EDUCATIONAL BRIEF
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Policy Rounds

Exploring Policies Shaping Addiction Medicine

ASAM American Society of Addiction Medicine

Patient Review and Restriction Programs

Patient Review and Restriction Programs (PRRPs) or lock-in programs are utilization management techniques used by public and private health insurers to varying degrees to restrict beneficiaries to a single designated provider, pharmacy, or both.

Generally, PRRPs use pharmacy claims data or prescription drug monitoring programs (PDMPs) to flag potentially inappropriate activity. Advocates for these programs assert that PRRPs control costs and reduce potentially dangerous prescribing practices, such as the prescribing of opioid analgesics outside of clinical guidelines.[1] However, concerns persist about their impact on access to addiction treatment medications and an inflexible bureaucratic structure that can create delays in treatment.

How Are PRRPs Used in Medicare, Medicaid, and Private Insurance?

In Medicare, Part D plan sponsors are authorized to establish drug monitoring programs for beneficiaries considered at-risk for misuse of frequently abused drugs (FADs).[2] While medications for addiction treatment like buprenorphine are exempted from this classification, concurrent use with benzodiazepines or other opioids may result in a flag. Subsequently, a process of review is initiated if a Part D plan sponsor deems that a beneficiary is potentially at-risk. Ultimately, at-risk beneficiaries have multiple opportunities for review and appeal before lock-ins apply.[3] The lock-in concludes at the earliest point where the beneficiary demonstrates that they are either: (1) no longer likely to be at risk for misuse of FADs including but not limited to a successful appeal; or (2) the date that is the end of a one-year or two-year limitation period without extension.

In Medicaid, PRRPs are overwhelmingly common and operate with significant state-level discretion. Federal regulations require that states give beneficiaries an opportunity for a hearing before imposing restrictions.[4] Additionally, federal regulations also ensure that beneficiaries have reasonable access to Medicaid services of adequate quality and that emergency services are not restricted.[5]

According to a report from Centers for Medicare & Medicaid Services (CMS), every state (and Washington, DC), except for California, Florida, Iowa, and South Dakota, has a lock-in program for Medicaid beneficiaries. Of these 47 states, a total of 29 states reported the ability to restrict a beneficiary to a specific prescriber, and 41 states reported restricting beneficiaries to a specific pharmacy.[6] States use a variety of criteria to identify candidates for lock-ins. The most common criteria are receiving prescriptions from multiple controlled substance providers or multiple pharmacies, which are adopted in 44 states each. Meanwhile, 31 states include multiple emergency room visits and 24 states use days' supply of controlled substances as a criteria item. Further, the specific lock-in period varies from state to state, with most states requiring lock-ins for 12 to 24 months.[7] Some states determine lock-in periods on a case-by-case basis. Additionally, all states have a process in place to document waste, fraud, and abuse among controlled substance prescribers and dispensing pharmacists. In turn, states can deny clinicians' claims, refer them to program integrity units for review, or refer clinicians/prescribers to professional licensing boards. PRRP's have been increasingly adopted among commercial payers, though information about their specific implementation is scarce.[8]

What Impacts Do PRRPs Have on Access to Addiction Medications?

There are few studies definitively establishing the impact that PRRPs have on access to addiction medications. Most studies into PRRPs evaluate their implementation at the state Medicaid level. Research indicates that establishing PRRPs in states can reduce controlled substance prescriptions and lower health plan expenditures.[9, 10] However, studies linking PRRPs to lower diversion rates, lower rates of substance use disorders (SUD), increased engagement in SUD treatment, and reduced overdose deaths have yet to be established.[11] One notable study in North Carolina associated participation in the PRRP with increased use of medications for addiction treatment during enrollment. This increased use was sustained for one year after participating in the program.[12] However, the study calls for more research into PRRPs and their impact on access to addiction medications and overdose risk.

In a report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) warned that pharmacy and provider lock-in programs may impede access to medications for addiction treatment such as buprenorphine.[13] Specifically, the report notes that prescribers may need to make several buprenorphine dosage adjustments in the early stages of treatment, increasing the likelihood that a beneficiary may get locked in because they are receiving multiple prescriptions within a certain time frame. These concerns remain saliant as the adoption of PRRPs gains momentum. Future research must investigate further links between the design of PRRPs and potential impact on access to addiction medications.

Conclusions

PRRPs must balance potential cost-savings and reduction of inappropriate prescribing with the need to ensure that evidence-based treatment is available to individuals with SUD. Explicit exemptions of medications for addiction treatment from PRRPs like those found in Medicare are helpful in this regard. But decisions about the implementation and design of PRRPs must include meaningful consideration about the unintended impacts on individuals with SUD.

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This educational brief does not reflect the official public policy of ASAM. The information herein is provided for educational purposes only.

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End Notes and References

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[5] Ibid.

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