

DHHS FY 16/17 Budget Initiative: Eliminate Reimbursement for Methadone Clinics

Background

According to the Substance Abuse and Mental Health Services Association, the integration of physical health and addictions care can help negate barriers to primary care, as providing primary care to individuals with addictions enhances their recovery from substance abuse. Primary care treatment yields better health outcomes for individuals, in contrast to back-and-forth referrals between behavioral health and primary care offices that leave up to 80 percent of individuals without care.

In addition to having substance abuse disorders, many of these individuals suffer from interrelated physical illnesses and/or co-morbid conditions that are not addressed when Methadone dosing occurs at a treatment center. For example, studies have shown that people with substance abuse disorders have:

- Nine times greater risk of congestive heart failure.
- 12 times greater risk of liver cirrhosis.
- 12 times the risk of developing pneumonia.

Prevention and treatment of chronic diseases does not occur at Methadone clinics. The high quality treatment that individuals with addiction need requires a team of diverse professionals that includes both specialty substance abuse providers and primary care providers. Under the integrated care of a primary care provider, members receive prevention, education, and treatment for health issues, including substance abuse disorders.

In addition, primary care providers maintain ongoing engagement with MaineCare members and oversight of prescribing patterns as well as an awareness of a member's substance abuse history. This further enhances a holistic approach to health care delivery, rather than perpetuating a fragmented one.

Treatment of addiction and opiate habits is complex, and there are factors that need to be considered in determining one treatment over another. For example:

- Withdrawal symptoms will occur for individuals trying to break an addiction habit. Suboxone has been shown to have less severe withdrawal symptoms than Methadone treatment.
- Suboxone is considered to be less addictive than Methadone.
- Suboxone is much more difficult to abuse, therefore patients are allowed to take this medication at home versus Methadone where individuals have to travel seven days a week to a treatment center until they can prove they will not abuse the treatment, at which point they are permitted to take home doses.

Initiative

This initiative proposes to eliminate reimbursement for Methadone clinics. While the State of Maine spends more than \$8 million annually disbursing Methadone, only a percentage of those expenditures would be realized as savings due to the fact that many of the individuals currently receiving Methadone would likely transition to Suboxone treatments.

Savings*

Year	State	Federal	Total
SFY 16	\$726,921	\$1,209,986	\$1,936,907
SFY 17	\$867,657	\$1,456,632	\$2,324,289

*The savings estimates assume 80 percent of current Methadone users will transition to Suboxone with the implementation of this initiative.

Clinical Research Supports the Switch to Suboxone

Suboxone is Safer than Methadone

- Because of its ceiling effect and poor bioavailability, Buprenorphine (Suboxone) is safer in overdose than opioid full agonists, such as Methadone. (*Substance Abuse and Mental Health Services Agency. <http://Buprenorphine.samhsa.gov/about.html>*)
- Buprenorphine possesses many clinical benefits such as lower abuse potential, lower level of physical dependence, a ceiling effect at higher doses, and greater safety in overdose compared to full agonists (including Methadone). (*Mady Chalk, PhD; Kelly Alanis-Hirsch, PhD; Abigail Woodworth, MS; Jack Kemp, MS; A. Thomas McLellan, PhD. The Effectiveness of Pharmacotherapies for the Treatment of Opioid Disorders: A Systematic Review. Treatment Research Institute. 2013.*)
- The risk of overdose on this medication is very small. (*Substance Abuse and Mental Health Services Agency. Buprenorphine for treatment of opioid addiction. 2011.*)

Suboxone is as Effective as Methadone

- Buprenorphine (Suboxone) is equally as effective as moderate doses of Methadone in opioid maintenance therapy. (*Substance Abuse and Mental Health Services Agency. Buprenorphine for treatment of opioid addiction. 2011.*)
- The availability of office-based treatment for opioid addiction is a cost-effective approach that increases the reach of treatment and the options available to patients. (*National Institute on Drug Abuse. Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition). <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies>*)
- Buprenorphine offers two important advantages over Methadone in the U.S.: it is a safer medication due to its partial agonist properties making overdose risks far lower than for Methadone; and Buprenorphine is far more accessible, as it is available from specially trained primary and generalist physicians. (*Mady Chalk, PhD; Kelly Alanis-Hirsch, PhD; Abigail Woodworth, MS; Jack Kemp, MS; A. Thomas McLellan, PhD. The Effectiveness of Pharmacotherapies for the Treatment of Opioid Disorders: A Systematic Review. Treatment Research Institute. 2013.*)
- “The benefits are high, the risk is low and it is worth it on a population-wide basis,” said Dr. Stuart Gitlow, the president of the American Society of Addiction Medicine. (*Sontag, D. NY Times. Treatment With a Dark Side. 11/16/2013.*)
- When compared with Methadone-aided withdrawal, patients treated with Buprenorphine experienced more rapid resolution of withdrawal symptoms, but there was no significant difference in treatment completion, or severity of withdrawal. (*Chalk & Alanis-Hirsch, p. 34*)
- Comparing the evidence from clinical trials on the effectiveness of Methadone and Buprenorphine for opioid agonist maintenance treatment, both medications provide good outcomes in most cases. (*The World Health Organization. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid dependence. 2009.*)

Suboxone is at Least as Cost-Effective as Methadone

- Buprenorphine is more costly than Methadone to purchase as a medication, but it is a cost-effective option for the management of opioid dependence within a maintenance program operated over sufficient duration to achieve health gains and a drug-free lifestyle.
- Results of the largest randomized controlled trial of Methadone to date (Mattick et al., 2003) showed no significant difference in *cost-effectiveness* when Methadone was compared to Buprenorphine (Doran et al., 2003), and potential cost-effectiveness for combined Buprenorphine/naloxone formulation was shown to be greater than Methadone due to reduced costs of treatment delivery in certain settings compared with Methadone (Rosenheck & Kosten, 2001). (*Proposal for the inclusion of Buprenorphine in the WHO model list of essential medicines. Department of Mental Health and Substance Abuse: Management of Substance Abuse. World Health Organization. 11/2004.*)

Primary Care Settings Offer Distinct Advantages Over Clinics

- There are more than 118 physicians in Maine who are registered to provide treatment using Buprenorphine. The availability of these physicians provides greater choice and options to consumers. (*SAMHSA. Buprenorphine physician locator. http://Buprenorphine.samhsa.gov/pls/bwns_locator/lprovider_search.process_query?alternate=CHOICEG&one_state=ME*)
- In 2007, researchers from Harvard Medical School published a study in the *Annals of Family Medicine* concluding that opioid-addicted patients can be safely and effectively treated in non-research primary care settings with limited on-site resources. They also concluded that a greater numbers of patients could have access to Buprenorphinenaloxone treatment in primary care settings. (*Mintzer, I, et al. Treating Opioid Addiction With Buprenorphine-Naloxone in Community-Based Primary Care Settings. Ann Fam Med 2007;5:146-150. DOI: 10.1370/afm.665.*)
- In a randomized contrail trial, researchers compared Methadone clinic based treatment to PCP office treatment using Buprenorphine. This study found that Buprenorphine maintenance therapy is an effective treatment for heroin dependence in a primary care setting and could substantially increase access to drug treatment services over Methadone clinics. (*O'Connor, P., et al. A Randomized Trial of Buprenorphine Maintenance for Heroin Dependence in a Primary Care Clinic for Substance Users versus a Methadone Clinic. THE AMERICAN JOURNAL OF MEDICINE. Volume 105. 8/1998*)
- Opioid withdrawal and relapse prevention services can also be provided in primary care, with similar efficacy as specialist clinics but at lower cost. (*The World Health Organization. Guidelines for the Psychosocially Assisted Pharmacological Treatment of Opioid Dependence. 2009. p.12.*)

MaineCare Spending

Methadone

Members receiving methadone treatment

SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14
2,421	3,039	3,498	4,073	4,169	3,951	3,858

Total paid for methadone treatment

SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14
\$6,841,292	\$8,621,426	\$9,750,941	\$11,113,017	\$11,353,464	\$9,231,922	\$8,286,413

Total paid for methadone transportation

SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14
\$5,462,377	\$6,688,309	\$7,148,833	\$8,157,569	\$7,477,178	\$6,341,459	*

* In August 2013, non-emergency transportation services transitioned from fee-for-service to a broker model. Brokers are now paid a fixed per member/per month (capitated) rate.

Suboxone

Members receiving Suboxone

SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14
2,720	3,321	3,951	4,821	5,155	5,094	5,079

Total paid for Suboxone

SFY 08	SFY 09	SFY 10	SFY 11	SFY 12	SFY 13	SFY 14
\$5,855,719	\$7,451,516	\$10,052,877	\$12,097,676	\$11,908,648	\$11,083,477	\$9,538,429*

*The decrease between SFY 13 and SFY 14 is due to the Suboxone/Subutex initiative explained below.

Recently implemented initiatives

Suboxone/Subutex

Beginning January 1, 2013, through legislative action, a two year lifetime limit was placed on MaineCare coverage of Suboxone and Subutex. This limit applies except when continuation is shown to be medically necessary. The adopted legislation required that this lifetime restriction be retroactive. Therefore, a new MaineCare policy went into effect January 1st, 2013 and was applied to any member who had received up to 24 months of treatment with Suboxone and/or Subutex prior to January 1st. Furthermore a PA process is now in place and reflects the medically necessary criteria including a required attempt at taper even if the medication is to be continued based upon medical necessity.

Methadone

This treatment modality for addiction to opioids was given a two year life-time limit for MaineCare coverage. This life-time limit was deemed to be written such that it would be applied in a prospective fashion. Thus, effective January 1, 2013, all current and future members of MaineCare treated through a methadone clinic would be allowed no more than two years of treatment at a methadone clinic. Past treatment is not included in the calculation of this limit. Similar to Suboxone, there is a provision for continuation beyond two years if medical necessity could be

demonstrated. In the case of methadone, these PA criteria are consistent with the six dimensions used to determine eligibility for the service at time of initial presentation.

Suboxone/Subutex Provider Capacity

	Number of Providers (2014)	Total Suboxone Patient Capacity
Providers licensed to treat up to 100 patients with Suboxone	133	13,300
Providers licensed to treat up to 30 patients with Suboxone	203	6,090