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

Carolyn J. Heinrich
*University of Wisconsin-Madison*
Prepared for Evidence-Based Health Policy Project Briefing, May 6, 2008
Acknowledgements

Thank you to...

- Co-author, Carolyn Hill, and research assistants, Nancy Chan, Katie Keck, Kevin Murphy and CJ Park
- The Robert Wood Johnson Foundation Substance Abuse Policy Research Program for funding
- The University of Wisconsin Graduate Research Fund and the Georgetown Public Policy Institute at Georgetown University for research assistance support
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
<table>
<thead>
<tr>
<th>Naltrexone adoption and state-level policies</th>
<th>All states</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% of facilities in state that adopted naltrexone</strong></td>
<td>12%</td>
<td>20% (10th)</td>
</tr>
<tr>
<td>% of Medicaid enrollees in managed care</td>
<td>60%</td>
<td>47%</td>
</tr>
<tr>
<td>Medicaid benefits for rehab: co-pay required</td>
<td>11%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid benefits for rehab: SA limitations</td>
<td>61%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid prescription drugs coverage limitations-quantity supplied</td>
<td>56%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid prescription drugs-other coverage limitations</td>
<td>45%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid policy: state preferred drug list</td>
<td>57%</td>
<td>Oct. 1, 2004</td>
</tr>
<tr>
<td>Medicaid policy: number of refills limited</td>
<td>54%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid policy: lower generic co-pays</td>
<td>38%</td>
<td>currently Yes</td>
</tr>
<tr>
<td>Medicaid policy: generic rate paid for brand</td>
<td>62%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid policy: generics on PDL/formulary</td>
<td>37%</td>
<td>currently Yes</td>
</tr>
<tr>
<td>Capitated/MCO delivers Medicaid benefits</td>
<td>88%</td>
<td>Yes</td>
</tr>
<tr>
<td>State-level policies and spending</td>
<td>All states</td>
<td>Wisconsin</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------------------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>State permits MCO/PCCM to set policies regarding formulary/PDL</td>
<td>72%</td>
<td>Yes</td>
</tr>
<tr>
<td>State permits MCO/PCCM to set policies regarding prior authorization</td>
<td>72%</td>
<td>Yes</td>
</tr>
<tr>
<td>State permits MCO/PCCM to set policies encouraging generics</td>
<td>66%</td>
<td>Yes</td>
</tr>
<tr>
<td>State permits MCO/PCCM to set policies restricting access to pharm network</td>
<td>38%</td>
<td>Yes</td>
</tr>
<tr>
<td>Medicaid policy: MCO delivers Rx</td>
<td>66%</td>
<td>Yes</td>
</tr>
<tr>
<td>Federal Medicaid Assistance %</td>
<td>56.7</td>
<td>58.6</td>
</tr>
<tr>
<td>Substance abuse treatment block grant funding per capita</td>
<td>5.75</td>
<td>$6.66</td>
</tr>
<tr>
<td>State discretionary funding for substance abuse treatment (per capita)</td>
<td>0.96</td>
<td>$1.19</td>
</tr>
<tr>
<td>State discretionary funding for substance abuse prevention (per capita)</td>
<td>0.56</td>
<td>$5.98</td>
</tr>
<tr>
<td>Needing But Not Receiving Treatment for Alcohol Problems in Past Year, Ages 18-25</td>
<td>18%</td>
<td>22%</td>
</tr>
</tbody>
</table>
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