The Role of State Policies in the Promoting the Adoption of Evidence-Based Treatments for Substance Abuse

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Overview

- Do state policies affect treatment facilities' adoption of pharmacotherapies?
  - Focus on naltrexone for alcohol abuse treatment
- Study analyzed relationships between facility- and state-level factors to explain naltrexone adoption
- General Findings: States have policy levers they can exercise to increase use of evidence-based treatments (e.g., naltrexone)

Research Motivation

- High stakes for governments to design effective alcoholism treatment policies
  - 19 million (8% of U.S. pop) meet standard diagnostic criteria for alcohol use disorder; few seek treatment
  - Direct and indirect costs of alcoholism: approx $185 billion/year
  - States spend $1 of every $7 on substance abuse programs and consequences; **less than 5% of this on prevention, treatment, and research**

Naltrexone: Pharmacotherapy for Alcoholism Treatment

- Quells cravings for alcohol; dulls “high” feeling
- FDA-approved in 1994; available as generic since 1998; included on most formularies
- No close therapeutic substitutes; effective alone or combined with behavioral therapies
- Relatively unrestricted supply; cost-effective
- **Yet prescription rates low (est. 2 to 13%) in specialty treatment settings; lower rates among wider population**

Clinically-proven, cost-effective treatments under-utilized: Why?

- Naltrexone adoption associated with treatment staff characteristics (education, treatment philosophy), patients' alcohol cravings/compliance orientation, insurance coverage, managed care participation
- Role for state-level policy factors in treatment decisions
  - Medicaid funds and related block grants constitute the majority of treatment spending
  - **Only 6% diagnosed as alcohol dependent get medication during treatment; one-third cite cost or insurance as key barrier**

Types of State-Level Variation That May Affect Treatment

- State Medicaid policies: setting co-pays, contracting with managed care programs, and imposing prescription limits (e.g., quantity supply/refill limits)
- State agency funding for treatment (for persons not covered by Medicaid or other insurance) and types of services funded
- Managed care/cost containment practices
- Economic and health care capacity conditions

Study Data

- **Facility-level measures**:
  - 2003 National Survey of Substance Abuse Treatment Services (N-SSATS): all public and private facilities providing treatment in U.S. (96% response rate, n=13,623)
- **State-level measures (**general categories**)**:
  - Medicaid enrollments and policies/benefits for mental health, rehabilitation services, and prescription drugs; state health care capacity and financing; state general fiscal and economic health, and state population characteristics

Naltrexone adoption and state-level policies	All states	Wisconsin
% of facilities in state that adopted naltrexone	*12%*	*20% (10th)*
% of Medicaid enrollees in managed care	60%	47%
Medicaid benefits for rehab: co-pay required	11%	Yes
Medicaid benefits for rehab: SA limitations	61%	Yes
Medicaid prescription drugs coverage limitations-quantity supplied	56%	Yes
Medicaid prescription drugs-other coverage limitations	45%	Yes
Medicaid policy: state preferred drug list	57%	Effective Oct. 1, 2004
Medicaid policy: number of refills limited	54%	Yes
Medicaid policy: lower generic co-pays	38%	No in 2003, currently Yes
Medicaid policy: generic rate paid for brand	62%	Yes
Medicaid policy: generics on PDL/formulary	37%	No in 2003, currently Yes
Capitated/MCO delivers Medicaid benefits	88%	Yes

State-level policies and spending	All states	Wisconsin
State permits MCO/PCCM to set policies regarding formulary/PDL	72%	Yes
State permits MCO/PCCM to set policies regarding prior authorization	72%	Yes
State permits MCO/PCCM to set policies encouraging generics	66%	Yes
State permits MCO/PCCM to set policies restricting access to pharm network	38%	Yes
Medicaid policy: MCO delivers Rx	66%	Yes
Federal Medicaid Assistance %	56.7	58.6
Substance abuse treatment block grant funding per capita	5.75	$6.66
State discretionary funding for substance abuse treatment (per capita)	0.96	$1.19
State discretionary funding for substance abuse prevention (per capita)	0.56	$5.98
Needing But Not Receiving Treatment for Alcohol Problems in Past Year, Ages 18-25	18%	22%

Key Findings from Empirical Analysis on Role of State Policies

- Estimates of state policy effects, controlling for facility-level factors
- Facilities *more likely* to adopt naltrexone in states that:
  - Allow MCO/PCCM to set policies encouraging generics: odds ↑ 96%
  - Contract with MCO to deliver Medicaid benefits: odds ↑ 76%
  - Include generics on preferred drug list/formulary: odds ↑ 44%

Key Findings from Empirical Analysis (cont.)

- Facilities *less likely* to adopt naltrexone in states that:
  - Contract w/MCO to deliver Medicaid pharm benefits: odds ↓ 49%
  - Allow MCO/PCCM to restrict access to pharmaceutical networks: odds ↓ 48%
  - Establish a preferred drug list: odds ↓ 21%
  - Limit Medicaid benefits for rehabilitation services (for use in substance abuse treatment): odds ↓ 16%

Implications of empirical findings

- No state completely consistent in establishing policies that increase (rather than impede) access to medical treatments
- Wisconsin improving, but still has policies with negative implications
  - Could further reduce substance abuse treatment limitations, monitor MCOs to ensure access to pharm benefits not restricted, more proactively encourage adoption of proven medical treatments
- California, Florida, Iowa, Maine, Massachusetts and Vermont most actively encourage adoption of naltrexone by explicitly including it on preferred drug list

Policy Implications

- Considerable potential for addressing unmet need for access to a clinically-proven, cost-effective treatment for alcohol abuse/dependence
  - <1% of those in need of treatment receive medication to aid treatment/recovery
  - ~33% needing treatment/recognizing need but not receiving treatment cited cost/insurance problems
  - $4-7 returned in reduced drug-related crime/criminal justice costs for every $1 invested in treatment; adding health care savings increases ratio of savings/costs to $12:1
- Deficit Reduction Act of 2005 allowed states greater flexibility for modifying/managing Medicaid programs; **evidence suggests for room and need for improvement**