

Medicaid: Addressing Tobacco & Opioid Addictions

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Medicaid's Role

- Medicaid now covers about 70 million enrollees. Serves low-income children, adults, seniors & disabled.
- Medicaid enrollees often at higher risk of multiple health problems, including tobacco and opioid addiction.
- Provides effective, comprehensive, low cost coverage
- Can help in reducing these serious problems and in treating health problems that occur due to addictions.
- Recent Medicaid expansions increase program's ability to serve those in need, but also poses challenges.
- 32 states expanded Medicaid, 19 did not. Widened geographic disparities.

Tobacco & Opioids: The Human Toll

- **Tobacco** #1 preventable cause of death. ~500,000 deaths in US. About 50 million smokers. Smoking on decline.
- About 30% (~13 million) of Medicaid adults smoke. Rate declining, but twice as high as general population.
- **Opioid** addiction and overdoses rising. 33,000 total deaths in 2015, twice the number in 2005. 2 million with opioid pain reliever abuse and 600,000 heroin addicts in total.
- About 600,000 opioid abusers on Medicaid in 2013. Probably more now.
- **Both:** Rates vary across states, especially for opioids
- Both linked to mental health problems like depression.

Economic Costs to Medicaid

- About 15% of all Medicaid expenditures are for illness related to smoking. ~\$75 billion in 2016.
- About \$100 million spent for cessation medications.
- In 2013, about \$9 billion directly spent on opioid treatment, including inpatient, outpatient, drugs, etc. Higher now.
- Likely additional costs for treatment of associated disorders.

Challenges in Overcoming Addiction

- Addictions have neurological, behavioral and social roots.
- Medication and behavioral therapy can help quitting.
- What works for one person may not work for another.
- Relapse is common.
- Supportive Medicaid policies can help, but ultimately efforts needed from patients, clinicians, family and others.

Tobacco

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Medicaid Covers Smoking Cessation

- Medicaid covers cessation services, including **FDA-approved medications** (nicotine replacement gum, patch, lozenge, spray, bupropion (Zyban), varenicline (Chantix) and **counseling** (individual and group).
- All states cover *some* tobacco cessation drugs and counseling. But often require copayments or prior authorization.
- Medicaid can help pay for toll-free **quitlines**.
- **Use of cessation services is low.** About 10% of smokers receive medications. Use of counseling less common. Utilization appears to vary widely by state.

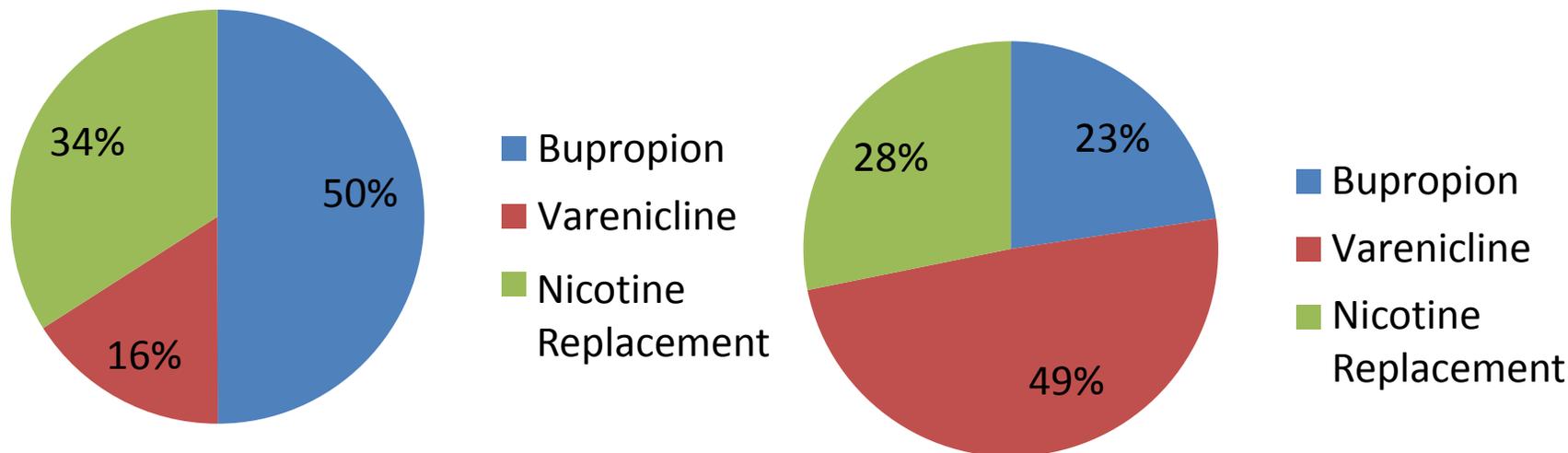
Massachusetts Initiative

- In 2006, MA began a comprehensive Medicaid cessation benefit, coupled with an outreach plan, including quitlines.
- Smoking prevalence fell by about from 38% to 28%.
- Rate of cardiovascular hospitalizations among users fell by a third to half.
- # of CVD deaths due to smoking exceeds lung-related.
- Richard et al (2012) found that **every \$1 spent on cessation benefits was associated with about \$3 in lower Medicaid hospital costs** within 1 ½ years.
- Even short-term quitting helps.

Volume and Cost of Medications, 2013

1.7 Million Prescriptions

\$103 Million in Payments
(Before Rebates)



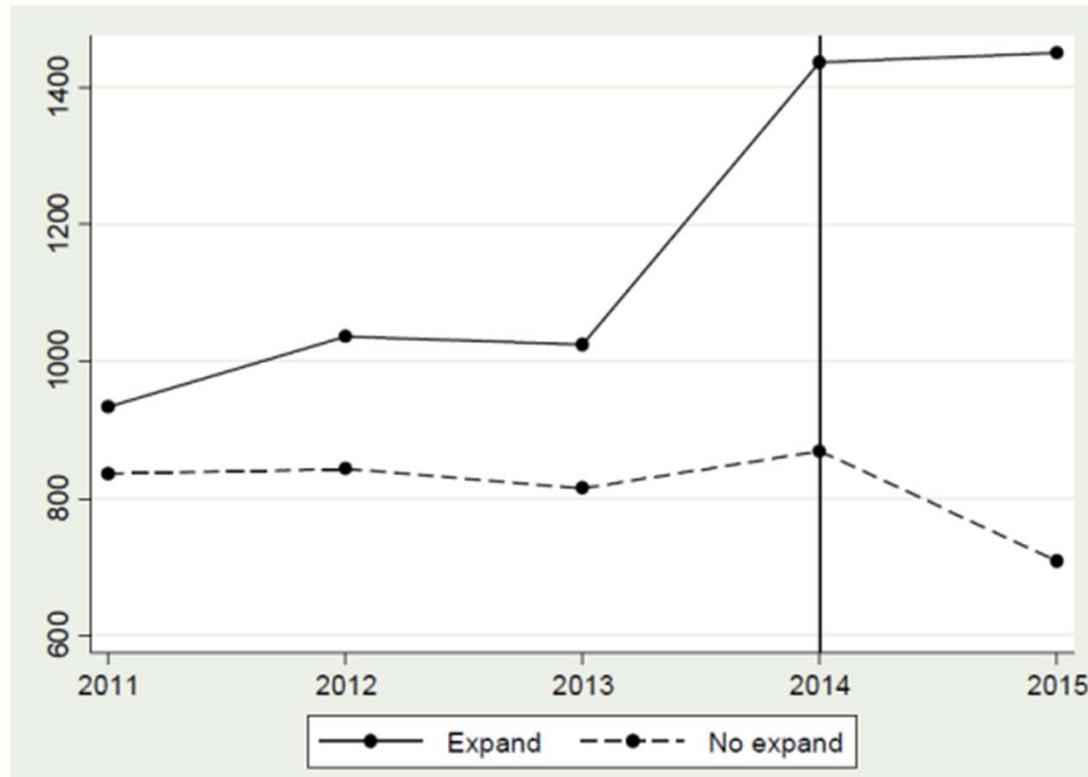
Although smoking costs Medicaid ~ \$75 billion a year, only about \$100 million is spent on smoking cessation meds.

Ku, et al. 2016a

What Policies Promote Cessation in Medicaid?

- We found that broader state coverage of cessation medications increased use of medications, while requirement for counseling to get medications lowered use. (Ku, et al. 2016b)
- CDC found that broader state coverage of medications (including varenicline) and cigarette excise tax rates associated with greater use of cessation medications. (Kahende, et al 2017)
- But other promotion and education efforts may be more important.

Medicaid Expansions Increased Use of Tobacco Cessation Prescriptions per 100,000



Maclean, Pesko & Hill 2017

What Can Medicaid & Health Agencies Do?

- Goal is to motivate providers to engage patients to use effective quitting methods and to get more patients to quit.
- Make smoking cessation a priority for Medicaid, public health and managed care organizations.
- Cover all medications and counseling. Eliminate barriers like copays & prior authorization.
- Work in conjunction with other state policies like cigarette taxes and indoor smoking laws
- Develop provider and patient education and promotion programs. Consider expanded use of other staff.

CDC's 6/18 Initiative

- Goal to expand Medicaid & commercial insurance efforts to promote cost-effective clinical prevention, e.g., smoking cessation, better contraception, diabetes prevention.
- Collaboration of Medicaid & public health agencies.
- Tobacco cessation: Colorado, Massachusetts, Michigan, Minnesota, New York, Rhode Island, South Carolina, Alaska, North Carolina.
- Example initiatives: Lower barriers to coverage of medications and counseling, worked with managed care organizations, behavioral health & quitlines, promoted physician and patient education, tracked utilization, etc.

The Critical Gap

- Medicaid, public health agencies & MCOs can collaborate to inform and motivate providers and patients.
- Work with quitlines and other behavioral approaches.
- Need to motivate health plans and physicians.
- A clue: Providing more advice about quitting leads to greater satisfaction with physicians and health plans.
- Clinicians can use 5As: Ask, Advise, Assess, Assist and Arrange.
- Physicians and nurses can work with educators, behavioral specialists and quitlines.

Further Steps

- Track progress by monitor Medicaid claims data on use of cessation medications and counseling.
- Use health survey data to track smoking among Medicaid enrollees
- Identify strategies to improve performance and outcomes

Unresolved Questions

- Incentive programs for physicians or patients?
- Use of e-cigarettes as smoking cessation method? Still highly debated.

Opioids

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Medicaid Role in Use, Prevention & Treatment

Pain Relief & Prevention

- Medicaid covers pain management, including opioids.
- Opioids often overprescribed and can lead to addiction. May progress to use of heroin, fentanyl, etc.
- There are systems to detect overuse, described later.

Substance Abuse Disorder (SUD) Treatment

- Screening for addiction, followed by treatment.
- Care for overdoses (e.g., emergency dept care, hospital admissions, availability of nalaxone).
- Ongoing substance abuse treatment, including counseling, medications, detoxification, monitoring.

Medicaid Coverage Policies

- In Medicaid, prescription drug coverage and substance use treatment are optional services. States have flexibility.
- All states cover pain medications. Some developing policies to reduce overuse of opioids
- Medicaid also covers substance abuse treatments. All MCOs must cover under parity requirements.
- All states cover treatment meds: naloxone & naltrexone, also buprenorphine or buprenorphine-naloxone combinations
- 32 - 34 states cover inpatient or outpatient detoxification
- 24 states cover psychotherapy. 14 cover peer support.

Prescription Opioids

- Opioids used for short-term pain (e.g, dental, post-surgery), chronic pain (e.g., back pain) and cancer/terminal pain. A commonly prescribed class of medications.
- 2012: 15% of Medicaid pts used opioids at least once:
 - 35% of disabled. 20% of females. Use rises with age.
 - Half prescribed < 2 weeks. One third for 2-4 weeks.
 - 5% for more than 1 month.
- About 5% of users got prescriptions from 5+ prescribers
- Diversion from prescribed patient to others can occur.
Risk due to low-income population and low cost-sharing.

Drug Monitoring & Restriction

- **Prescription Drug Monitoring Programs (PDMP).** State systems monitor controlled substance data from pharmacies and prescribers. Used to monitor abuse, e.g., including multiple prescriptions, doctor shopping, high prescribers. Multiple agencies (sometimes not Medicaid)
- **Patient Review & Restriction.** Medicaid data reviewed to identify high-risk patients who use multiple doctors or pharmacies for controlled substances. May lock into designated providers.
- Programs vary. Incomplete evidence of effectiveness.

Policies to Limit Overprescribing

- General CDC guidance for chronic pain: First, consider non-pharmacologic and non-opioid pain management. Use low doses for brief periods. Monitor higher use.
- Medicaid may impose prescribing rules, quantity limits, preferred drug lists or step therapy.
- May require prior authorization, e.g., for higher doses, longer duration, certain opioids like fentanyl.
- Could require review of patient's PDMP data or use of Screening, Brief Intervention and Referral to Treatment (SBIRT) to screen for substance use disorder (SUD) prior to prescribing or dispensing opioids.

SUD Monitoring & Treatment

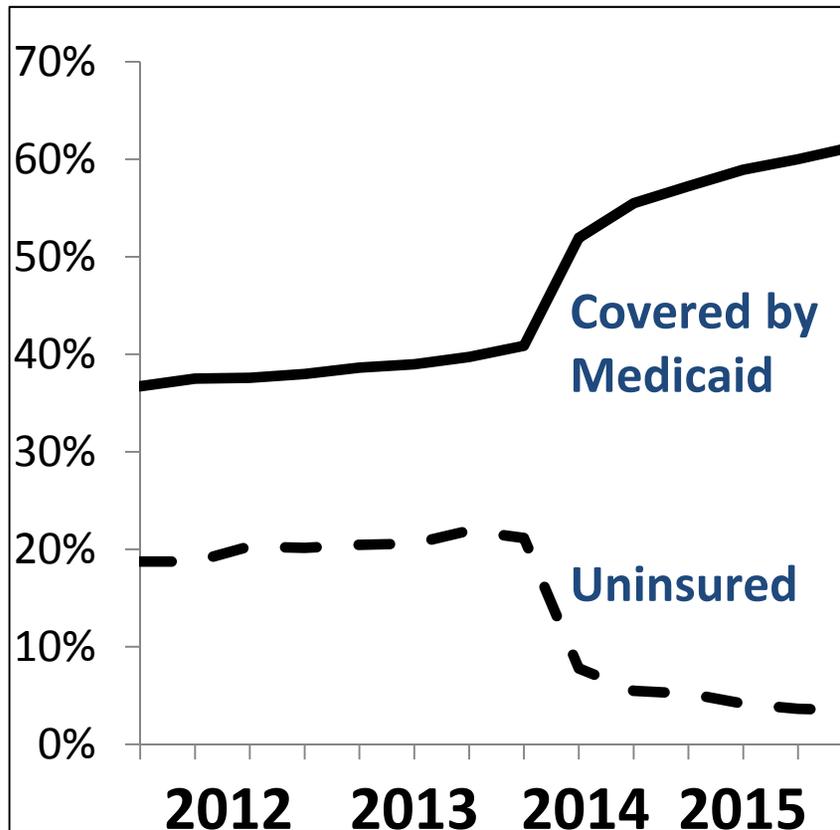
- Clinicians should screen for substance abuse disorder (SUD), including opioids, and refer for treatment.
- Opioid addicts can be helped by behavioral and medication-assisted therapies (**MAT**: buprenorphine, methadone, naltrexone)
- *Note*: Recent Pennsylvania study found deficiencies in care for Medicaid patients treated for overdoses from 2008-13. Post-overdose: very small increases in MAT and marginal reductions in opioid prescriptions. Health system did not respond appropriately, not necessarily just a Medicaid problem.

Medicaid Major Payor for Opioid Care

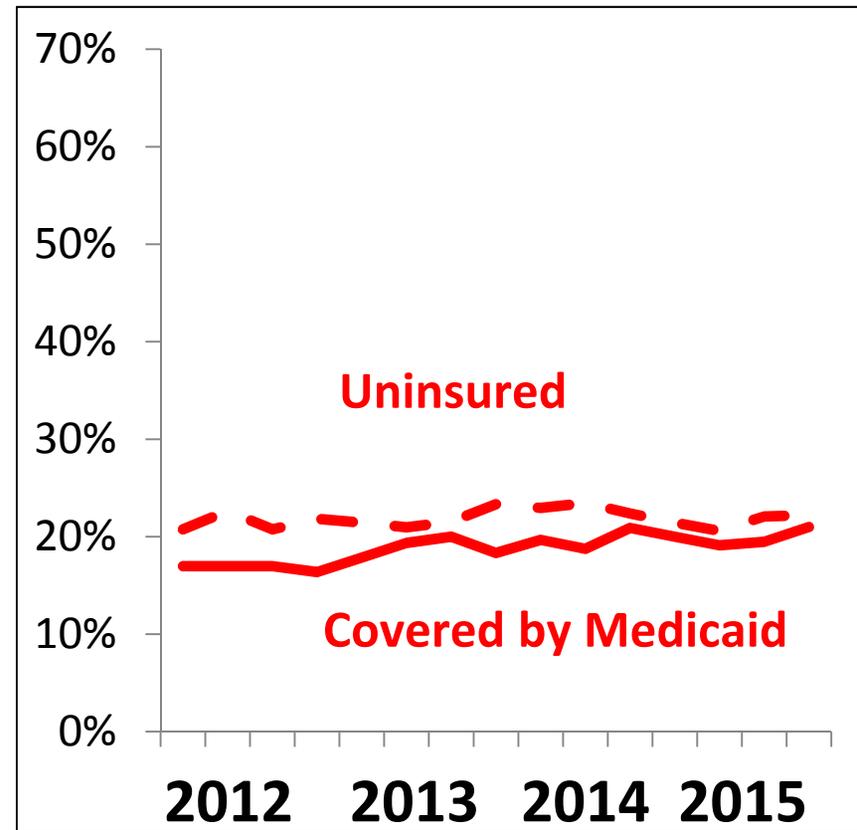
- Medicaid has been critical in supporting costs of care related to opioid use disorder (OUD).
- Major payor for:
 - Emergency and inpatient care for overdoses and other acute care
 - Buprenorphine and other treatment medications
- Without Medicaid, increased uncompensated care burdens and less treatment.
- **Medicaid expansions have helped health systems provide care**

Medicaid Expansion Helped Cover the Costs of Opioid-Related Inpatient Care

Ohio (Expanded Medicaid)

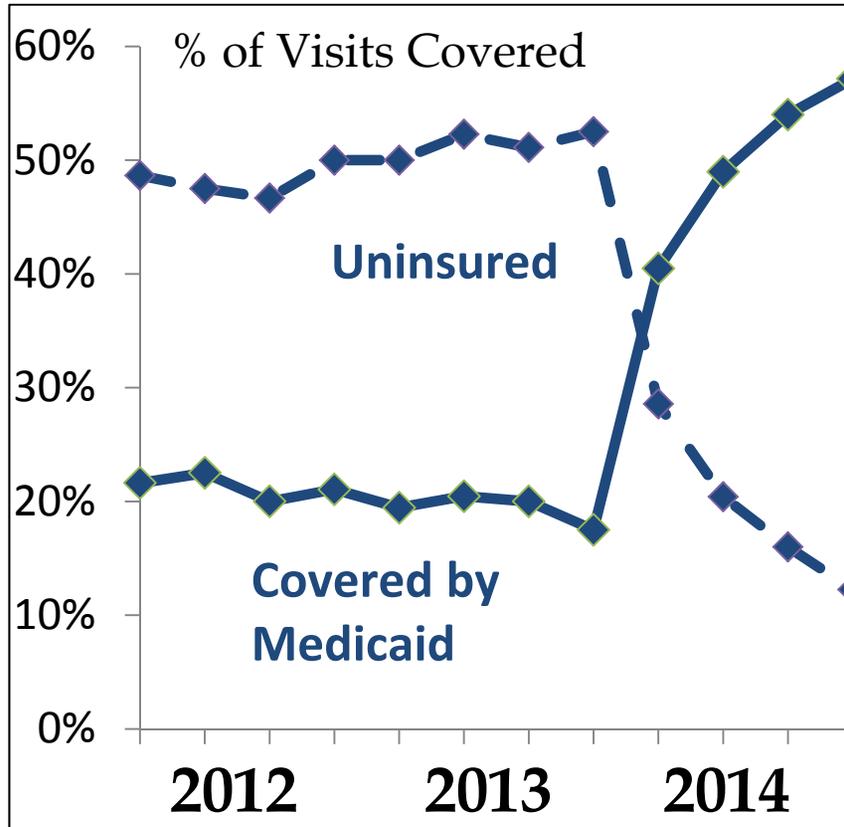


Virginia (No Expansion)

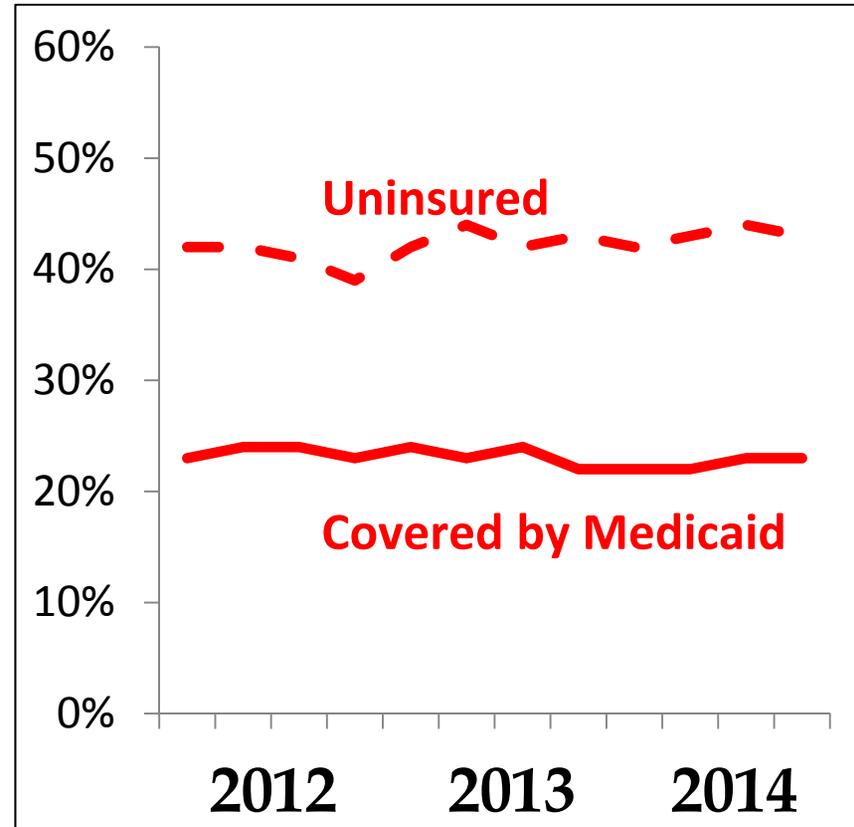


Medicaid Expansion Helped Cover the Costs of Opioid-Related Emergency Room Visits

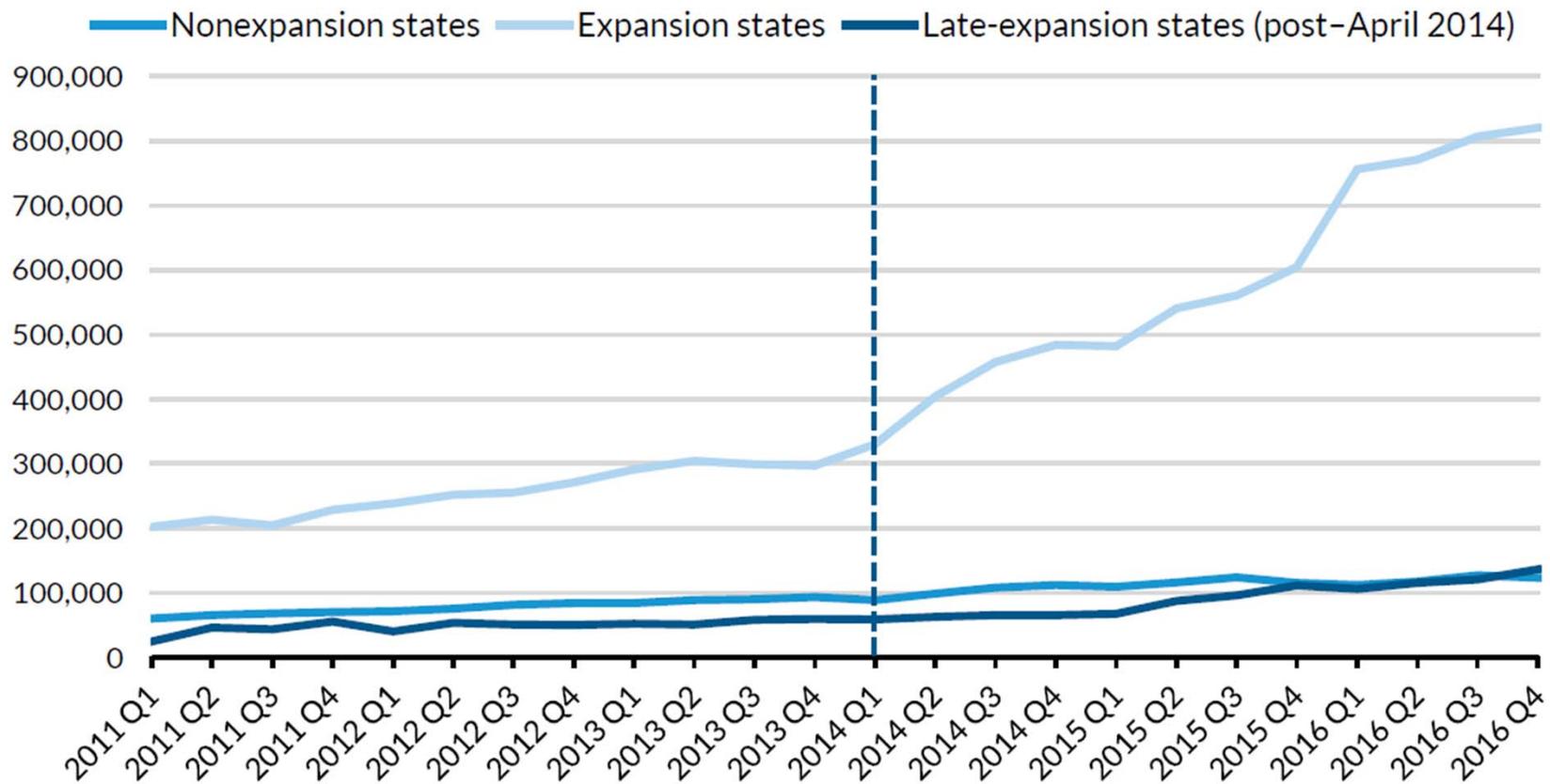
Kentucky (Expanded Medicaid)



North Carolina (No Expansion)



Total Buprenorphine Prescriptions for OUD by State Expansion Status



Source: Clemans-Cope L, et al., Urban Institute 2017

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Shortage of SUD Treatment Options

- Limited availability of outpatient and inpatient SUD care.
- Large growth of behavioral care at community health centers (CHCs), but SUD services have lagged.
- Grants to help CHCs expand SUD care.
- Expand training and support to primary care doctors for medication-assisted therapy, including telehealth
- Let Medicaid pay psychiatric hospitals for SUD care, including waivers. Suggested by Presidential Commission.
- Innovative team/case management approaches being tested.

Vermont's Hub & Spoke Model

- 5 regional Hubs which have specialized opioid use capabilities. Receive cases from overdoses, EDs, jail, mental health. Assess, initiate treatment, refer to Spokes.
- Multiple Spokes (community physicians, psychiatrists, FQHCs). Work with MAT team of nurse & behavioral providers.
- Medicaid develops special payment rates for hubs and spokes.
- Results in greater treatment capacity and greater use of treatment services, e.g., MAT.