bias in fact may be downward. Covered medications and characteristics of state Medicaid programs described in this article are subject to change; these data were accurate as of 2013. Finally, some heterogeneity across state programs may not be reflected in our data. For example, some states have multiple managed care organizations that may not have uniform policies.

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