Memo:	Senate Health & Welfare Committee
From:	Vermont Medical Society Jessa Barnard, Executive Director
Date:	April 5, 2023
Re:	H.222, Removing Barriers to MOUD

On behalf of the 2,600 physician and physician assistant members of the Vermont Medical Society (VMS), we would like to express our strong support for H. 222 and the methods in the bill to increase access to harm reduction strategies and access to medications for opioid use disorder. In particular, Sections 6, 7 and 8 will modernize language around treatment for opioid use disorder and remove barriers like step therapy and time-consuming prior authorization for medications for opioid disorder (MOUD). These changes will help prevent costly delays when patients are ready to take a critical, first step to recovery and alleviate unnecessary administrative burdens on clinicians providing treatment.

Section 6 – Step Therapy:
Section 6 will prohibit health insurers from using a step-therapy, "fail first," or other protocol that requires documented trials of a medication, including a trial documented through a "MedWatch" (FDA Form 3500[1]), before approving a prescription for the treatment of substance use disorder. VMS has heard from our members, and the House Human Services Committee received testimony about instances of payers requiring patients to "fail first" or document adverse effects from one medication before being prescribed another medication for opioid use disorder. One model used is to require documentation on the FDA Form 3500, which is actually intended by the FDA to be used as a voluntary method of reporting side effects from medications.[2]

This practice by payers is often referred to as "step therapy." VMS opposes step therapy payer policies, which can result in delayed access to appropriate medication, patients dropping out of treatment, and subjecting patients to adverse side effects. The negative impact on patients of step therapy policies is well documented.[3] VMS strongly supports the language added in the House regarding a prohibition on step therapy for MOUD.

Section 6 –Updating Opiate Treatment System Language & Telehealth
Section 6 of the bill proposes amendments to state statute creating Vermont's opiate treatment system. VMS supports several modifications to this statute. First, as our system of care for opiate use disorder has evolved to treat OUD like other health conditions, some of this language has become overly prescriptive and prevents the Department of Health from modifying rules regarding treatment as the evidence changes. Other aspects of current statutory language unnecessarily stigmatizes MOUD, for example, suggesting medication should be tapered as soon as possible and highlighting discharge from care – which can be addressed in rule or practice policy. VMS supports the language as proposed by the House, which removes much of the language from statute and defers to VDH rules for Spoke practices.[4]

[1] https://www.fda.gov/media/76299/download
[2] https://www.fda.gov/safety/medwatch-forms-fda-safety-reporting/instructions-completing-form-fda-3500#:~:text=Form%20FDA%203500%20may%20be,hospital%20or%20outpatient%20infusion%20centers.
[3] See for example, https://www.statnews.com/2016/08/22/step-therapy-patients-insurance-treatments/; https://www.ajmc.com/view/how-prior-authorization-step-therapy-result-in-medication-discontinuation-and-worse-outcomes-
[4] https://www.healthvermont.gov/sites/default/files/documents/pdf/2023%20E-Rule.MAT%20Rule.Final_.annotated.pdf

Second, VMS supports subsection (d) of this section, which states that clinicians may prescribe MOUD via telehealth in accordance with federal regulation. This is an area of federal regulation currently undergoing rapid change – with rules pending both with SAMHSA[5] (regarding OTPs or hubs) and the DEA[6] (regarding OBTPs or spokes) for prescribing via telehealth after the end of the federal public health emergency in May. Both of the rules recognize the value of ongoing access to care using remote means. For example, in recommending ongoing induction via audio-visual or audio-only telehealth by OTPs, SAMHSA finds:[7]

Recent research has demonstrated that telehealth can be an effective tool in integrating care and extending the reach of specialty providers, and that among those requiring treatment with buprenorphine, there are high levels of satisfaction with the use of telehealth services. Additionally, there are no significant differences between telehealth and in-person buprenorphine induction in the rate of continued substance use, retention in treatment or engagement in services. Research also shows that there is no significant difference in client and provider ratings of therapeutic alliance when using telehealth technology platforms. In the face of an escalating overdose crisis and an increasing need to reach remote and underserved communities, making the buprenorphine telehealth flexibility permanent is of paramount importance.

VMS members strongly support ongoing prescribing of MOUD via telehealth. Given federal regulation in this area, and the fact that federal rules are undergoing revision, VMS recommends allowing prescribing via telehealth at the state level as long as prescribers are following federal law and regulation.

Section 7– Prior Authorization for Medicaid

According to last year's testimony from the Department of Vermont Health Access (DVHA), Medicaid has made it a practice to remove prior authorization requirements for at least one dosage form for every class of MOUD: methadone, buprenorphine and naltrexone. We support putting this requirement in statute, as proposed in section 7.

When people with opioid addictions initiate treatment, they significantly reduce their potential of relapsing back into opioid use and dying from an overdose. Yet, we know we need to reach more Vermonters. According to a January 2023 report from the Vermont Department of Health on 2021 Substance Use Disorder Treatment Initiation and Engagement, only 44% of patients diagnosed with a substance use disorder sought out one SUD treatment and only 23% continued treatment.

Patients struggling with OUD often have very small windows of opportunity when they have the courage and ability to seek out treatment. Therefore, more and more Vermont treatment clinicians strive to start same-day induction of MOUD, also referred to as medication-assisted-treatment (MAT), through a program called RAM, Rapid Access to MAT. This program was developed because *treatment timing can be critical* after patients are treated for an overdose in an ED. In the 24 to 72 hours it can take to get to a separate treatment center patients are vulnerable to another overdose, death, or changing their minds about whether they're ready to start treatment.

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[5] https://public-inspection.federalregister.gov/2022-27193.pdf. The rule proposes to allow initiation of buprenorphine via audio-only or audio-visual telehealth technology, and methadone via audio-visual telehealth, if an OTP physician, primary care physician, or an authorized healthcare professional under the supervision of a program physician, determines that an adequate evaluation of the patient can be accomplished via telehealth.

[6] https://www.dea.gov/press-releases/2023/02/24/dea-announces-proposed-rules-permanent-telemedicine-flexibilities. Proposes to allow all renewals via telemedicine, and initial prescriptions for 30 days before an in-person examination is conducted.

[7] https://public-inspection.federalregister.gov/2022-27193.pdf (pages 25-26)

Prior authorization can be a cause for delay in immediate access to treatment. A 2021, Journal of Managed Care Specialty Pharmacy white paper studied the impact of removing prior authorization for MOUD for Medicare Advantage patients and found that removal of PAs was followed by a decrease in opioid utilization, an increase in MAT initiation, and a 4% decline in relapse. Vermont's Medicaid program provides payment/coverage for roughly 70 percent of all buprenorphine prescriptions in the state. According to a 2020 report, 17 states have laws that limit state-regulated commercial plans from imposing prior authorization on MOUD, and 13 states and the District of Columbia *limit* Medicaid from doing so, including Vermont. For these reasons we support access for those with Medicaid to at least one class of medications without prior authorization.

Section 8 – Gold Carding

We know from our members that even slight modifications to Medicaid's prior authorization requirements for buprenorphine have made big differences in removing barriers to MOUD and reducing clinician burden. Therefore, we also strongly support providing a "gold carding program" for clinicians who prescribe MOUD and meet a 90% approval rate. Gold card programs exempt from prior authorization those clinicians who have a high approval rate. DVHA has implemented Gold Card Programs in other areas of medicine and has found that they can have "success in improving clinical results and reducing administrative burden for health care professionals."

Act 43 required Medicaid to report on PAs for MOUD from 2020 to 2022.[8] Over the last 3 years, there were a total of 9,256 prior authorization requests, 8,627 approvals and 629 denials. Which means **93.2% of the prior authorization requests were approved and only 6.8% were denied**. This likely means that many prescribers could meet the 90% threshold and not have to go through the prior authorization process. We understand that over time DVHA has responded to clinician feedback and worked to reduce PAs. As the next step in harm reduction we urge you to reduce PAs for MOUD by expanding Vermont's current gold-carding programs.

Thank you for your consideration. For questions and clarifications please contact me at jbarnard@vtmd.org.

[8] The three reports can be found here: 2020; 2021; 2022. They addressed: Which medications required prior authorization; How many prior authorizations requests the Department received and, of these, how many were approved and denied; and the average and longest lengths of time the Department took to process a prior authorization request.