Current National and State Policy/Regulatory Landscape Regarding Use of Evidence-Based Medications to Support Addiction Recovery

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Using Medications to Support Addiction Treatment in the U.S.

- NIH and other Federal and privately funded research in neuroscience, as well as extensive demonstration and pilot projects funded by SAMHSA, HRSA and DOJ have produced growing clinical and regulatory understanding of addiction to alcohol and drugs including nicotine as a chronic medical disorder from which patients can recover successfully by participating in evidence-based care and support
- Best when combined with validated screening, comprehensive assessment and intensive psychosocial interventions, continuing care, and emerging recovery supports, FDA-approved addiction treatment medications, beginning with Dole and Nyswander's pilot project on methadone in 1964, demonstrate efficacy in helping addicted individuals to achieve and sustain more certain recovery
- Addiction treatment and regulation are coinciding rapidly to align with that science, supporting the related growing policy emphasis on paying for better outcomes in more accountable science-based systems of care
- NIH/NIDA and SAMHSA/HRSA are continuing to increase clinical and policy initiatives on older and new/er medications to support comprehensive addiction treatment, with several now approved currently for alcohol and opiate dependence, as well as nicotine dependence
- Many new medications (and even vaccines) addressing these and other addictions now are closer to emerging from clinical trials and heading towards the market
- State SSA's, State and County and City Departments of Behavioral Health/Substance Abuse Treatment have initiated and evaluated government policy demonstrations focused on using addiction medications in combination with other evidence-based interventions, to support positive treatment outcomes and sustain treatment participation and recovery
- Coverage of these medications under private and public insurance plans or block grant varies considerably and is sometimes excluded, even with MHPAEA (Parity); contracted managed care firms may impose additional constraints such as utilization review, copays, tiered benefits, fail first requirements, managed limits on length of treatment, eligibility issues for patients and providers
- Can be medical or pharmacy benefits

Policy, Patients and Providers May Need Encouragement

- State, county and local policymakers and patients/families may not be aware of or in synch with scientific advances as yet but interest is growing
- Need to have clinical and policy champions of the changes necessary to implement all EBP's, including medications for addiction, because evidence challenges long established paradigms of care and recovery
- Sustaining and financing change, even with ACA and MHPAEA, can be especially challenging but having demonstration programs widely publicized, with transparent sustainability planning, can have a major effect in moving ever closer to the tipping point
- Systems are also heading fast towards a time when not providing addiction medications can be broadly challenged legally and ethically, as well as from the basis of cost-effectiveness in comparison with usual treatments or no treatments

Cooperation Forced by Medicaid Reform, Justice Sector and Addiction Epidemics

- With additional push from SAMHSA/HRSA, ACA/Medicaid, courts and criminal justice organizations/DOJ and clinical champions such as ASAM (Patient Advocacy Task Force), APA and AOAA, change and medication adoption is accelerating
- EG:
- CA: Medicaid Expansion, Criminal Justice and MH/SA Realignment, Supreme Court Mandate, Agency Reorganization and Integration, County initiatives, increasing prescription drug dependence may help movement towards MAR if it continues to produce results (eg LA County)
- Ohio: Major Criminal Justice and Medicaid Changes (Easier Financing) and Pressures at Governor's level and County Levels, increasing prescription drug dependence driving change
- MD: Statewide mandated Medicaid Managed Care, county initiatives, especially Baltimore (foundation funded too) but others also, still increasing rates of heroin dependence and prescription drug dependence

What are the approved nicotine dependence medications?

- Nicotine Dependence Treatment:
  - Nicotine replacement (NRT) products (transdermal patches, spray, gum, lozenges, sublingual tablets) and
  - Medications: Varencicline (Chantix), Buproprion (Zyban/Wellbutrin), Nortriptyline (Pamelor), Clonidine (Catapres).

Currently Approved Alcohol Medications

- **Disulfiram (Antabuse)**
- **Tablet Naltrexone (ReVia, DePade)**
- **Injectable Naltrexone (Vivitrol)**
- **Acamprosate Calcium (Campral)**

Currently Approved Opioid Dependence Medications (Non-Detox)

- Methadone
- Buprenorphine (Suboxone)
- Injectable Naltrexone (Vivitrol)
- Tablet Naltrexone (ReVia, DePade)

Resistance Takes Shape

- Kentucky: Coventry Care trying to stop Medicaid payment for Suboxone
- Maine: State cutting provider reimbursement and imposing treatment limits on OTP's and buprenorphine (2 years)
- Health plans: exclusion from covered benefits, formularies, tiered systems, time limits
- CJ preferences for entirely "drug free" treatments
- Security and liability issues re methadone and bup
- Lack of training, lack of staff, lack of financing
- Prohibition of use of MAT in some CJ settings
- Underutilization in special populations

Use of Addiction Medications in Primary Care (Integrated or Separate)

- Survey in 2010 by NACHC of 1250 FQHC's at 8000 sites (response rate 39%) serving uninsured, low income in areas with substantial socioeconomic issues, underserved and now experiencing tremendous patient increases
- FQHC's served 20M patients in 2010, 114, 565 with SA identified) in 2009
- Expected to serve many more by 2015
- 70% of respondents said they offered MH, 55 % offer some SA but only 32% of this is on site and most is by staff, not contractors
- 35% do not screen for SA, only 15% reported offering MAT but 43% said they would like to do so (only 1 or 2 doctors interested)
- Favor co-location of services, coordination, shared treatment plans, shared problem lists, shared medical and lab results, joint decision making
- BH staff mainly LCSW, psychologists, "other" non MD's, some nurses
- Non-FQHC Health Centers not included: many have less financing, less staffing, less infrastructure, less interest

State Medicaid Expansion/MMC Managed Care and ACA

- Clearly major stakeholders: executives and medical/clinical staff
- Medical or pharmacy benefit
- Covered or excluded, type of utilization review varies by contract
- 8 states not expanding Medicaid (as of 8/2012, Kaiser FF): Florida, Iowa, KS, LA, Nebraska, SC, TX, Wisc) but most are, however, HIE implementation is becoming more of a Federal responsibility than expected
- Medicaid managed care: 70% of 58M enrollees, 28 states with 1915(b) waivers, MD has statewide mandatory managed care but CA and Ohio are county-based and do not
- CA has new 1115 waiver for seniors and persons with disabilities (Dual Eligibles); program nationally has some implementation challenges and some enthusiasts

Perceptions of State and County Policy Environment Affect Willingness to Adopt MAT

- Knudsen, 1/2012, Psychiatric Services, pp. 19-25:
  - Surveyed 250 administrators of publicly funded specialty treatment programs
  - 37% reported having prescribed any form of MAT in 2011
  - MAT offering depended on: perceived support from SSA, inclusion or exclusion of MAT from Medicaid formulary, whether or not state/county contracts covered medications, adequacy of dissemination of policies and priorities supporting MAT, availability of staff (esp. RN and MD) and training opportunities
- Implications
  - Specialty Providers, Health Centers, PCP's/office based providers need special training and encouragement/incentives to provide any MAT, need TA, HIT to facilitate sharing information to the extent possible under HIPAA and 42CFR, need network partners who are champions of change, need to learn how to engage relevant partners and stakeholders efficiently, must demonstrate and evaluate outcomes of initiatives to community stakeholders and policymakers