Georgia Department of Audits and Accounts
Performance Audit Division
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Follow-Up Review
Opioid Use Disorder – Access to Medication-Assisted Treatment

State plan created and many policies improved, but some issues remain

Why we did this review

This follow-up review was conducted to determine the extent to which recommendations presented in our November 2017 performance audit (Report #17-11) have been addressed.

The 2017 performance audit was conducted to evaluate the state's efforts to ensure that the estimated 180,000 Georgians with opioid use disorder have access to the recommended treatment when it is needed.

The opioid epidemic has generated significant national attention in recent years due to the increasing number of opioid-related overdoses and deaths.

About Medication-Assisted Treatment

MAT is a combination of medication and counseling, in which medication stabilizes the brain's cravings for the substance and behavioral therapies assist with underlying issues that led to the addiction.

Three medications are used to treat opioid use disorder. Methadone and buprenorphine are opioids that have longer effective periods that prevent the peaks and valleys associated with short-term opioids like heroin or oxycodone. Naltrexone blocks the effects of opioids entirely. Due to the varied nature of each individual's addiction, access to all three medications is recommended.

What we found

Steps have been taken since the 2017 audit to address report recommendations, including the development of a state strategic plan, improved policies and practices to allow MAT, and more providers available to Medicaid recipients. Administrative barriers have been eliminated for many Medicaid recipients needing to access MAT. However, there are still responsibilities not clearly identified, such as the entity responsible for evaluating the capacity of treatment providers.

The original audit noted that Georgia did not have a comprehensive strategy to address all aspects of the opioid epidemic and found that the state's efforts to expand the availability of MAT had been limited. In addition, the audit found barriers to obtaining MAT for individuals with opioid use disorder. These barriers included provider availability, awareness of provider types, restriction by state entities, and public insurance coverage and requirements, among others.

State Strategic Plan

The Department of Public Health (DPH) created a statewide strategic plan in partnership with the Office of the Attorney General, the Department of Behavioral Health and Developmental Disabilities (DBHDD), DCH, and stakeholders representing federal, state, and local organizations. The plan identifies lead entities for broad areas of responsibility and establishes evaluation metrics. However, the plan does contain gaps related to defining treatment task responsibilities. For example, the plan does not identify the entities responsible for encouraging providers to

obtain the waiver to prescribe buprenorphine, providing practitioners and the public with information on MAT, or providing a comprehensive list of narcotic treatment providers (NTPs) and buprenorphine prescribers.

Healthcare Providers

Since the release of the original audit, the number of buprenorphine providers in Georgia has increased by approximately 35% and the number of NTPs is unchanged. However, it is unclear whether the state has an adequate supply to meet current need. DPH has not analyzed available datasets to evaluate the need for and capacity of existing providers to provide treatment to individuals with opioid use disorder. While DPH has stated that they believe this should be a DBHDD responsibility, certain data useful in this analysis (e.g., prescription drug monitoring program data) is only accessible to DPH. (Responsibilities should be clearly defined in the statewide strategic plan.)

The original audit found that many county nurse managers were not prepared to identify opioid use disorder and were unsure of local treatment options. DPH indicated that there had been no change in the ability of public health practitioners to attend trainings related to identifying opioid use disorder or to obtain information on local treatment options available for referral.

State Supervising Entities

Agencies supervising individuals with opioid use disorder (OUD) have adopted policies and practices that no longer discourage these individuals' use of MAT. The Department of Community Supervision (DCS), the Department of Human Services' Division of Family and Children Services (DFCS), and accountability court judges have attended DBHDD trainings on MAT. In addition, DCS and DFCS have developed policies that address MAT as an appropriate medication and explicitly allow individuals with opioid use disorder to utilize MAT when prescribed and monitored by a certified provider and receiving necessary counseling. The allowance of MAT by accountability court judges varies by jurisdiction, but, trainings by DBHDD and technical assistance provided by the Council of Accountability Court Judges (CACJ) have resulted in more courts adopting policies and allowing the use of MAT.

MAT and Medicaid

The Department of Community Health (DCH) has made progress towards ensuring managed care members have access to NTPs. Since the original audit, two of the four care management organizations (CMOs) in Georgia have increased from one provider to 22 and 16 providers in their network, while the other two CMO networks remain limited. Notable gaps exist for all CMOs in south and east Georgia.

DCH has made progress towards addressing the Medicaid administrative requirements that limit members' access to MAT. Fee-for-service Medicaid removed the prior authorization requirement for preferred buprenorphine products and Vivitrol in 2017 and the four CMOs have since removed prior authorization requirements for buprenorphine or buprenorphine-naloxone, as well as Vivitrol. This results in fewer patients ready to begin treatment waiting for approval and is consistent with best practices. In addition, WellCare eliminated the requirement that patients document trial and failure with the preferred buprenorphine before covering Vivitrol and CareSource eliminated trial and failure for generic, but not brand buprenorphine. However, step therapy continues to exist for two CMOs and time limits for MAT continue to exist for all four CMOs. Time limits restrict the total amount of time one can receive coverage for a medication or service, while step therapy requires patients to document trial and failure of a preferred, more cost-effective medication before trying non-preferred medications. Both are unnecessary barriers for individuals seeking treatment for opioid use disorder.

DPH Response: *DPH found the information helpful in identifying critical areas that need to be addressed in our state and stated, that as noted in the report, much progress has been made since the original 2017 audit. Several working groups were formed to develop the state strategy, including one focused on treatment and recovery, and this group has begun outreach to*

encourage providers to obtain the federal Drug Addiction Treatment Act waiver. In addition, with respect to county nurse managers, DPH stated that it was committed to assessing the current staff and will determine appropriate guidance and training needs upon completion of the assessment.

DCH Response: *DCH provided technical corrections to the report. Those corrections were made to the final report.*

DBHDD Response: *DBHDD concurs with the current status of the findings in the follow-up review. DBHDD also noted that they lack the authority and infrastructure related to evaluating the capacity and need of buprenorphine providers. DBHDD stated that they have engaged in providing required addiction continuing medical education (CMEs) to physicians that also encourages waiver enrollment consideration and have impacted access to existing NTPs for uninsured and buprenorphine services within our network by providing grant funding for both.*

DHS Response: *DHS DFCS concurs with the current status of the findings in the follow-up review.*

DCS Response: *DCS concurs with the current status of the findings in the follow-up review.*

CACJ Response: *CACJ concurs with the current status of the findings addressed to them in the follow-up review.*

REPORT REVISION: *On June 3, 2019, a revision was made to the report to correct a sentence in the first paragraph that described administrative barriers to MAT for Medicaid recipients. The discussion of administrative barriers on pages 2 and 6 of the report were correct.*

The following table summarizes the findings and recommendations in our 2017 report and actions taken to address them. A copy of the 2017 performance audit report 17-11 may be accessed at http://www.audits.ga.gov/rsaAudits.

19-09 – Access to MAT Follow-Up Review, May 2019	
Original Findings/Recommendations	**Current Status**
The state does not have a comprehensive strategy to address the opioid epidemic, which would include ensuring Georgians have access to MAT. We recommended that DPH create a statewide strategic plan that includes key stakeholders in other social services and public safety areas. We recommended that the plan include activities related to preventing, monitoring, and treating opioid use disorder; define lead entities for specific tasks; and create evaluation metrics. We also recommended that the General Assembly consider directing funds to MAT-related activities within DBHDD, felony drug courts, and DCS day reporting centers.	**Partially Addressed** – DPH has created a statewide strategic plan to address the opioid epidemic, but the General Assembly has not been asked to provide significant funding for MAT due to the availability of federal grant funding. With help from other entities, DPH created the "Multi-Stakeholder Opioid & Substance Use Response Plan." Other stakeholders involved in plan development included DBHDD, DCH, Office of the Georgia Attorney General, and other federal, state, and local agencies. The plan includes activities related to preventing, monitoring, and treating opioid use disorder, defines lead entities for broad areas of responsibility, and creates evaluation metrics for activities. The General Assembly has not directed additional funds to MAT-related activities. However, the federal government has provided opioid crisis funding, a portion of which has been used to expand MAT through both social service and criminal justice entities.
While most Georgians live within 20 miles of both an NTP and a buprenorphine prescriber, the state likely does not have an adequate supply to meet current need. We recommended that DPH use available datasets to evaluate the need for and capacity to provide treatment (using all three medications) to individuals with an opioid use disorder. We also recommended that DCH ensure its new application process and rules are not overly burdensome to prevent NTPs from opening in identified areas of need. In addition, we recommended that DPH ensure the statewide strategic plan identifies the entities that can encourage providers to obtain the waiver to prescribe buprenorphine through education and outreach.	**Partially Addressed** – No state agency has taken the lead in assessing the sufficiency of the state treatment options; therefore, it is unclear if the increased number of providers is sufficient to meet current need. Since the release of the audit, the number of buprenorphine providers in Georgia has increased by approximately 35%, while the number of NTPs is unchanged. DPH staff do not currently use available data to evaluate the need for or capacity to provide MAT to individuals with an OUD. While DPH has incorporated data monitoring into its strategic plan and uses prescription drug monitoring program (PDMP) data to track overdoses and overprescribing, the agency has not analyzed available data to determine if regions in Georgia have a shortage of NTPs or buprenorphine prescribers. DPH staff have stated that this is the responsibility of DBHDD; however, only DPH staff have access to the PDMP data. DPH noted that while the PDMP collects the quantity and dosage of different MAT drugs dispensed, the number of individuals receiving MAT, and the number of prescribers prescribing MAT, it does not collect data regarding any unmet need for MAT. While DPH is correct that PDMP data alone cannot determine capacity, it can be used to evaluate the number of prescribers and patients served by each prescriber, each of which provides information in terms of the state's capacity to provide treatment. The new application process and rules have not decreased the number of NTPs in Georgia. DCH staff stated that the NTP rules and regulations include criteria for approving new NTPs that are consistent with the NTP Enforcement Act and should not be overly burdensome for NTPs opening in areas of need. In addition, the rules give the agency broad authority in granting variances and waivers. DPH has ensured the strategic plan includes an objective to provide training to physicians within certain organizations to obtain the waiver to prescribe buprenorphine as a treatment option. While the plan identifies DBHDD as the lead agency for

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Original Findings/Recommendations	**Current Status**
	increasing access to treatment, the plan only lists potential entities that could encourage additional physicians to prescribe buprenorphine. As noted above, DPH is not currently measuring the sufficiency of the state's supply of buprenorphine prescribers and no entity is clearly responsible for encouraging additional providers if a shortage still exists.
Training and resources are needed to improve practitioner knowledge of where to refer individuals identified as having an opioid use disorder. We recommended that DPH ensure public health practitioners, such as county health department nurses, are trained to identify opioid use disorder and refer patients to treatment, including MAT. We also recommended that DPH ensure the statewide strategic plan identifies a state entity responsible for ensuring practitioners and the public can easily obtain a comprehensive list of NTPs and buprenorphine prescribers. This can be accomplished through a website and other communication with providers. In addition, we recommended that DPH ensure the statewide strategic plan identifies state entities to coordinate with the various stakeholders that work with practitioners (e.g., Georgia Composite Medical Board, Medical Association of Georgia) to ensure they know where to obtain MAT information and what providers offer such treatment.	**Partially Addressed** – Public health practitioners continue to lack the opportunity to attend trainings and become better prepared to both identify opioid use disorder and know what local treatment options are available for referral. No entity is identified in the statewide strategic plan as responsible for ensuring practitioners and the public can easily obtain a comprehensive list of NTPs and buprenorphine prescribers. As a result, there is no comprehensive list available. DPH has worked with the Medical Association of Georgia (MAG) to distribute to providers information on MAT, with emphasis on buprenorphine. The providers include doctors, physician assistants, and nurse practitioners.
State entities have inconsistent practices related to whether those they supervise are allowed to obtain MAT. We recommended that state entities permit individuals with opioid use disorder under their purview to utilize any of the three types of MAT medications, according to need. We also recommended that state entities ensure those supervising individuals with opioid use disorder (e.g., DFCS caseworkers, DCS officers, accountability court judges, juvenile court judges) receive MAT training. We recommended that DCS and DFCS clarify policies related to drug screens to more explicitly indicate that MAT medications (methadone and buprenorphine) are permitted when prescribed and monitored by a certified provider.	**Fully Addressed –** Agencies supervising individuals with OUD have adopted policies and practices that have reduced the agencies' previous restrictions on the use of MAT. DCS and DFCS permit individuals under their purview to utilize any of the three types of MAT. Both have created MAT policies that explicitly support MAT as an acceptable form of treatment for individuals with opioid user disorder. Furthermore, each policy addresses drug screening processes by indicating that MAT medications are permitted when prescribed by a certified provider. Given the nature of the judiciary, the allowance of all three types of MAT by accountability court judges varies by court. However, CACJ stated that training and technical assistance efforts have resulted in more courts adopting local MAT policy and allowing the use of MAT. DFCS caseworkers, DCS officers, accountability court judges, and juvenile court judges have sent representatives to trainings hosted by DBHDD.

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Original Findings/Recommendations	**Current Status**
Finally, we recommended that DFCS consider partnering with substance abuse treatment providers that can offer MAT themselves or can refer caregivers to outside providers.	
Individuals with Medicaid or private insurance may not receive coverage for all forms of MAT due to plan limitations or lack of network providers. We recommended that DCH ensure that both FFS and managed care members have access to NTPs. We also recommended that DCH notify CMOs of NTPs in the Medicaid provider network and encourage/require them to work to include them in their provider network. In addition, we recommended that DCH use a study commissioned prior to the original report's release to evaluate network access to buprenorphine prescribers to ensure adequate access throughout the state. If gaps are identified, DCH should consider methods to recruit additional prescribers, such as increasing reimbursement rates.	**Partially Addressed** – Managed care members' access to NTPs has significantly increased since the release of the original audit. This is particularly evident for two of the four CMOs. Amerigroup's network of NTPs grew from one to 22, while CareSource went from one to 16. However, Peach State and Wellcare still have a limited provider network. Only one CMO (Amerigroup) has NTPs in their provider network throughout the state. However, DCH has made no policy changes to ensure adequate network access to buprenorphine prescribers. While there have been no changes since the original audit in how DCH notifies CMOs of NTPs in the Medicaid provider network, CMOs are now aware of NTPs in the Medicaid provider network. As noted above, the number of NTPs in each CMO provider network have increased.
Certain administrative requirements implemented by Medicaid or private insurers may delay or deny members' access to MAT. We recommended that DCH encourage CMOs to eliminate prior authorization for treatment medications or, in lieu of removing prior authorization entirely, that decisions be made in real-time to avoid any treatment delays. We also recommended that DCH continually evaluate FFS and CMO policies as they pertain to MAT to ensure there are no unnecessary barriers for individuals seeking treatment for opioid use disorder. DCH should specifically evaluate current CMO practices related to step therapy and time limits for treatment medication coverage.	**Partially Addressed** – DCH eliminated the requirement that fee-for-service members receive prior authorization before obtaining MAT just before the release of the original report. The four CMOs have now also eliminated prior authorization requirements for Vivitrol, as well as buprenorphine or buprenorphine-naloxone. WellCare eliminated the requirement that patients document trial and failure with the preferred buprenorphine before covering Vivitrol and CareSource eliminated trial and failure for generic, but not brand buprenorphine. However, other CMOs still require step therapy and all four still have time limits for treatment medication coverage.
6 Findings	**1 Fully Addressed** **5 Partially Addressed** **0 Not Addressed**

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