POLICY BRIEF

Coverage of Buprenorphine Medications That Treat Opioid Use Disorder by State Medicaid Programs

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Background

Buprenorphine is an effective medication for the treatment of opioid use disorder (OUD). It promotes long-term recovery and decreases the risk of mortality.[1–6] Buprenorphine treatment increases engagement in addiction treatment,[7] reduces emergency department admissions,[8,9] and is cost effective compared with brief intervention or referral treatments.[10]

A persistent barrier to buprenorphine access is prior authorization (PA)—a utilization management practice employed by insurers that requires healthcare providers to obtain approval from a health plan before a service is delivered to the patient in order to qualify for payment coverage. Existing literature demonstrates that PA policies achieve their intended effects of reducing prescribing of the targeted prescription of buprenorphine and other products.[11–16] A 2020 study using Medicare Part D claims showed plans that removed PA for buprenorphine–naloxone products had an associated increase in the number of buprenorphine–naloxone prescriptions filled, and that PA removal was associated with a decrease in healthcare utilization and expenditures.[17]

This study analyzes how state Medicaid programs apply PA to buprenorphine products. As Medicaid is the dominant payer for behavioral health services in the U.S., an analysis of Medicaid PA requirements for buprenorphine products is essential to understanding how states use insurance policies to impact access to medications essential to the treatment of OUD.

Methods

Investigators searched Medicaid preferred drug lists (PDLs) to gather information on how Medicaid programs covered buprenorphine formulations in October 2019. As of this date, there were 8 buprenorphine products available, including brand name and generic versions of buprenorphine and buprenorphine/naloxone combination forms, as well as long-acting and daily methods of administration. The research team identified publicly available Medicaid PDLs for 45 states. A researcher determined if the PDL covered a buprenorphine form, and if coverage required PA. For each buprenorphine product, the team calculated the proportion of PDLs that covered, covered with PA, and covered without PA, as well as the percentage of plans that covered at least 1 buprenorphine formulation.

Key Findings

Table 1 displays state Medicaid coverage of buprenorphine products in 2019. An overwhelming proportion of Medicaid programs included brand buprenorphine/naloxone in the preferred drug list; 100% of PDLs covered Suboxone™ and Zubsolv™, and 98% of PDLs covered Bunavail™. Long-acting buprenorphine forms were less likely to be covered by state Medicaid programs. With the exception of Suboxone™, all other

buprenorphine formulations were subject to PA by more than two thirds of PDLs. Although all plans (100%) covered at least 1 buprenorphine form, PDLs varied on whether they applied PA to covered products. Almost 75% of plans did not apply PA to at least 1 buprenorphine product. When examining buprenorphine/naloxone forms, 66.6% of PDLs covered at least 1 product. Almost 80% of PDLs imposed a PA requirement to either Probuphine™ or Sublocade™.

Table 1. Buprenorphine coverage by state Medicaid programs, 2019

Buprenorphine formulation	Plans that cover the drug n (%)	Plans that cover without prior authorization n (%)	Plans that cover with prior authorization n (%)
Versions of drug preferred for opioid use disorder maintenance treatment			
Long-acting implant (Probuphine™)	24 (53.3%)	2 (8.33%)	22 (91.67%)
Long-acting injection (Sublocade™)	34 (75.56%)	6 (17.65%)	28 (82.35%)
Buprenorphine/naloxone (Bunavail™)	44 (97.78%)	6 (13.64%)	38 (86.36%)
Buprenorphine/naloxone (Suboxone™)	45 (100.00%)	29 (64.44%)	16 (35.56%)
Buprenorphine/naloxone (Zubsolv™)	45 (100.00%)	9 (20.00%)	36 (80.00%)
Buprenorphine/naloxone (generic tablet)	42 (93.33%)	12 (28.57%)	30 (71.43%)
Buprenorphine/naloxone (generic film)	29 (64.44%)	6 (20.69%)	23 (79.31%)
Versions of drug recommended only for select opioid use disorder populations			
Buprenorphine (generic tablet)	45 (100.00%)	11 (24.44%)	34 (75.56%)
At least 1 buprenorphine form	45 (100.00%)	33 (73.3%)	44 (97.78%)
At least 1 long-acting form	34 (75.56%)	7 (20.59%)	28 (82.35%)
At least 1 buprenorphine/naloxone form	45 (100.00%	30 (66.67%)	41 (91.11%)

Conclusions & Policy Considerations

The key findings demonstrate that although Medicaid programs largely cover buprenorphine products, many continue to apply PA requirements. Nearly 30% of PDLs reviewed do not cover a single buprenorphine form without PA, and almost 80% of PDLs do not cover a long-acting buprenorphine form without PA. In the midst of the opioid epidemic, it is challenging to justify the exclusion and imposition of burdensome utilization management practices on essential medications used in the treatment of OUD. As policymakers consider strategies to decrease opioid-related morbidity and mortality, they should consider opportunities to mandate the removal of PA. Future research can expand upon this project by exploring the care access and health consequences of PA requirements and shedding light on how to define adequate buprenorphine access in light of PA requirements.

Acknowledgements

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $900,000. The contents are those of the author and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

References

1. National Institute on Drug Abuse. How effective are medications to treat opioid use disorder? National Institute on Drug Abuse. https://www.drugabuse.gov/publications/research-reports/medications-to-treat-opioid-addiction/efficacy-medications-opioid-use-disorder. Published June 2018. Accessed November 11, 2020.
2. Sordo L, Barrio G, Bravo MJ, et al. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. BMJ. 2017;357:j1550. doi:10.1136/bmj.j1550.
3. Nielsen S, Larance B, Degenhardt L, Gowing L, Kehler C, Lintzeris N. Opioid agonist treatment for pharmaceutical opioid dependent people. Cochrane Database Syst Rev. 2016;May 9 (5):CD011117. doi:10.1002/14651858.CD011117.pub2.
4. Mattick RP, Breen C, Kimber J, Davoli M. Buprenorphine maintenance versus placebo or methadone maintenance for opioid dependence. Cochrane Database Syst Rev. 2014;Feb 6(2):CD002207. doi:10.1002/14651858.CD002207.pub4.
5. Ma J, Bao Y-P, Wang R-J, et al. Effects of medication-assisted treatment on mortality among opioids users: a systematic review and meta-analysis. Mol Psychiatry. 2019;24(12):1868-1883. doi:10.1038/s41380-018-0094-5.
6. Larochelle MR, Bernson D, Land T, et al. Medication for opioid use disorder after nonfatal opioid overdose and association with mortality. Ann Intern Med. 2018;169(3):137-145. doi:10.7326/M17-3107.
7. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department–initiated buprenorphine/naloxone treatment for opioid dependence. JAMA. 2015;313(16):1636-1644. doi:10.1001/jama.2015.3474.
8. Mohlman MK, Tanzman B, Finison K, Pinette M, Jones C. Impact of medication-assisted treatment for opioid addiction on Medicaid expenditures and health services utilization rates in Vermont. J Subst Abuse Treat. 2016;67:9-14. doi:10.1016/j.jsat.2016.05.002.
9. Schwarz R, Zelenev A, Bruce RD, Altice FL. Retention on buprenorphine treatment reduces emergency department utilization, but not hospitalization among treatment-seeking patients with opioid dependence. J Subst Abuse Treat. 2012;43(4):451-457. doi:10.1016/j.jsat.2012.03.008.
10. Busch SH, Fiellin DA, Chawarski MC, et al. Cost effectiveness of emergency department-initiated treatment for opioid dependence. Addiction. 2017;112(11):2002-2010. doi:10.1111/add.13900.
11. Haffajee RL, Bohnert ASB, Lagisetty PA. Policy pathways to address provider workforce barriers to buprenorphine treatment. Am J Prev Med. 2018;54(6 Suppl 3):S230-S242. doi:10.1016/j.amepre.2017.12.022.
12. Schuckit MA. Treatment of opioid-use disorders. N Engl J Med. 2016;375(4):357-368. doi:10.1056/NEJMra1604339
13. The PEW Charitable Trusts. Medication-Assisted Treatment Saves Lives While Increasing the Chances a Person Will Remain in Treatment and Learn the Skills and Build the Networks Necessary for Long-Term Recovery. 2016:8.
14. Drug Addiction Treatment Act of 2000. 2000.
15. Davis CS, Carr DH. Legal and policy changes urgently needed to increase access to opioid agonist therapy in the United States. Int J Drug Policy. 2019;73:42-48. doi:10.1016/j.drugpo.2019.07.006.

16. Burak EW. Behavioral health services in separate state CHIP programs: is your state in compliance? Center For Children and Families. https://ccf.georgetown.edu/2020/05/29/behavioral-health-services-in-separate-state-chip-programs-is-your-state-in-compliance/. Published May 29, 2020. Accessed November 11, 2020.
17. National Conference of State Legislatures. Mental health benefits: state laws mandating or regulating. https://www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx. Published December 30, 2015. Accessed November 11, 2020.