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RE: AN ACT to amend the social services law and the public health law, in relation to medication for the treatment of substance use disorders

A7246-A (Rosenthal)
S5935 (Harckham)

MEMORANDUM IN OPPOSITION

Submitted on behalf of the Blue Cross and Blue Shield Plans

The New York State Conference of Blue Cross and Blue Shield Plans oppose enactment of this Bill, which would prohibit Medicaid Managed Care (MMC) plans from exercising any oversight of medication prescribed to enrollees for the treatment of substance use disorders. The Medicaid prescription drug benefit was "carved in" to the benefit package for the express purpose of managing the benefit, both from a quality and cost perspective. In eliminating the use of prior authorization for both emergency and non-emergency supplies of all FDA approved forms of medication assisted treatment (MAT), the Bill ignores the importance of the use of prior authorization to ensure patient safety and manage costs.

In 2016, legislation was enacted that prohibits the Medicaid program and MMC plans from requiring prior authorization for the initial or renewal prescription for buprenorphine or injectable naltrexone for detoxification or maintenance treatment of opioid addiction, unless the prescription is a non-preferred or non-formulary form of the drug. As a result of this legislation, prior authorization for initial and renewal prescriptions for buprenorphine or injectable naltrexone is only required when the prescribed medication is non-preferred or a non-formulary form. This legislation struck the appropriate balance between ensuring immediate to opioid addiction medication when necessary and allowing for clinical oversight in non-emergency situations. Eliminating prior authorization requirements for all treatments of opioid addiction medication would dangerously remove important clinical oversight of the use of this product.

There are three drugs approved by the FDA for the treatment of opioid dependence: buprenorphine, methadone, and naltrexone. All three of these treatments have been demonstrated to be safe and effective in combination with counseling and psychosocial support. Intended as a long-term treatment for people addicted to opioids, these drugs can produce euphoria and cause dependency. Physicians who provide MAT must be authorized by the Drug Enforcement Agency (DEA), as mandated under the Drug Addiction and Treatment Act of 2000. Physicians who are not

authorized to treat may refer a patient to a practitioner who is certified to prescribe and dispense this medication. The use of prior authorization by plans is necessary to ensure that the prescribing physician is certified for the treatment of opioid addiction, the prescription is not being used for an off-label purpose, such as the treatment of pain, and that the form prescribed is clinically appropriate for the member. This Bill would eliminate important clinical and safety oversight for buprenorphine and methadone, which are partial opiates.

While the Bill provides that the prohibition on the use of prior authorization only applies to MAT prescribed "according to generally accepted national professional guidelines for the treatment of substance use disorder", plans would have no opportunity to review the prescription to determine whether this standard is met. This is especially concerning because New York's Medicaid program is not permitted to reimburse for prescription drugs for uses that are not included in FDA labeling or listed as an acceptable use in certain compendia. Plans would have no opportunity to confirm that the drug is being prescribed for an accepted use and is therefore reimbursable under Medicaid.

From a cost perspective, MMC plans operate a formulary so that members have access to effective, safe and cost effective drugs. Members are able to access non-preferred drugs upon a demonstration by the prescriber that justifies justify the use of a particular non-preferred drug over another preferred product, such as the patient has tried and failed on a preferred product or the patient is already stabilized on the non-preferred product. This Bill removes this important limitation, and as a result, would require plans to cover all FDA approved drugs for the treatment of opioid addiction, even if the prescribed medication is non-preferred or non-formulary form without any justification.

Most importantly, the risks that this Bill creates from both a quality and cost perspective are unnecessary in light of the existing provisions governing MAT in managed care. Specifically, MMC plans are prohibited from requiring prior authorization for emergency supplies of buprenorphine and naltrexone. Thus, in emergency situations where obtaining prior authorization is not practical, prior authorization is already not required. In addition, plans prohibited from requiring prior authorization for any initial or renewal prescription for buprenorphine or naltrexone unless the prescription is for a non-preferred or non-formulary form of the drug. Again, all plans cover FDA-approved products for the treatment of opioid dependence, but not every form, and the current structure allows plans to manage their formulary in order to deliver the most safe and cost effective drugs.

This legislation unjustifiably will completely undermine MMC plans' ability to properly manage the prescription drug benefit in Medicaid, resulting in potentially dangerous health outcomes, increased fraud and abuse and increased costs in an already strained Medicaid budget.

For the foregoing reasons, the Blue Cross and Blue Shield Plans urge that this bill not be enacted.

Respectfully submitted,

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