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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

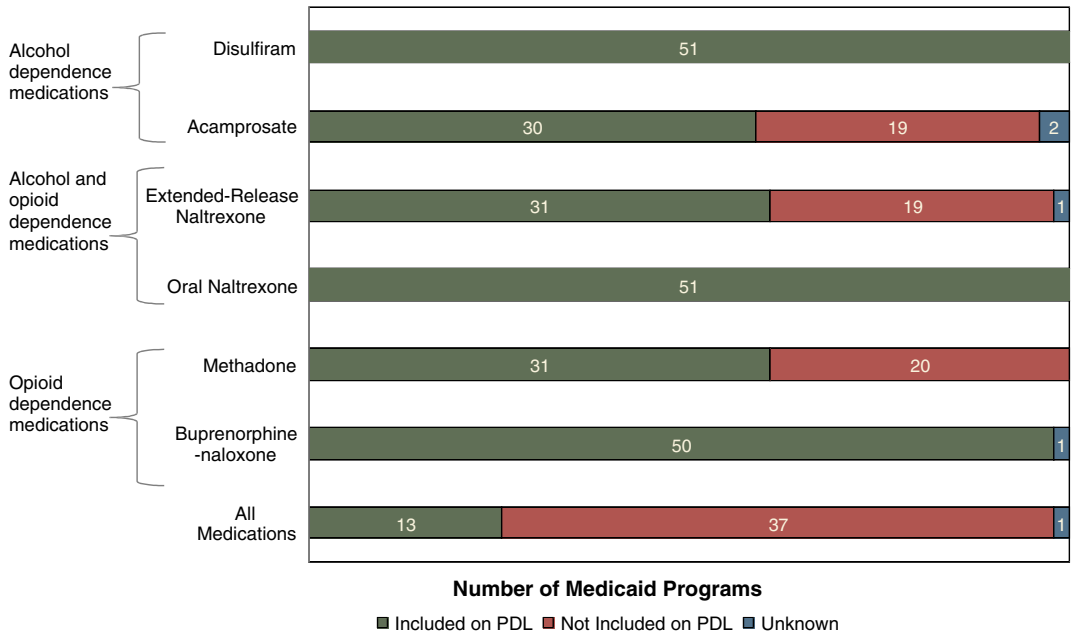

Fig. 1. Availability of medications for alcohol and opioid use disorders on Medicaid Preferred Drug Lists (PDLs) for 50 states and the District of Columbia, 2011–2013. *Sources.* Centers for Medicare & Medicaid Services, 2011 and 2012 Medicaid state drug utilization data, and the American Society of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