



MEDICATION-ASSISTED TREATMENT ACCESS ROUNDTABLE: A DISCUSSION OF BARRIERS TO A PATIENT-CENTRIC APPROACH

MEETING SUMMARY AND NEXT STEPS

Meeting Participants

- Dan Alexander, *Mallinckrodt Pharmaceuticals*
- Brad Bachman, *American Society of Addiction Medicine*
- Dr. Kelly Clark, *President, American Society of Addiction Medicine (via teleconference)*
- Gabrielle de la Guéronnière, *Legal Action Center*
- Patricia D'Antonio, *The Gerontological Society of America*
- Phyllis Greenberger, *Healthy Women*
- Julian Hoffman, *National Safety Council*
- Van Ingram, *Kentucky Office of Drug Control Policy*
- Dr. George Kolodner, *American Society of Addiction Medicine*
- Dr. Joseph Liberto, *American Academy of Addiction Psychiatry*
- Jackie Maffucci, *Iraq and Afghanistan Veterans of America*
- Kimberly Moser, *Kentucky State Representative, Roundtable Moderator*
- Mark Parrino, *American Association for the Treatment of Opioid Dependence*
- Matthew Rubin, *CEPOP*
- Paul Samuels, *Legal Action Center*
- Jeff Valliere, *Advocates for Opioid Recovery*
- Kevin Walker, *Penn Quarter Partners*
- Kevin Webb, *Mallinckrodt Pharmaceuticals*
- Anne Woodbury, *Advocates for Opioid Recovery*
- Dave Zook, *CEPOP, Roundtable Moderator*

Meeting Background

The Collaborative for Effective Prescription Opioid Policies (CEPOP; www.CEPOPonline.org) was formed in January 2015 as a platform to engage diverse stakeholders in a comprehensive and coordinated strategy against the opioid epidemic. The CEPOP Safe Use and Prevention Working Group identified access to Medication-Assisted Treatment (MAT) as a priority topic for the 2017 work plan, including a convening of key thought leaders to identify the most significant barriers to access and to a patient-centered approach to MAT. This session took place on July 18, 2017 in Washington, DC (Appendix A). The balance of this document summarizes the proceedings and recommended next steps in developing the CEPOP strategy.

Summary

Following introductions of all MAT Access Roundtable participants and a brief overview of the goals of the roundtable by meeting moderator Kimberly Moser, the following items were discussed:

I. Background on Office-Based Opioid Treatment Programs and Associated Barriers

- Source of Barrier: Insurance Coverage and Reimbursement
 - Pre-authorization requirements by payers delays the time in which treatment can be initiated, often by a period of 24-72 hours, which is deeply inconsistent with the best patient outcomes.
 - Some states have taken up legislation that would look to drop prior authorization for patients to receive buprenorphine treatment.
- Source of Barrier: Government
 - Dosage caps and formulation limits reduce availability of clinically appropriate MAT therapies for patients.
 - Strict regulation from the DEA under the Controlled Substances Act around the storing and destruction of medication.
 - OBOTs are unable to contract with TRICARE to receive payment for MAT administered in a physician office setting.
 - Some state legislation prohibits the prescribing of products that lack an agonist/antagonist, often referred to as ‘mono-buprenorphine products’.
- Source of Barrier: Clinical
 - Clinicians are often unable to act swiftly in getting a patient to treatment; often very small window to engage patient and refer to an appropriate program.
 - Some program types precipitate withdrawal in requiring abstinence from opioids for 24 hours prior to initiation of treatment.
 - While some treatment centers have begun to prescribe MAT for opioid use disorders, many groups and residential programs have opposed the use of buprenorphine and other products as treatment.
- Especially in rural communities, healthcare providers are not equipped to handle an increase in number of patients that require MAT nor do they have the appropriate specialty training.
- Utilization of the *Vermont Hub-and-Spoke* or the *Kentucky Bridge Clinics* models as a best practice to ensure patients are appropriately directed to MAT programs following an overdose or other intervention.

II. Background on Opioid Treatment Programs and Associated Barriers

- There is a clear need to streamline and promote interoperability of prescription drug monitoring programs as OTP providers should check current prescriptions and past histories before initiating treatment. Providers should leverage PDMPs in helping to diagnose substance use disorders. Additional outreach and education must be done to help convey the importance of a PDMP as an integrated tool within the healthcare delivery system.
- Available Resources to Opioid Treatment Programs and Patients
 - Opioid treatment programs are available to patients in 49 states, as Wyoming is the only state without an existing program.
 - OTPs are able to prescribe any of the three FDA-approved medications. Methadone is the most popular with use of buprenorphine increasing. Slower uptake of Vivitrol.

- Coverage and Reimbursement
 - 34 states have Medicaid reimbursement for MAT. In these states, 85-90% of patients are Medicaid-eligible.
 - There are 16 states without Medicaid reimbursement for MAT in which 80-85% of patients are responsible for payment out-of-pocket.
 - As some OTPs require multiple dosing each week, commercial insurance has been slow to cover. Discussions are occurring, however, around how to bill for such services.
 - In addition to Medicaid, private insurance plans often lack coverage for OTPs, with patients having to pay out-of-pocket for services rendered.
- Non-emergency medical transportation to-and-from opioid treatment programs is a continued issue around ensuring appropriate access to treatment (Medicaid in particular).

III. Discussion on Current Initiatives and Development of an Issue Matrix

- The draft *Issue Matrix* as developed during the roundtable can be found in Appendix B.
- There is a need for increased education across the board – policymakers, healthcare providers, patients and consumers – around the treatment of patients with substance use disorders. These efforts would work to help address the stigma of addiction and provide clarity on the differences among evidence-based medication-assisted treatment programs and faith-based, 12-step or abstinence-only programs.
- There are barriers to access for MAT across the lifespan from adolescents to older adults, veterans and pregnant women. Each demographic experiences unique barriers to access or coverage, treatment modalities, and associated stigmas with substance use disorders and care.
- Nalaxone and other opioid overdose reversal medications are used for harm-reduction purposes and ought not to be thought of as a treatment option.
- There is a need to not just treat existing substance use disorders, but also to prevent new addiction and to ensure that any prospective solutions do not ignore either population.
- There are opportunities to address existing and prospective regulations that would disincentivize physicians from entering the profession or to simply set up “strip mills”.
- Up to this point, drug courts and the judicial system have been under-utilized as an option to expand access to MAT for which all FDA-approved medications and services should be provided to individuals in the judicial system. While state-based Medicaid expansion has afforded coverage for many incarcerated individuals, additional efforts must be made to offer treatment and coverage for those who do not fall into the Medicaid expansion population.
- Compliance with parity laws must be enforced as the majority of all actions against payers is retrospective. Prior to entering the market, all commercial plans should be parity-compliant.
- There are opportunities to further expand the DATA 2000 waiver process and leverage existing regulations to increase telemedicine uptake as a viable source of treatment and counseling for patients with substance use disorders.
- There is still a need to reduce the stigma around substance use disorders as we only hear about the individuals in OBOT/OTP programs who relapse. Those who are actively engaged in the programs are often ‘invisible’.
- As the first year of 21st Century Cures Act funding is being dispersed and the second tranche is set to be delivered in the coming year, it is important to ensure the operational integrity of the substance abuse disorder treatment providers.
- Further research and evaluation is needed to fully understand why providers are not prescribing MAT for patients and barriers for physicians to enter the field.

Next Steps and Action Items

Following the July 18 MAT Access Roundtable, the following action steps were developed:

- I.** Roundtable participants could submit models and best practices to help facilitate the development of a CEPOP-sponsored database of available tools;
- II.** Prospective development of demographic-specific toolkits to reach target audiences such as women, older Americans, healthcare providers, and others;
- III.** Review opportunities to engage federal agency partners to help provide stability and facilitation of best practices (such as the Federal Interagency Opioid Policy Review Board);
- IV.** Engage other organizations that were not present during the initial convening but have been active in this space, including the National Conference of State Legislatures or National Governors Association; and
- V.** Determine 1-2 policy priorities for CEPOP to pursue in 2017-18.

APPENDIX A

MEDICATION-ASSISTED TREATMENT ACCESS ROUNDTABLE: A DISCUSSION OF BARRIERS TO A PATIENT-CENTRIC APPROACH

Location: CEPOP – Faegre Baker Daniels Consulting Offices
1050 K Street NW, Suite 400
Washington, DC 20001

Date: Tuesday, July 18, 2017

Time: 9:00am – 1:00pm Eastern

AGENDA

1. Welcome and Introductions9:00am – 9:15am
2. Roundtable Goals.....9:15am – 9:20am
3. Identifying Barriers to Access9:20am – 11:00am
 - a. Office-Based Opioid Treatment Programs
 - i. Framing the issues..... *Dr. Kolodner, ASAM*
 - ii. Discussion
 - b. Opioid Treatment Programs
 - i. Framing the issues.....*Mr. Parrino, AATOD*
 - ii. Discussion
4. Advancing Access to Patient-Centered Care11:00am – Noon
 - a. Discussion of current initiatives.....*All Participants*
5. Working Lunch: Develop Consensus Matrix and Policy Opportunities 12:15pm – 1:00pm

APPENDIX B

Barriers to Access Concept Matrix

	BUPRENORPHINE	METHADONE	NALTREXONE	COUNSELING
Office-Based Opioid Treatment Programs (OBOT)	<ul style="list-style-type: none"> • Preauthorization requirements for Medicaid and commercial insurance. • Dosage caps. • Inability to contract with TRICARE and certain public payers. • Stigma of addiction. • Diversion of product. • Network adequacy. 		<ul style="list-style-type: none"> • Preauthorization requirements for Medicaid and commercial insurance. • Dosage caps. • Inability to contract with TRICARE and certain public payers. • Network adequacy. 	<ul style="list-style-type: none"> • Need for an evidence-based approach. • Primary care concerns regarding healthcare provider education and accessibility. • Psychiatric comorbidities and limited support structures available.
Opioid Treatment Programs (OTP)	<ul style="list-style-type: none"> • Utilization of PDMPs. • Public and private reimbursement. • NEMT coverage. • No Medicare Coverage. • Preauthorization requirements for Medicaid and commercial insurance. • Network adequacy. 	<ul style="list-style-type: none"> • Utilization of PDMPs. • Public and private reimbursement. • NEMT coverage. • No Medicare Coverage. • Preauthorization requirements for Medicaid and commercial insurance. • Network adequacy. 	<ul style="list-style-type: none"> • Utilization of PDMPs. • Public and private reimbursement. • NEMT coverage. • No Medicare Coverage. • Preauthorization requirements for Medicaid and commercial insurance. • Network adequacy. 	<ul style="list-style-type: none"> • Need for an evidence-based approach. • Primary care concerns regarding healthcare provider education and accessibility.