OUD Death Rates Rise, Methadone is Underused, and Insurers Favor Buprenorphine; Would Coverage of Methadone in Broader Practices Beyond OTPs Be a Solution?

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The problem of methadone underuse isn't new—but the authors of a recently published paper offer ways to fix the situation; ways that are both new and innovative. If broad regulatory changes aren't going to happen, they say, the solution may be to empower private insurers to make methadone more accessible to patients by, for example, allowing it to be prescribed without the comprehensive care required under the current system.

And they offer specific steps to make this happen.

There's no question that something needs to be done. Opioid overdose deaths increased by 157% during the past 10 years, the authors point out, while the number of treatment facilities stayed roughly the same.

Background

- More than half of U.S. treatment facilities still treat patients without using medication—an approach that just doesn't work for the vast majority of people
- Facilities offering buprenorphine have doubled in number over the last 10 years

- Yet methadone availability lags; facilities offering methadone have increased by only 19%

The suggestions for changing the situation come from "Private coverage of methadone in outpatient treatment programs," published in December in *ps.psychiatryonline.* The authors are highly qualified to tackle the topic; lead author Daniel Polsky, PhD, has an impressive background in health care management, and currently serves as Bloomberg Distinguished Professor of Health Economics at Johns Hopkins University School of Public Health; Samantha Arsenault, MA, is vice president of National Treatment Quality Initiatives for Shatterproof, a national nonprofit group dedicated to reversing the nation's addiction crisis; and Francisca Azocar, PhD, is vice president of Research and Evaluation of Behavioral Health Sciences at OptumHealth Behavioral Solutions.

Methadone, Long-Time Treatment Leader, Is Now a Laggard

Of the three medications approved to treat opioid use disorder (OUD), the other two being buprenorphine and naltrexone, methadone has been in use the longest time, and is backed by excellent treatment-related data. Yet it remains underused.

The reasons are clear:

- First, it's the restrictions. Methadone for addiction treatment, unlike methadone for pain, must be administered at opioid treatment programs (OTPs). And that involves, at least initially, daily visits, and sometimes lengthy travel. Programs may be overcrowded, with long lines at the OTP, and costs to enter the program may be high
- OTPs have faced heavy regulation for about 50 years, not only from government agencies, but from the Substance Abuse and Mental Health Services Administration and the Drug Enforcement Administration as well
- Alternatives to methadone offer convenience and time-savings: naltrexone treatment usually means a monthly injection in a doctor's office; buprenorphine therapy may mean obtaining a prescription from a nurse practitioner or a physician, then picking up the medication at the pharmacy

So, why hasn't the methadone treatment system been changed? Why can't methadone offer the conveniences its competitors do, so it can challenge them on an equal footing?

Stigma against methadone maintenance treatment continues—yet no treatment has proven more effective in helping OUD patients. A high level of stigma, according to the paper's authors, "has made it difficult to generate the cooperation among many stakeholders necessary to produce the regulatory reforms that are needed to trigger transformation."

Needed, the authors say, are those reforms—as are measures "that directly address the issue of stigma."

The Reformers

Reforms require action, and that means players. Here are players the authors called upon to accomplish reforms—and why they chose them:

Health insurers and employers —because they can build incentives for making methadone more available and more widely used, while they address immediate barriers to methadone access; and because they can act faster "than legislative and regulatory reform"

Financial systems—for they can improve access by driving "overdue changes" to the methadone maintenance system

Roles for Commercial Insurance Companies

When private health insurers have paid for methadone treatment, historically it's been through the prior-authorization route. So, the authors undertook some field research, scheduling interviews with key people at three large health insurance companies. Topics included how private insurance firms can help overcome barriers to OUD treatment. The two groups collaborated; the actions directly below reflect their joint efforts.

Actions for Private Insurance Companies

Below is a brief summary; consult the published article for details.

Expand methadone coverage

Expansion begins by making sure that commercial health plans cover methadone treatment. Issuing a directive isn't good enough; additional key steps include educating clients who are employers; the goal is to "help them overcome reticence to covering methadone."

Delete prior-authorization requirements

Verifying medical necessity can take time—and, for patients, taking time can mean relapse and even death. The health insurers the authors interviewed indicated that some among them had tried to reduce prior authorization requirements, but that their efforts could be improved.

Reduce patients' out-of-pocket costs

Patients may face unexpectedly high costs, even if they're insured for methadone treatment, and their OTP accepts their insurance. Typically, a copay exists for each visit, and 20 visits per month could mean a copay exceeding $700 per month—more than many patients can afford.

Possible remedies: methadone could be prescribed, like buprenorphine, and covered by insurance; or, the authors suggest, "a single bundled payment for a weekly or monthly course of methadone treatment" could be provided.

Manage provider networks

In many areas, people seeking methadone treatment face two unpleasant options. One is a long drive each day to the nearest OTP, or, lacking an OTP nearby, payers could "work with state and community partners to identify reasons behind the shortage of providers and to implement solutions."

Private Insurance Carriers Face Limitations

In the closing section, the authors point out some limitations private carriers face in trying to address barriers to access. OTPs tend to be tucked away in relatively less-safe areas, distant from medical complexes—a situation they describe as requiring a reversal in attitudes toward methadone. Behavioral health, they say, often is "'carved out' of the medical benefit and managed separately." They see the system as favoring acute episodes of care, and failing to encourage the coordination of care.

Conclusions

Having set up a viable plan for making methadone more accessible to patients, the authors stress the importance of having options available, "so that every individual's needs can be met." For many, they point out, "methadone would be the best option if barriers to treatment access could be addressed." And they would like to see addiction treatment viewed "on par with other chronic illnesses."

A valuable short-term approach for directly increasing patient access, the authors say, is to change the ways methadone treatment is paid for. But greater efforts will be needed over the long term, they point out, to "reverse social stigma, promote system integration, and support regulatory reform, in order to transform methadone treatment and addiction treatment.

Another key point is the importance of greater access to methadone, "through commercial insurance reform and by streamlining public and private payment." This, the authors believe, "would create incentives for new providers and investors to participate in and expand access to methadone treatment."

Reference

Polsky D, Arsenault S, Azocar F. Private coverage of methadone in outpatient treatment programs [Epub ahead of print]. *Psychiatr Serv.* 2019; Dec 11:doi: 10.1176/appi.ps.201900373