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**Session 2B: Medicaid Prior Authorization for Buprenorphine as a Surveillance and Carceral Technology by Max Jordan Nguemeni**

And

**Chicano Mental Health Activism and the Struggles for Culturally Aware Services in South Texas, 1954-1977 by Ximena Lopez Carrillo**

Speaker: Welcome back. If you want to submit a question, you can wait for the Q&A panel. We have live closed captioning available. To access the captions, select “Show Captions”.

This session is divided in 2. The first is 35 minutes long with one presenter, and after that a break. We'll hear from the presenters first and then Q&A at the end. Please safely distance yourself for COVID. Please take space and make space. Use "I" statements instead of generalizations and avoid detailing stress and violence. I'm thrilled to introduce the next session. I'll let the presenter introduce themselves. Thank you.

Max Jordan Nguemeni: Thank you. My name is Max. I am a second-year internal resident. I want to Yale for medical school, so this is a homecoming for me. My presentation, I'll talk about the authorization forms for buprenorphine and Medicaid populations. I've been doing research on opioid for the last couple years and focusing on prior authorization. I will share my slides.

Can everyone see this?

I've already described the title. I'll jump into the background here. First of all, what are prior authorizations for? It's to help health care providers justify medications. It can be used to reduce overall cost, or safety concerns to reduce or "prevent" abuse of certain medications that are expensive.

[Reading points on screen.]

So, when it comes to opioid abuse, buprenorphine is used as a therapy. Buprenorphine and methadone. If you ask an addiction specialist, these two have survival benefits. With buprenorphine, the survival benefits are reaped immediately. With methadone, there's a delay because there's a period where you need to know what's the most effective dose. It takes weeks to a month for survival benefits of methadone to kick in.

To administer methadone, they need to go to the clinic and take medication under supervision and drug tested. Until generic versions of buprenorphine is available, it was very expensive. Prior authorization was used to deter appropriate prescribing.

If we look at the disorder, methadone was introduced the New York City. The FDA oversaw the administration. Fast forward to 30 years later, they approve it for OUD. In 2004, state Medicaid plans covered it. It's became mainstay. In the realm of prior authorization, CMS had issues instructions that Medicaid plans should limit use for SUD.

Around the same time frame, many states began to forbid private insurance plans for SUD which are in line with our current opioid epidemic. As of 2020, 21 states enacted laws to limit public insurers from imposing prior authorization. In light of the pandemic, they've asked for complete removal of buprenorphine.

We talk about buprenorphine as the active agent. There are different formulations. The most commonly prescribed opioid use disorder is buprenorphine naloxone. Naloxone is supposed to be inactive when taken sublingually. It's not entirely inactive though. The reasons why this formulation exists is because when the US government were collaborating with pharmaceutical companies to introduce buprenorphine in the US market, they asked whether it was possible to deter people from injecting buprenorphine.

In the 90s, the mono product of just buprenorphine, was introduced in France, had a high street value. People did inject it. I don't know how to describe it. People injected the mono product in France and had a high street value. It's much safer than any other commonly used opioid. There is no documented evidence of overdosing on buprenorphine by itself. The few cases were when they were taking another opioid.

Injecting buprenorphine is far better than injecting other opioids in reducing overrides risk. The US government wanted a mechanism to prevent people doing that. Adding naloxone to buprenorphine, so if people were to inject the combined product, they'd experience undesirable side effects.

It's been studied. People enjoy this far less, than the mono product. People still do inject the combined product. The flip side is that many patients report experiences, related to opioid withdrawal. Some people might be more sensitive to it, so they experience nausea, upset stomach, anxiety.

For those patients, it turns them away from buprenorphine. It's not necessarily explained that what they're experiencing is because of the agent combined. They'll say they don't want it because they had a bad experience. They don't want to hear about the mono product. How do they know? It's not well communicated.

There are other formulations like the mono product. It's more commonly use, but recently made clear it's safe for pregnancy. They're all more difficult to access. They have fewer side effects because there's no naloxone and more expensive.

When I think about the impact on patient care . . . [Reading first point.]

It's annoying to fill out a form or fax it. The AMA released a report, saying 92% of physicians report prior authorization delay care for patients. They also associate it with lower retention and treatment. It raises the activation energy to want to prescribe it. You can see it might lower retention being of ceilings on dosage or mandates like tapering the dose after they're on the medication.

Despite staggering evidence, state Medicaid plans require prior authorization. It's been 3 years now; Medicaid is the insurance plan for older adults. It's a federally sponsored plan for people that are poor are uninsured, or pregnancy people who don't have private insurance at the time of pregnancy, or post partum pride. There are 32 states as of last year, that require Prior authorization for at least 1 formulation of buprenorphine.

15 of them -- all of them do require a prior authorization for the mono product. 15 states require prior authorization for buprenorphine naloxone. You have to try this first and if the patient doesn't like it or has side effects, they will try the mono products because they didn't tolerate the first version.

There are 15 states that still require prior authorization for this and half of these -- it is not a matter of preferred drug list. Insurance companies have a preferred drug list which is to help reduce the cost. That isn't the only reason why they continue to require prior authorization.

We think of the impact on how this plays out. I have talked about the bureaucratic burden which is born out by the providers. There is an element of restrictive surveillance when you look at these forms. In some states these forms will have fields requiring random pill counts, random urine drug screenings or they sign a contract with the provider. There are extraneous requirements also that might require them to take part in a 12-step group.

The medicine itself has survival and while therapy is helpful, it should be a requirement before providing someone with the medication. There are things like dose limitations. 11 states require additional steps for a daily dose higher than 16 milligrams. They usually take 8 to 15 milligrams a day. They may require a higher dose. That is usually 24 to 32 milligrams daily.

There is good evidence that high dose of buprenorphine is associated with greater retention rates and decreased odds that people will also use other substances. They compared patients who are on different mgs and drug test them when they come to clinic and the patients on higher doses were less likely to have positive urine drug testing. It is clear that the barriers are annoying. I am going to read some quotes from some patients.

[Reading prompt on screen.]

It has a street value and people use buprenorphine on the street and the majority of people who use it that is not prescribed do so to self treat their own disorder or to treat pain that isn't addressed or to treat withdraw. I will read the quotes.

[Reading quotes on screen.]

All these barriers mean some people opt out of the formal treatment in favor of an informal treatment through the street drug market. This costs more for the patients to buy it off the street because they are set up to buy through the healthcare system.

I want to talk about theory. This might be boring. This French scholar has two notions: Biopower which is how institutions exert power to regulate life via disciplinary power such as in prisons and biopolitics is how the state administers and optimizes the life of populations through Medicaid and other benefits.

Bourgeois studied the methadone treatment and maintenance therapy. He made it clear through his studies that it is a hostile exercise of disciplining people and punishing them for unruly misuse of pleasure and when we think about buprenorphine and the ways we have gotten to this point, [naloxone] is the one that insurance plans are covering.

There is an element of disciplining the unruly misuse of pleasure. The reason it was combined with buprenorphine is because people aren't allowed to have fun. People aren't going to overdose with buprenorphine.

In contrast, Harris describes based on her research, buprenorphine as a symbol of freedom and normalcy. That is context dependent. People who have easy access to PC and you can pick up the buprenorphine and go to a doctor once a month and get it at the pharmacy and that affords people with privacy, and it is different than standing in line at a methadone clinic.

Hansen and team further contextualize the meaning of buprenorphine if the patients are poor, and it is a site of abandonment. They are often victims of brutal sociopolitical systems or of violence. Taking these positions around buprenorphine versus methadone means and how restrictive the prior authorization system works, and it has not been made clear that prior authorizations are not helpful.

Why is it that the place we are most likely to see them is in the Medicaid population? What that means is that the evidence that has been made clear, the cost saving that comes from lifting prior authorization requirements and there was a downstream reduction in healthcare spending.

Patients report having to get buprenorphine off the street because of the bureaucratic hurdles and signing contracts and being randomly tested and pills are counted there is an element of control and punishment. People who are on Medicaid are disproportionately poor and of color and they are not lifting prior authorization requirement.

They are producing a system of control and punishment of poor people who use drugs. There is a conflict between the states and the optimizing of medical and a strong urge to discipline poor people who use drugs. There is a stigma against these people in society. It overwhelms the states population health aims and there is a need for state Medicaid plans to lift prior authorization requirements. I am going to stop here for questions and discussion.

Thank you for paying attention to your presentation.

Speaker: Are there any questions? I have one that I was thinking about. I don't know if you can -- there are a lot of buprenorphine being prescribed and I don't know how it is here in Connecticut or in Massachusetts. I am in Tennessee. In terms of the different states -- have you seen any states that have legislature that make it easier to get buprenorphine?

Max Jordan Nguemeni: I think Massachusetts is leading in that regard. The cap in Massachusetts before you have to do more paperwork is 24 milligrams and most other states is 16. If I have a patient, I do have the flexibility to prescribe 8 milligrams 3 times a day without having to fill out an extra form. There is no prior authorization for buprenorphine but if I want to prescribe [Inaudible.] I do have to file a prior authorization.

When you study these individual cases and compare it with the context and with the fact there was only one psychologist speaking English in the region and there were only 3 institutions available and combine that with the historical legacy you can easily understand why they preferred traditional medicine over professional mental health providers.

Speaker: We do some of it in Nashville. I don't know if you have experience in that. Just add some personal experience.

Max Jordan Nguemeni: I don't have a big patient panel and I haven't done the sub locator. In the hospital, I know they do long-acting agents there. Eventually, probably after residency, I'll get experience in that regard.

Speaker: We appreciate your time, as the video chat.

Max Jordan Nguemeni: Thank you.

Alright.

Speaker: I want to let you know; we have 5 minutes before you need to get started. If anyone wants to take a break.

Speaker: It will take me a few to put up my PowerPoints.

Should I start? Do you need rest? Should I start the presentation? I'll start then.

Ximena Lopez Carrillo: Thank you very much for being here. I'm very excited. This is my first conference where I interact with people from the medical sciences. I'm grateful to have the opportunity to interact and see what the concerns on the other side of the aisle are. I'm a historian and lecturer at Ethnicity, Race and Migration here at Yale. I teach courses as the history of public health.

My concerns are more on social issues, on the role that the medical sciences have on the nation and race. I'm excited to see what your perspectives are from the other side.

My presentation talks about the region of South Texas which has a large Hispanic population. There is a big mental health problem in the Latino community. Not necessarily because they have higher rates of mental illness, but more than half of the Latino community has suffered of disparities in access in mental health care and the quality they receive.

The region of South Texas reflects the national trends. I would say it's worse in this region. [On screen.]

Most of the population is rural, where health services don't arrive easily. It's mostly an immigrant population. Many are undocumented. They already have low access to health care. Their legal status makes it worse. This is not a new problem.

Up until the 1960s. . .

Speaker: Sorry. They can't see it online. We need to adjust.

Ximena Lopez Carrillo: Should I start again?

Speaker: They could hear you, but not see the slides.

Ximena Lopez Carrillo: Thank you very much. Sorry about that to everyone online.

So, I was saying this is not a new problem. Up until the 1960s there were only 3 institutions they could go to. Historians, [naming historians] noted that the only sustained contact with a mental health professional, are the psychologists that conduct tests in public schools. The IQ testing legitimized segregation and incarceration. They justified the policies. The United States was trying to cut back immigration through the US Mexico border.

My presentation focuses on a case study. It's a group of Chicano psychologists and leaders. They opened an institution of an outreach program. It was located in Crystal City, Texas which is close to the border. It was incredibly innovative because mental health professionals collaborated and community leaders.

It also counted with the collaboration of traditional healers. There was interesting. Until the 1960s, traditional leaders were associated with black magic and not with healing. I started studying this topic because I wanted to understand what the tensions were, and what opportunities could open with this collaboration.

My presentation is divided into 3 parts. The first is in the 1950s and 60s. A specialist from the mental health foundation identified there was a big mental health problem in the region, and this problem was furthered by the fact that Mexican and Mexican American preferred traditional healers over mental health professionals.

The second part is the mental health movement in Texas and how this occurred with the rise of the Chicano movement and how mental health policies became politicized and centred around the Chicano doubts.

The third part is the rise and fall of the mental health program.

This story starts when the Hogg Foundation for mental health posted stories, exposing the bad conditions of asylums and mistreatment. They prompted the government to reform the mental health care and create a system that helped former patients to reintegrate into society.

I start here because as a result of this documentary, specialists looked at how the reform will look like, what populations to address and what kind of services should be provided?

They found that -- first of all, mental health professionals were convinced that mental health issues came from broken families, they have low levels of education, live in crowded households, or in families with working mothers. There was already a cultural and racial bias.

They identified the populations that fit were African American, Puerto Ricans and poor in general. They expected that the Mexican population would present higher rates of mental illness.

When they presented this to psychiatrist, the Mexican population was the most unrepresented in both public and private institutions. They don't have many mental health issues, or they deal with it in their homes.

What he suspected is that it was a big problem. Epidemiologists expected. Instead of going to professionals, they used an underground system of folk medicine. Practiced by witch doctors and herbalists. These healers were so well respected, that even when they died, they sanctified them like Jaramillo who moved to the US in the 30s. He was famous. There were lines of people outside his home, waiting to get consulted.

The specialists were anthropologists, sociologists, and psychologists. They analyzed this phenomenon. Mexicans deal with their issues in a different framework, they have different classification of disease. It is a mix of naturality and religious acts. They would include prayers, herbal remedies, pilgrimages or ask for forgiveness etc.

According to anthropologists William Madsen . . . [Reading quote on screen.]

So, in my research, I studied how scientists looked at this case and how they portray them as a symbol of how preserving these cultures could damage the communities' wellbeing.

It gives us something that they weren't able to give us. It was affordability and availability, and we have that to validate Mexican culture especially in a hostile environment. They are forced to assimilate to American values. They act as confesses and they help their patients get jobs. They help patients to connect with the community.

They took all these other important roles and because they play such an important social and cultural role in the community, they were prompting Texas to incorporate curanderos into the healthcare system. The idea was that New York was already doing it and it was to attract the Puerto Rican community.

They wanted to do something similar in Texas. The idea is that while curanderos could fill the gaps and offer a culturally relevant service, they would also be able to teach mental health professionals about Mexican culture and help them improve their image with the community and divorce themselves with their history.

They saw a lot of benefits for doing it, but the proposals were not followed up. This is a great book, and she analyzes the portrayal in newspapers and in articles. The portrayals were dramatic. They didn't recognize them as healers but as religious healers. This is another example of a negative portrayal. He said that curanderos is a contributing factor to the disability among the Mexican population.

When a Mexican person had emotional issues, they went to curanderos and to the point that the emotional illness became impossible to deal with. That leads us to the second part of my presentation. The state of Texas applied for a community mental health plan. The idea of this policy was not only for the institutionalized patients but to expand mental health services to under served communities.

Texas got it in 1965. By 1967, Texas managed to open 27 community mental health clinics across the state, but this is something that is interesting. The state created the Texas Department for Health and Mental Retardation. There was a bias they created. Normally in urban centers they offered comprehensive services but in rural areas they created mental retardation centers.

They were special education centers that offered diagnostic services and helped the parents deal with the disability and the different opportunities for the kids. The massive IQ testing stopped be the 1960's these associations continued. It might not have been so much in racial discourse talked about biological differences, but it was based on cultural differences.

Why did they have this bias? Why did they stress mental retardation? That is the term during that time, and it is problematic now. They used that term in the 60's. Why did they set these up in rural areas? Both populations fit with the profile of culturally deprived populations. They were concentrated in areas tending toward little industrial and economic development.

They have higher rates of unemployment, and their salary was half of that received by Anglos. In the case of Mexican descent population, it was even more because of their language handicap. It was problematic. You can imagine that in the eyes Mexican Americans and Chicano youth all these interpretations were troubling, and they legitimized school segregation of Mexican children into special education programs.

There are arguments that these serve as pipelines to the carceral system. They used this as a strategy to segregate them into farm work and not as professionals. Since the 1940's Chicano activists have warned about this and complained about the racial interpretations and have asked for change. Until the 1960's they didn't do anything. In 1968, all of the tension surrounding intellectual disability and the complicity of the school system with the criminal system exploded.

On December 2nd of 1969, 2000 students were mobilized by Chicano activists in Crystal City. This is interesting because the protest was not targeted to the Texas Department of Mental Health. It took place in the schools because these were the places where the children were diverted into the mental retardation facilities. The students walked out.

The low performance of Mexican students in school was not a matter of culture or language. There was only Anglo stuff in school, and they were penalized for speaking Spanish in school. The Anglo students had preferential treatment.

They were persuaded to take vocational programs. Female students would go into home economics where they would learn to cook and take care of their families and the boys would learn manual labor. I hear after the student walk out the same activists pushed the local school board to create a drop out prevention program.

When she arrived at Crystal City, she was shocked because even though the Texas state mental health plan labeled this as one of the high priority areas there was nothing nearby. For her, this was severe because of the political tensions there was an increasing amount of violence and racially motivated attacks.

She believed it was necessary to do a mental health prevention program. It was more to offer Mexican students support on how to cope with hostility coming from outside and how to do better in school despite the obstacles. She and her supervisors went to Wayne Holtzman and asked for funding to create a pilot program of culturally competent mental health programs.

He approved the funding for $35,000 for each year for a period of five years and thanks to this funding, the activists could create the mental health outreach program which leads to the final part of the paper.

It had these collaborations at multiple levels. It directly challenged the biases. As I see it, it offered a promising alternative as a social and more structural level. It was a project completely managed by the Chicano community. They were private so had more liberty on experiments.

You're all seeing this in the PowerPoint, and it seems unrelated to mental health. They did a Home Chore program to help them cook, do groceries. They also bought a van to provide transportation to help hospitals nearby. They help the residents to apply for food stamps, welfare services and offered a drug and counseling program. It seemed unrelated to mental health, they combined these with visits from psychiatrists who diagnosed residents and provided medical treatments.

I really like this case study. I focused on it because it's very telling about how disembodied the idea of the ideals of the mental health services. It should be designed around the community needs and tackle the problems of mental health from a social perspective.

Another ideal is to diversify the health care system to make it more culturally relevant to diverse populations. Simultaneously, this program in some ways appropriated the philosophy of traditional medicine. They didn't have to rob the egg over the body. They appropriated the idea to take responsibility of the community. Making health care accessible to people. Make it a positive experience for the patients. Make them feel comfortable.

Make them feel like the health worker understands what they're going through. Understanding the social problems. Unfortunately, the project failed in 1997.

Neither the Hogg Foundation nor Department of Health could measure the results in people's behavior. The results were about community building, and formation. Since the mid 70s, both the Hogg foundation and state of Texas attacked the program and criticized it.

One was that the goals were so ambiguous, the program was a catch-all and umbrella for support to people. The second critique was that even though the professionals said they were positively surprised by the political involvement in the Chicano movement, they were concerned that by supporting it too much, it would reflect alliances with a political movement. The role of scientists is to remain neutral to what's going on in society.

The third critique is the lack of professionalism. The only criteria to join as a mental health worker was to answer 3 questions. Do you like to work with the community? Are you willing to give more than work hours? Do you like to work as a team?

Many women who were unemployed joined and they became the health workers. They were so overworked; it was very difficult for them to catch up with so many patients.

Not only were they overworked, but they also didn’t have a training on how to deal with emergency crisis. The evaluators gave an example of a health worked who died by suicide because of the stress.

The last critique is poor record keeping. This is understandable because they reported at some point, they had 5000 high schoolers. It was too many patients for so few people.

In 1977, the Hogg Foundation sent a letter to the directors, saying they couldn't support for all these reasons. This devastated the community. Many members depended on the program to do their groceries or get food stamps. They even sent letters saying the program helped and they couldn't survive with out it. Because they depended so much on Hogg, they ended up closing.

The health workers, there was no evidence, but they believed the state of Texas was blocking their review process.

Eventually the Zavala County was absorbed, and they had a much more biomedical approach. Many community members who were not diagnosed, they lost of the support. They didn't want to go this new place because of the association with eugenics and intellectual disability.

With this historical case study, I hope to show historically marginalized populations, treatment is most effective when the approach incorporates community measures that traditional treatment offers.

The Zavala County illustrates the combination of social and medical. I hope with the case study and my research, I can explore spaces with collaboration in social science and humanities who can offer this view not from biomedical view but from social and cultural. That's my presentation. I thank you for being here, and to pay attention to the presentation.

I'm open to your questions and comments. Whatever. Thank you very much.

Speaker: First, thank you that was excellent. Just a comment. I saw a presentation on television about a similar thing with students in the UK. Students of color, or poor being funneled into separate schools. I was interested to hear it happened in Texas.

Even though it failed, there were exciting potentials there with community support.

Ximena Lopez Carrillo: I would say it's relative because many of the women health workers became social workers or psychologists. They were the activists who included the feminist critique. It failed in a sense; it really empowered the population in ways that a mental health professional couldn't see easily. Thank you very much for your comment.

Speaker: That was a fantastic presentation and insightful case study. It was clear to see how things can be applied and this model has been re-invigilated

The social focused model definitely had benefits. There were issues around legitimizing. Do you have any advice for how one can go about measuring these difficult to measure parameters? As we see, there are helpful and beneficial in today's space. When you think in the context of grants or approval, it's hard to quantify.

Speaker: Echoing what Max presented in his own talk, I think the key to identify the benefits from a marginalized perspective, is to listen to the patient testimonial. Listen to what you need as a community. Maybe you don't need psycho or pharmacological treatment. They needed transportation and help taking care of their children.

Bringing the patient's voice is a way you can respond to the needs and by bringing the voice, you can sense if they feel satisfied with the service.

The other one I have tried to do by joining the ERNM program is to facilitate education of issues of race and culture. Have courses open to medical students. People who are probably not familiar with debates.

In terms of how do you quantify that for grant application? I think that's the harder challenge. I don't have the answer yet but maybe when I'm more advanced I'll have one.

Speaker: I work for a Yale program. I don't know if you went to the breakout session, but they do participatory research and qualitative research. It is about community and people experiencing the services guiding what they need.

Ximena Lopez Carrillo: Something I forgot was one of the main priorities was to democratize the mental health sciences. If you didn't have that population representing those interests in the sciences, how do you respond to those needs. They were doing affirmative action programs, teaching students about psychology and how to get into it. Thank you for your question.

Speaker: I am a resident of internal medicine in New Mexico. Those are my neighbors. We talk about culturally competent care for other folks, but we don't talk at all about Chicano folks. I am Googling and my university [Inaudible.] but it never trickles back. I am feeling ignorant. It doesn't seem to have made its way to the [Inaudible.] Where is all that today?

Ximena Lopez Carrillo: It is still very popular among [Inaudible.] communities. It happened more in the health sciences, and they have to do with herbal medicine and not so much those that are spiritual and religious. Those are still marginalized but still very popular. There is a case in New Mexico of another and it shows how our attitudes are filtered by notions of race and gender.

There was another case, and she was accepted in Anglo groups, but she was accepted as a performer. It was more exotic as opposed to [Inaudible.] who was a threat to the nation. I would say those debates about this are still changing and will change over time depending on issues of race being solved but still marginalized.

After COVID there was a revival of traditional healing and botanical shops because of the political context and lack of health insurance. This form of traditional medicine is the only option they have for healthcare. I don't know if that answers your question but thank you very much.

Speaker: We are out of time. Thank you for your presentation. We have a break until 3:30. The coffee will be where the keynote speaker was. Thank you everyone.

[End of session.]