The Impact of Managed Care on Addiction Treatment: An Analysis

INTRODUCTION

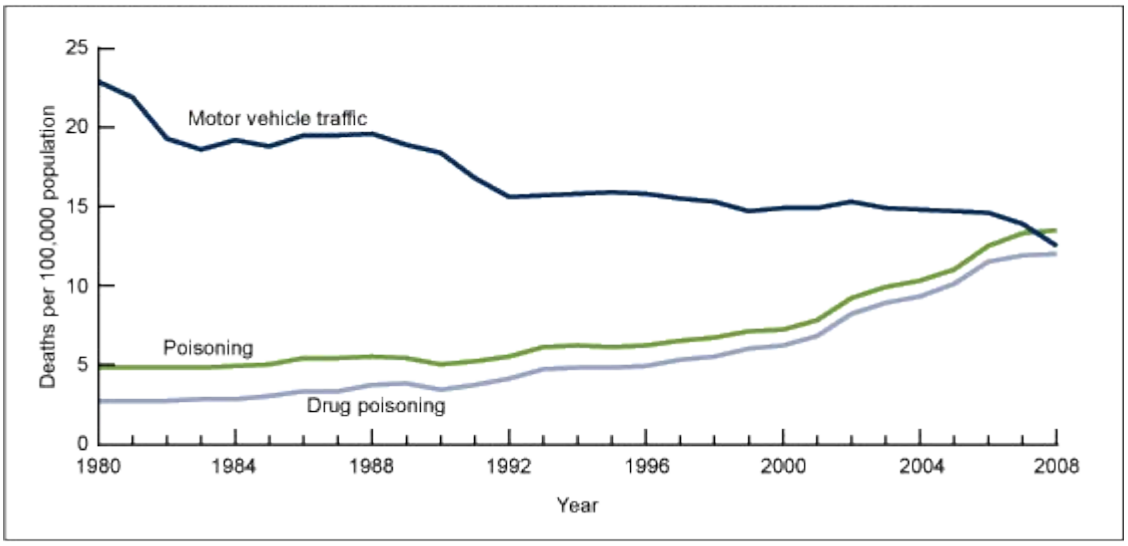
Opiate addiction and the treatment of opioid dependence has received increased attention in recent years associated with the epidemic rise in the number of cases of opioid misuse, abuse, dependence, and over dose deaths in the United States.

In society, as a whole, we are losing productivity in the workplace and the classroom; increasing societal costs as a result of crimes; and the costs of incarceration; and increasing the financial burden on federal and state budgets, in part due to poorly conceived policies for paying for addiction treatment services. Addiction to opioids—both prescription drugs and heroin—is a national epidemic.

There is a significant rise in the number of cases presenting to addiction treatment facilities where opioid dependence is the primary diagnosis. Associated with the increase in cases of abuse and dependence—and, arguably—one of the contributing factors to the recent epidemic—is the dramatic increase of number of prescriptions for opioid analgesics authorized in the past 15 years. According to the **National Survey on Drug Use and Health,** as highlighted by the White House Office of **National Drug Control Policy (ONDCP)**, there has been a greater than 400 percent increase between 1997 and 2007 in the number of cases of opioid abuse and dependence, which has led to increases in the need for treatment.

According to the **Centers for Disease Control and Prevention**, *accidental deaths by poisoning and drug overdosing have now exceeded deaths from motor vehicle accidents.* MVA's have been on the decrease due to a national crackdown on Driving under the Influence of alcohol and increased safety demands on auto manufacturers as well as laws to increase seatbelt usage. In contrast to policy initiatives that have reduced the number of highway deaths, policy changes regarding opiate pain medications have not yet turned around the increases in the number of prescription-drug-related deaths. Public policy reforms are needed across all levels of government (federal, state, local) to stop this rampant epidemic that has killed more Americans in the past 2 years than died during the entire Vietnam War.

Figure 1. Motor vehicle traffic, poisoning, and drug poisoning death rates: United States, 1980–2008



More needs to be done in terms product development and safety, prescribing and marketing education, and prescription drug monitoring and regulation. Equally important is the need for better patient access and appropriate level of addiction treatment.

Insurance company denial of access to appropriate and clinically indicated opiate addiction treatment levels of care

While interventions can be made on many levels to reduce the rates of inappropriate prescribing of opioids, to improve the education of both prescribers and patients about this epidemic, to target overdose deaths directly via the use of overdose reversal medications, to increase the use of safe prescription drug disposal and "take-back" programs for unused opioid pill supplies, no one should ignore the role of addiction treatment services in addressing the epidemics of opioid addiction and opioid overdose deaths. Clinical interventions for the best possible outcomes must include four basic elements: **Detoxification, rehabilitative counseling, continuing care, and Medication Assisted Therapy** (when indicated). (*National Quality Forum Standards for the Treatment of Substance Use Disorders 2007)*. Detoxification services are essential in assisting patients to achieve a state of abstinence, but the ultimate goal of sustained abstinence cannot be obtained by detoxification only. Unfortunately, too many stakeholders in addiction treatment represent that detoxification alone is treatment. "Detoxification alone" only increases the probability of relapse into active use and overdose deaths. Studies on the outcome of detox-only interventions are not promising

with regard to the rates of sustained abstinence and recovery achieved after such services.

In a recent study of inpatient detoxification versus outpatient detoxification for opiate treatment shows that **inpatient detoxification for opiate addiction is superior to outpatient detoxification (51.4% versus 36.4%)** in terms of completing treatment. (*Journal Substance Abuse Treatment. 2011 Jan: 40(1):56-66))*

Furthermore, it is also vitally important that individuals with any addiction be able to access the appropriate level of addiction care. The levels of care for addiction treatment vary. The **American Society of Addiction Medicine Patient Placement Criteria 2R (ASAMPPC-2R)** is the only beta tested peer reviewed patient placement tool that is widely accepted in the addiction treatment field by treatment providers and managed care agencies. Concisely, it can predict with reasonable clinical accuracy the level of care a patient requires. The levels range from **level 0.5** (brief intervention); **level I** (traditional individual outpatient); **level II** (Intensive outpatient); **level III** (Residential); and **level IV** (Hospital based). The appropriate selection of the next level of care after detoxification is critical to the entire treatment outcome.

When patients are limited to detoxification only or are not allowed access to the next indicated level of care, the result is predictably less than optimal. These patients fail and may need to start treatment all over again **or they die from overdose** due to an ineffective "treatment" that they underwent as a result of denied access to the appropriate level of care. In a study published in the Journal of the American Medical Association *(JAMA 2004 A. Thomas McLellan, PhD)* it was learned that when patients receive the aforementioned four essentials of addiction, their treatment outcomes were equal to or better than treatment outcomes of other chronic medical illnesses (diabetes, hypertension, and asthma). Surprisingly to many, **opiate depended patients recovered at a rate of nearly 80%** at one year compared with a 50% recovery rate for diabetics. Most of those successful opiate dependent patients underwent *inpatient detoxification and residential rehabilitation stays.*

The application of multiple episodes of detoxification-only services will drive up health care costs without reducing the overall rates of addiction or the rates of disability or death attributable to opioid addiction. Studies show that inpatient detoxification and residential treatment have completion rates of up to 81% while outpatient detoxification treatment have completion rates that are much lower (Outpatient versus inpatient opioid detoxification: a randomized controlled trial. (*Day, E. J Substance Abuse Treatment. 2011 Jan: 40(1); 56-66)).*

While inpatient treatment is more costly when compared to outpatient detoxification only and outpatient treatment, repeat detoxifications and outpatient treatment as a result of

an inappropriate initial selection is wasteful and ultimately costs more. **Inappropriate treatment selection is detrimental to patient health and is a waste of already limited financial resources** available for addiction treatment.

We firmly believe that offering a medically-necessary continuum of psychosocial, as well as, medication assisted therapy when indicated, following of Levels of Care as outlined in the ASAM Patient Placement Criteria, results in an enhanced likelihood of success, greater compliance and less chance of recidivism. Thus, for "drug free treatment" of opioid addiction, this could include several weeks of residential treatment where detox could be accomplished on a non-outpatient basis; followed by step-down to several weeks of **Partial Hospitalization Program (PHP); f**ollowed by up to **90 days of Intensive Outpatient Program (IOP) care;** followed **by 6 or more months of professional follow-up via individual and group recovery-oriented therapy.** Some patients benefit from **halfway house or sober-living-house services** to provide a stable recovery environment when they are stepped down from Level III (residential care) to Level II (PHP and IOP care) and Level I (ongoing individual and group therapy) care. This continuum of care presents the best model for achieving abstinence via psychosocial therapies, and supplementing this professional help with peer support through the self-help programs of Narcotics Anonymous or other 12-Step groups can improve outcomes even more. Because of the chronic nature of the illness of addiction, **12-Step participation** for a lifetime is the commitment that many persons in recovery make and uphold.

Continued misguided denial of access to the appropriate levels of care established by national expert organizations (SAMHSA, NQF, and ASAM) and controlled best practice studies is not cost effective or clinically prudent in the care of patients with addictions.

Medication Assisted Therapy (MAT)-Insurance rules and regulations

Medication Assisted Therapy for addiction treatment, especially opiate addiction, has proven to be safe and effective in successful treatment outcomes and cost. (*CSAT TIP#43 Medication Assisted Therapy for Opiate Addiction).*

Medication Assisted Therapy (MAT) has given patients with addiction new hope and a better prognosis for ongoing sustained recovery over the past decade. The research conducted by NIDA, NIAAA, SAMHSA, and other organizations have discovered that addiction is a chronic medical illness much like diabetes and hypertension, with distinctly genetic components, measureable physiologic changes, and yes, can be addressed and put into remission. More recently medications have been developed and are FDA approved for the treatment of addiction. The unfortunate development is that

many of these FDA approved medications for the treatment of addiction, especially those approved for opiate addiction, are subject to pre-approval, and their use and dosage is time limited or restricted, respectively. This does not largely occur with other FDA approved medications for other chronic medical illnesses.

When opiate or other addicted patients present for help, this must be recognized as a window of opportunity that may not occur again. It is clinically imperative that all of the available tools, interventions and medications be available. Any delay in providing care for patients with an addiction can be and has been life threatening. Oftentimes the **prior authorization process can be burdensome for patients and providers and ultimately result in untoward outcomes and death from overdose.** Some patients go on to commit crimes to sustain their habits or otherwise injury themselves or other fatally.

There have also been reported instances where **patients, who are finally stable on a maintenance medication, are forced to discontinue** by the insurer length of time limitations of detoxification only, or 6-12 month limits. **Many of these patients relapse and some of the others die**. The FDA has approved these medications for ***detoxification and maintenance!*** Some insurers try to limit the use for detoxification only and seek to define the length of time for maintenance, in disregard of the FDA and CSAT recommendations. It has been reported in other cases that insurers also seek to limit the dose of medication beyond that set by the FDA. The FDA and CSAT have indicated that dosages of buprenorphine in the form of Suboxone or Subutex has efficacy between 2-32mg daily. While it is acknowledged that the average dose prescribed is 16mg, there are some individuals that require 32mg and these people should not be denied. This fact is clearly stated in the CSAT TIP#40.

Insurers should not dictate or restrict the dosages or length of opiate maintenance treatment that are well established and determined to be efficacious and in line with the best practices recommendations by the FDA and other agencies (CSAT, NIDA, and NQF) solely to manage cost concerns.

CONCLUSIONS AND RECOMMENDATIONS

Our nation's current opiate abuse and opiate overdose epidemic is real and it is undoubtedly the cause of an increased morbidity and mortality that has surpassed the numbers of people that have been killed as a result of motor vehicle accidents over the past several years. While there are many contributing factors involved, the interface of access to appropriated addiction treatment and affordability for the same is fertile ground to begin to plant the seeds for solutions. The federal, state and local governments are taking vigorous actions to stem the availability of illegal opiates and inappropriately prescribed medication. It is now time that the treatment and managed

care communities examine the issues on the treatment side of the equation and develop policies that will lead to better access to clinically indicated treatment and better treat outcomes with patients who suffer from opiate and other addictions.

Health insurance should pay for all the costs of professional addiction treatment. There is some variance of opinion with regard to whether health insurance should cover the costs of **recovery support services**, such as the use of **recovery coaches** or the use of **sober living services** (halfway houses or even structured housing made available to participants in PHP and IOP levels of care). These additional components are very important in terms of increasing the success rate of recovery for many individuals; however more research and data collection needs to occur to quantify the actual value of these services.

1. SELECTION OF TREATMENT LEVELS OF CARE

Insurers need to rely upon trained and certified addiction treatment professionals to determine the level of care that a patient requires based upon evidenced based and peer reviewed standards that are readily available for use, today. These standards of care have already been vetted by NQF, SAMHSA, CSAT, and others. The ASAM PPC-2R has specific guidelines to determine the appropriate levels of care for patients with addiction. The adoption and the monitoring of adherence to these guidelines by managed care agencies should be sufficient in terms of their need to be assured that resources are being appropriately allocated and spent.

2. MEDICATION ASSISTED THERAPY (MAT)

Physicians trained and certified in Addiction Medicine, or who are otherwise wavered and trained to prescribe FDA approved medications to assist or maintain a patient's recovery, should have the ultimate authority in issues determining which medication, FDA approved dosage and length of use is clinically required to appropriately treat a patient. The selections of medications and FDA approved dosages and length of treatment should be left of to the practitioner, not the insurance company.

3. **PRIOR AUTHORIZATION REQUIREMENTS FOR MEDICATION AND PROGRAM ADMISSION**

At the time a patient presents for treatment and help for an addiction, he or she needs to be able to receive care that cares! When patients are denied access to treatment, whether it is for medication or admission into a treatment facility, the results are devastating. Many of them continue to use or they die. It is recommended that these patients seeking help are allowed to enter into treatment and have their situations evaluated by trained, certified addiction professionals for a comprehensive evaluation and assessment. The findings can then be reported to the insurers for approval.

4. **CO-OCCURRING MENTAL HEALTH TREATMENT**

As it is well known and documented everywhere, successful addiction treatment is not guaranteed when co-occurring psychiatric issues are not identified and simultaneously treated. We encourage recognition and treatment of **co-occurring disorders.** *(www.samhsa.gov/co-occuring/topics/healthcare-integration/index.aspx)*

5. PRESCRIPTION OPIATE ABUSE

Prescription drug abuse is already being addressed by federal, state and local officials. More needs to be done in terms of prescriber education about addiction and pain issues, appropriate prescribing of opiates in general and the ethics of appropriate prescribing. Prescribers and dispensers need to be encouraged to make use of the Prescription Monitoring Programs that are available in states to help curb the prescribing to patients that are abusing CDS.

It is our belief that these few recommendations, if seriously reviewed and accepted, will significantly change our experience with opiate abuse, misuse and addiction treatment. While it is generally expected that federal, state and local agencies will address the "illegal aspects" of this epidemic, the "treatment side" of the equation also needs to weigh into the solution as well. Patients who suffer from addiction are entitled to a full, evidenced based treatment just as any other patient who suffers from a chronic medical illness. Patients with addiction should not have evidence based treatment practices nor FDA approved medications withheld because of non-clinical concerns. The implementation of these few recommendations will surely make an impact on this current epidemic and treatment crisis in our nation.

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