Alcoholism & Drug Abuse Weekly

News for policy and program decision-makers

Volume 36 Number 20
May 20, 2024
Online ISSN 1556-7591

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Study: More than 321,000 children lost a parent to drug overdose 2011-2021

The oft-cited statistic of 100,000 overdose deaths a year in the United States has an oft-unspoken hidden additional tragedy: the children left behind when a parent dies.

A study published this month found that more 321,500 children in the United States lost a parent to drug overdose death from 2011–2021, with the rate of loss more than doubling during this period. According to the study, published in the current issue of *JAMA Psychiatry*, the highest number of bereaved children were those with non-Hispanic white parents, but communities of color and tribal communities were disproportionately affected.

> ***Bottom Line...***
> *The hidden toll of drug overdose deaths in the United States is children who lost their parent: a federal study quantifies this for the first time.*

The study was conducted by the National Institute on Drug Abuse (NIDA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC).

From 2011–2021, 649,599 people aged 18 to 64 died from a drug overdose. This is the first study to look at the number of children left behind

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Paper: State Medicaid expansion holdouts and managed care impede treatment

The expanded scope of the Medicaid program has accomplished a great deal in bolstering substance use treatment, but further progress will depend on correcting deficiencies in non-expansion states and within Medicaid managed care entities, a newly published commentary suggests.

Published online May 6 in the *American Journal of Psychiatry*, the paper advises substance use treatment advocates to undertake a coordinated effort at the state level. "The most important states to target are those that have limited benefits sharply or have not expanded Medicaid at all," wrote the commentary's co-authors.

> ***Bottom Line...***
> *A newly published commentary suggests that despite numerous inroads that have broadened Medicaid's role in substance use treatment, more progress is needed at the state level to ensure equitable access.*

The paper, titled "Progress and Challenges in Medicaid-Financed Care of Substance Use Disorder," points out that several of the 10 states that have not expanded Medicaid have higher-than-average overdose rates. These states include Florida, South Carolina and Tennessee. These states lack the funding flexibility that has allowed Medicaid expansion states to free up federal Substance Use Prevention, Treatment and Recovery Block Grant funds for innovative programming such as crisis care and wraparound services.

"In South Carolina, the block grant pays for just medication and

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by these deaths. Despite these tragic numbers, no national study had previously estimated the number of children who lost a parent among these deaths.

"It is devastating to see that almost half of the people who died of a drug overdose had a child. No family should lose their loved one to an overdose, and each of these deaths represents a tragic loss that could have been prevented," said Nora Volkow, M.D., NIDA director, when the study was released May 8. "These findings emphasize the need to better support parents in accessing prevention, treatment, and recovery services. In addition, any child who loses a parent to overdose must receive the care and support they need to navigate this painful and traumatic experience."

Children with older parents — ages 41-64 — had the highest rates of parental loss due to drug overdose.

Below are some of the stratified rates of loss:

- Children with non-Hispanic American Indian/Alaska Native parents consistently experienced the highest rate of loss of a parent from overdose, with 187 per 100,000 children affected in this group in 2021, more than double the rate among non-Hispanic white children (76.5 per 100,000) and among non-Hispanic Black children (73 per 100,000);
- Children with young non-Hispanic Black parents (18 to 25 years old) experienced the highest increase — roughly 24% — in rate of loss every year;
- Children lost more fathers than mothers (192,459 compared to 129,107 children) during this period; and
- The highest rates by parents' age group were consistently found among children whose parents were aged 41 to 64 years followed by those aged 26 to 40 years and 18 to 25 years.

Methods

For this study, researchers used data from the National Surveys on Drug Use and Health (NSDUH), 2010–2019, to determine the number of children younger than 18 years who were living with a parent age 18 to 64 years old with past-year drug use. NSDUH defines a parent as biological parent, adoptive parent, stepparent, or adult guardian.

The researchers then estimated the number of children of the nearly 650,000 people who died of an overdose in 2011 to 2021 based on the national mortality data from the CDC National Vital Statistics System. The data were stratified by age — 18 to 25, 26 to 40, and 41 to 64 years old — sex, and self-reported race and ethnicity.

Implications

"This first-of-its-kind study allows us to better understand the tragic magnitude of the overdose crisis and the reverberations it has among children and families," said Miriam E. Delphin-Rittmon, Ph.D., Health and Human Services Assistant Secretary for Mental Health and Substance Use and the leader of SAMHSA. "These data illustrate that not only are communities of color experiencing overdose death disparities, but also underscore the need for responses to the overdose crisis moving forward to comprehensively address the needs of individuals, families and communities."

"Children who lose a parent to overdose not only feel personal grief, but also may experience ripple effects, such as further family instability," said Allison Arwady, M.D., M.P.H., director of CDC's National Center for Injury Prevention and Control. "We need to ensure that families have the resources and support to prevent an overdose from happening in the first place and manage such a traumatic event."

The researchers stressed that "whole-person health care," which treats a person with substance use disorder as a parent or family member, is the best way to prevent generational cycles of substance use. The study also stresses the need to provide "culturally informed" approaches to prevention, treatment, recovery and harm reduction.

"One component of the strategy for reducing future harms of paren-

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Alcoholism & Drug Abuse Weekly (Online ISSN 1556-7591) is an independent newsletter meeting the information needs of all alcoholism and drug abuse professionals, providing timely reports on national trends and developments in funding, policy, prevention, treatment and research in alcohol and drug abuse, and also covering issues on certification, reimbursement and other news of importance to public, private nonprofit and for-profit treatment agencies. Published every week except for the first Monday in April, the second Monday in July, the first Monday in September, and the first and last Mondays in December. The yearly subscription rates for **Alcoholism & Drug Abuse Weekly** are: Online only: $672 (personal, U.S./Can./Mex.), £348 (personal, U.K.), €438 (personal, Europe), $672 (personal, rest of world), $8717 (institutional, U.S./Can./Mex.), £4451 (institutional, U.K.), €5627 (institutional, Europe), $8717 (institutional, rest of world). **Alcoholism & Drug Abuse Weekly** accepts no advertising and is supported solely by its readers. For address changes or new subscriptions, contact Customer Service at +1 877 762 2974; email: cs-journals@wiley.com.

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tal loss is to save lives by expanding prevention, harm reduction, treatment, and recovery services that are accessible and acceptable for parents and people of child-bearing age," the article noted. "While expanding these services has been a priority of federal, state, and local efforts over the past decade, a specific focus on parents has been lacking. Having a role as a parent can be a strong motivator to participate in substance use disorder treatment, but disrupted neurobiological reward and stress systems in persons with substance use disorders may also cause difficulties with parenting. Directly addressing parenting during treatment is a natural focus that has been examined by multiple studies that generally show positive outcomes. However, specific parenting interventions, including peer-to-peer parenting training, are not often included in treatment. It is also evident that being a parent may increase challenges with obtaining substance use disorder treatment or harm reduction services due to concerns about child protective services, internalized guilt and shame, and the practical demands of parenting."

> **"Living in a household with parental substance use is itself an adverse childhood experience.... This existing vulnerability is subject to compounded trauma in cases of parental overdose death."**
>
> Christopher Jones, Ph.D., et. al. in *JAMA Psychiatry*

The researchers also cited the problem of parental substance use being viewed as a criminal matter, which creates a barrier to pregnant women seeking help for a substance use disorder. "At least 25 states and the District of Columbia consider substance use during pregnancy to be child abuse," the researchers wrote. "If states take more harm reduction–centered approaches rather than punitive measures, the existing health care resources may help reduce pregnancy-associated drug overdose mortality and impact on offspring."

There also needs to be "ready access to services designed to support the full family unit," the researchers concluded. "Living in a household with parental substance use is itself an adverse childhood experience, increasing risk of lasting negative impact on a child's long-term health and well-being. This existing vulnerability is subject to compounded trauma in cases of parental overdose death."

The study, "Estimated Number of Children Who Lost a Parent to Drug Overdose in the US From 2011 to 2021" by Christopher Jones, Ph.D., of NIDA and colleagues, is published in the May 8 issue of *JAMA Psychiatry*. •

CM group calls on SAMHSA to rescind $75 cap

This month, the Contingency Management Policy Group (CMPG) headed by H. Westley Clark, M.D., issued a statement calling on the federal government to rescind the $75 limit on what can be paid per year to patients being treated for substance use disorder. Contingency management is the only effective treatment for stimulant use disorders, involving payment for negative drug tests, but it doesn't work unless the dollar figure is much higher.

The group is headed by Sarah Wattenberg of the National Association for Behavioral Healthcare.

Below is the statement that was issued on May 8:

"Members of the Contingency Management Policy Group (CMPG) and other stakeholders are very concerned with the Substance Abuse and Mental Health Services Administration's (SAMHSA) recent State Opioid Response and Tribal Opioid Response grant announcements that limit the use of funding for contingency management (CM) incentives to $75 per patient, per budget year. Research does not support this incentive amount, which will lead to ineffective interventions that will not reduce stimulant-related overdose deaths. Call to Action: The CMPG calls upon SAMHSA to rescind the $75 limit on patient incentives and reissue these grant announcements to permit the use of evidence-based amounts for CM. Evidence-based CM could reduce stimulant-associated overdoses and save tens of thousands of lives every year. Background: CM is the only evidence-based treatment for stimulant use disorder, which is involved in almost half of the country's overdoses. This policy is inconsistent with federal funding for higher CM incentives through the California 1115 waiver and with the report by the Office of the Assistant Secretary for Planning and Evaluation (Nov. 7, 2023)."

Sign-on letter

Last week, the group sent a letter to Xavier Becerra, secretary of the federal Department of Health and Human Services (HHS); Miriam Delphin-Rittmon, Ph.D., assistant secretary for mental health and substance use at HHS; Rahul Gupta, M.D.,

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director of the White House Office of National Drug Control Policy, and Neera Tanden, director of the White House Domestic Policy Council, calling for the change. *ADAW* obtained a copy of the May 14 letter. A copy is below, along with a list of the signatories.

Dear Federal Officials:

We are writing to express our concern that the Substance Abuse and Mental Health Services Administration (SAMHSA) recently released two Notices of Funding Opportunities (NOFOs) with a combined total of about $2 billion for State Opioid Response (SOR) and Tribal Opioid Response (TOR) grants, both with non-evidence-based limits on funding for contingency management (CM), despite CM's proven efficacy in the treatment of stimulant use disorder (StimUD). The grants require applicants to implement evidence-based CM and also limit grant funding for CM to $75 per patient per budget year. Research does not support this funding amount, which we believe will likely render such interventions ineffective.

Recent Centers for Disease Control and Prevention data indicate that cocaine and methamphetamine continue to worsen the number of our nation's overdose deaths dramatically. Stimulants are now implicated in almost half of America's overdoses. CM is the standard of care for StimUD which has been clearly and consistently demonstrated to produce positive treatment results.

Decades of National Institutes for Health-funded research and more than 100 published studies, all using significantly higher incentive levels ranging from $650 to $1,800, have shown robust positive treatment outcomes. In short, CM is highly effective for treating StimUD when using clinically effective incentive amounts.

Scientific and policy experts and other stakeholders have expressed concerns about the ineffectiveness of the $75 limit with federal leaders since 2018. This policy limit wastes taxpayer money, promotes ineffective treatment, and, according to a recent government report, unnecessarily obstructs effective treatment for StimUD.

> **"By embracing evidence-based CM, the Biden Administration can help SAMHSA grantees reduce stimulant-associated overdoses and save more lives."**
>
> Contingency Management Policy Group

The undersigned leaders in addiction call upon the Biden Administration to rescind the $75 'cap' and direct SAMHSA to re-issue these NOFOs permitting the use of evidence-based amounts for CM. Such action would not only align with science. It would also align with actions from the Centers for Medicare & Medicaid Services that have approved state requests to offer CM with incentive levels surpassing the $75 'cap' as part of those states' Medicaid demonstrations. By embracing evidence-based CM, the Biden Administration can help SAMHSA grantees reduce stimulant-associated overdoses and save more lives.

Please contact Sarah Wattenberg at sarah@nabh.org with any questions or comments.

Sincerely,

American Academy of Addiction Psychiatry
American Indian Health Commission for Washington State
American Osteopathic Academy of Addiction Medicine
American Psychiatric Association
American Psychological Association Services
American Society of Addiction Medicine
Association for Behavioral Health and Wellness
California Consortium of Addiction Programs & Professionals
Connecticut Certification Board
Contingency Management Policy and Practice Group (CMPG)
DynamiCare Health, Inc.
Faces and Voices of Recovery
Legal Action Center
National Association for Behavioral Healthcare
National Association of Addiction Treatment Providers
National Behavioral Health Association of Providers
National Council for Mental Wellbeing
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FROM THE FIELD...

Opioid settlement funds — We need to get back on track!

By Rob Kent

As this country continues down the tracks on what is a runaway train of opioid overdose deaths, I am fearful that we are going to squander the opportunity to target the billions that state and local governments will receive from opioid manufacturers and distributors for their misdeeds. We need to pull the train brakes before we go off the tracks!

Let's begin by taking a step back to understand that the legal basis for the opioid litigation was to seek damages from the opioid manufacturers and distributors to fix, or abate, the nuisance they created. Those who settled the litigation surely expect that the money will be used to make things better. So far, the government gets, at best, a "D" on their abatement efforts.

We are already witnessing the government repeat the same mistakes they made with the tobacco settlement funds. Too many are using the opioid funds to replace current government spending, to buy toys and other new and shiny miracle tools and elixirs; others sit on the money while more die; and others limit the tools they make available. Too many governments are ignoring the voices of the families impacted by opioids and those with lived experience and they are also lacking in transparency!

All is not lost, and I offer the following ideas to help us get control of the train to ensure that it stays on the tracks:

1. The federal government, through the Substance Abuse and Mental Health Services Administration, should direct states to provide detailed information explaining how their spending of opioid settlement funds is complementary to, and not duplicative of, their use of the State Opioid Response funding and the Substance Use Prevention Treatment and Recovery Services Block Grant funding. Any state that fails to provide such information would risk losing such federal funding.
2. The federal government, through the Department of Health and Human Services and the Department of Justice, should review how states are spending their opioid settlement funds to determine whether they should consider "clawing back" or recouping federal Medicaid funds that were spent to provide services that would not have been necessary if the opioid manufacturers and distributors had not flooded the country with highly addictive drugs. If states are being transparent and are spending the settlement funds consistent with the settlement agreements, they would not be at risk of any Medicaid recoupment.
3. State auditors should conduct audits of the use of their state settlement funds and make their reports and findings public. As part of the audits, they should also ensure that all settlement funds are spent only through open, competitive procurements.
4. The opioid manufacturers, distributors and the state attorneys general should review the settlement fund spending in their states to determine whether it is aligned with their settlement agreements. If yes, the efforts should continue. If not, they should ask courts to appoint trustees to manage the spending of the funds.

The government owes it to all of us — taxpayers, impacted families, folks with lived and living experience — to make sure that the train arrives at a station where we have truly abated the nuisance! •

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Kamilla Venner, Ph.D., Center on Alcohol, Substance Use, & Addiction
Jeremiah Weinstock, Saint Louis University
Rachel Winograd, University of Missouri Saint Louis •

Rapid initiation protocol for naltrexone: 5-7 days instead of 10-15

Your idea of "rapid" may be different from that of the National Institute on Drug Abuse (NIDA), which funded a study showing that it is possible to start patients on injectable, extended-release naltrexone (trade name Vivitrol) within five to seven days after they stop opioid use – and called that "rapid initiation." But it's all relative. The standard treatment method was within 10-15 days, according to NIDA.

Of the three medications for opioid use disorder (OUD) — methadone, buprenorphine, and naltrexone — by far, the most difficult to start is naltrexone. That's because the patient must have absolutely no opioids in the body at the time of administration, or there will be serious withdrawal symptoms. For patients to have to experience 10-15 days of unpleasant withdrawal symptoms while their body clears itself of opioids made Vivitrol unattractive as an alternative. Even waiting five to seven days may seem like a lot.

But the study, a clinical trial published in the May 8 issue of *JAMA Network Open*, found that the rapid protocol could be effective for those patients committed to naltrexone. It also found that those in rapid treatment left treatment at a greater rate than those in the usual protocol. Patients in rapid treatment only got one day of buprenorphine.

Methods

The researchers enrolled and followed 415 patients with OUD who were admitted at six community-based inpatient addiction facilities across the U.S. and who chose treatment with XR-naltrexone. Every 14 weeks, the sites were randomized to provide either the standard XR-naltrexone procedure or the more rapid procedure.

In the study, standard XR-naltrexone prescribing included a three- to five-day treatment period with buprenorphine to ease withdrawal symptoms, followed by a seven- to 10-day opioid-free period. The rapid procedure consisted of one day of buprenorphine (up to 10 mg), a 24 hour opioid-free period, and a gradual increase in low-dose oral naltrexone for three to four days prior to getting an injection of XR-naltrexone.

Withdrawal symptoms were also managed with non-opioid medications such as clonidine and clonazepam throughout the process. Buprenorphine is an opioid.

Results

The study found that patients on the rapid five- to seven-day treatment procedure were significantly more likely to receive a first injection of XR-naltrexone compared to those on the standard seven to 15-day treatment procedure (62.7% vs. 35.8%). Withdrawal severity was generally low and comparable across the two groups.

However, serious adverse events, such as a fall or overdose, occurred more on the rapid patients (5.3% and 6.7%) than on standard procedure patients (2.1% and 1.6%). This shows that greater clinical expertise and closer monitoring may be required with the rapid procedure.

Implications

Still, challenges remain. Most patients in both groups who chose not to receive the first dose of naltrexone said they just wanted to leave treatment early. Withdrawal is not comfortable. Patients initiated on methadone or buprenorphine do not have to experience withdrawal, if given adequate doses.

"When someone is ready to seek treatment for opioid use disorder, it is crucial that they receive it as quickly as possible," said Nora Volkow, M.D., NIDA director, when the study was released. "This study paves the way for more timely care with one of the three medications for opioid use disorder we have available, better supporting people in their ability to choose the treatment option that will work best for them."

"Time has been an important barrier that we've seen hinder the use of extended-release naltrexone for opioid use disorder in the past, both among individuals and treatment providers," said Matisyahu Shulman, M.D., a clinician researcher at New York State Psychiatric Institute and Columbia University Irving Medical Center, New York City, and lead author on the study. "We hope that these findings can help encourage more treatment settings to offer extended-release naltrexone as a safe and effective option for patients to help prevent overdose and support recovery."

And a note of caution: As is often the case, the cost savings from the rapid procedure in terms of days could be undercut by the additional resources needed for intensive monitoring, the researchers wrote.

The authors note that future studies should explore sustainability, feasibility, and health economic aspects of this more rapid treatment protocol for XR-naltrexone. Despite cost savings from fewer days on the rapid procedure, the resources needed for intensive monitoring should also be considered.

The study is the "Surmounting Withdrawal to Initiate Fast Treatment with Naltrexone (SWIFT)" study, and was led by researchers at New York State Psychiatric Institute and Columbia University Irving Medical Center. The study, "Rapid Initiation of Injection Naltrexone for Opioid Use Disorder," is by Matisyahu Shulman, M.D. and colleagues. •

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outpatient treatment," commentary co-author Christina Andrews, Ph.D., associate professor in the Arnold School of Public Health at the University of South Carolina, told *ADAW*.

Andrews' co-authors are Keith Humphreys, Ph.D., the Esther Ting Memorial Professor of Psychiatry and Behavioral Sciences at Stanford University, and Richard G. Frank, Ph.D., director of the Center on Health Policy at The Brookings Institution.

> **"Managed care is probably at this point the single most significant area for research and further policymaking in this entire realm. There's no reason we can't begin to share this information. These aren't trade secrets."**
>
> Christina Andrews, Ph.D.

Accomplishments and shortcomings

The commentary states that Medicaid has become the nation's largest funding source for substance use treatment and "also is a major contributor to health insurance equity because enrollees under age 65 (i.e., those not eligible for Medicare) are disproportionately from disadvantaged racial and ethnic populations."

The authors point out several policy actions that have increased Medicaid's role in substance use treatment over the past decade and a half, starting with states' opportunity to enact Medicaid expansion via the Affordable Care Act. Years later, adoption of mandates in the SUPPORT Act led to a significant expansion of evidence-based treatments such as medication treatment for opioid use disorder.

"By 2021, every state covered buprenorphine, oral naltrexone and injectable naltrexone, and 85% covered methadone maintenance," the authors wrote. "Use of quantity limits, prior authorizations and other utilization management methods also declined from 2017 to 2021."

Andrews said that among these accomplishments, perhaps the most impactful one recently has been "the really substantive movement around extending coverage into sites of incarceration." As of the time of the commentary's writing, California and Washington had become the first two states to receive federal waivers to allow reactivation of Medicaid coverage pre-release, an important step leading up to the high-risk period when incarcerated individuals return to the community. Fifteen more states had applied for similar waivers. the commentary states.

"The Biden administration has taken an important opportunity, through [the Centers for Medicare & Medicaid Services], for states to pursue innovative strategies," Andrews said.

On the other side of the coin, however, a lack of Medicaid expansion has hamstrung the 10 states that have not taken that step, the commentary's authors indicate. In expansion states, Medicaid has covered some of the treatment services traditionally paid for through the block grant, freeing block grant funds for other key objectives.

This is illustrated in a look at funding for substance use prevention. The authors cite data reported from the states to the Substance Abuse and Mental Health Services Administration (SAMHSA), showing that while the proportion of block grant funding devoted to primary prevention increased by 15% in Medicaid expansion states in the 2010s, it declined by 10% in non-expansion states during the decade.

While some expansion states have been able to offer an array of services on demand through the block grant, non-expansion states have no alternative funding sources when block grant funds for basic services run out, Andrews explained.

The other main challenge cited in the journal article involves the use of restrictive policies in the Medicaid managed care plans that cover around 75% of the nation's Medicaid beneficiaries. "Overall use of utilization management policies within Medicaid fee-for-service programs has declined in recent years, but such policies remain widespread in Medicaid managed care plans," the authors wrote.

They added, "Rates of denial of prior authorization requests across all medical conditions reach as high as 40% in some Medicaid managed care plans; the rate of denial specific to [substance use disorder] care is unknown."

Andrews said researchers in this area have to mine multiple sources of data to get a firm handle on these managed care practices, which managed care organizations are not required to report to the states. As a result, what state officials have said the managed care plans cover for substance use services doesn't always match up with what's actually being covered, she said.

"Managed care is probably at this point the single most significant area for research and further policymaking in this entire realm," Andrews said, adding, "There's no reason we can't begin to share this information. These aren't trade secrets."

Prognosis for policy change

It's possible that given the country's divided and usually contentious political climate, advocates in non-expansion states might see dim prospects for Medicaid expansion in those 10 jurisdictions. But Andrews said she sees the situation differently, citing the history around some

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policymakers' views in the earliest days of the Medicaid program.

"When Medicaid was first created, some states said they would never participate," Andrews said. "Within 10 years, all but Arizona had joined."

The recent decision in conservative-leaning North Carolina to adopt Medicaid expansion could offer advocates elsewhere some reason for optimism. Andrews said a feasibility review is under way in South Carolina.

She and her co-authors wrote in their commentary that "although some of Medicaid's challenges can be addressed at the federal level, in many, if not most cases, the power lies in states. This includes state legislators and governors as well as state Medicaid commissioners and single state agency leads." •

Coming up…

The annual meeting of the **College on Problems of Drug Dependence** (CPDD) will be held **June 15-19** in Montreal. For more information, go to **https://cpdd.org/**

The annual meeting of the **Research Society on Alcoholism** (RSA) will be held **June 22-26** in Minneapolis. For more information, go to **https://researchsocietyonalcohol.org/**

The **National Prevention Network** annual conference will be held **August 13-15** in Phoenix, Arizona. For more information, go to **https://npnconference.org/**

The **Cape Cod Symposium on Addictive Disorders** annual conference will be held **September 5-8**. For more information, go to **https://www.hmpglobalevents.com/cape-cod-symposium**

Briefly Noted

Annual outcomes study out from NAATP

FoRSE, the research foundation of the National Association of Addiction Treatment Providers (NAATP), will release its annual summary report at this week's annual meeting, which *ADAW* will cover in person. The report provides NAATP members, as well as the public, with descriptive and graphic reports of the impact of addiction treatment. This will give them insight into how effective their programs are, compared to others across the country. The 42 page report, a copy of which was obtained by *ADAW*, is stunning in terms of content and presentation. The report is free. The focus is on outcomes. For anyone who has ever been asked "Does treatment work?" or "Does your treatment program work?" this report is invaluable. It breaks down the answers and includes the how and why. We asked Annie Peters, Ph.D., NAATP's director of research and education, for the top takeaways from the report. Her response:

- Individuals who participated in more than 30 days of treatment were 65% less likely to relapse, compared to those with less than 30 days of treatment.
- Individuals who were observed to have high psychiatric acuity at admission were 60% more likely to relapse and discharge prematurely from treatment, compared to those with low admitting acuity.
- On average, individuals experienced a 42% decrease in symptoms of depression, a 39% decrease in symptoms of anxiety, and a 51% decrease in symptoms of SUD observed during the course of treatment.
- Following the release of this summary report, FoRSE will provide individualized reports to each participating treatment center, giving them insight into the effectiveness of their programs compared with other providers across the country.
- A nationwide data collection program at this scale is not without its expected limitations (e.g., missing and erroneous data, low long-term survey response rates). FoRSE is in the process of ongoing data validation to make reports of treatment outcomes more meaningful and useful. Collaboration across providers and health technology partners is key to our ability to communicate the value of SUD treatment.

For the report, go to https://online.fliphtml5.com/xqpok/xvlk/#p=1. •

In case you haven't heard…

Yet another state has fallen for the "it's not the pandemic anymore, but hospitality…" argument. Alcohol-to-go is now legal in Colorado. Originally approved on a temporary basis four years ago to prevent transmission of COVID (and, unspoken at the time, to help keep restaurants alive), the measure was extended by lawmakers last year. It was due to expire in July 2025. Now, Gov. Jared Polis — the same person who signed the emergency to-go alcohol rule in 2020 — has signed a bill to make alcohol-to-go legal. *ADAW* isn't objecting to this, any more than we would object to people drinking alcohol in a restaurant or at home. But let's be clear on who wants this: drinkers, perhaps who drive, and alcohol sellers. Meanwhile, there are no masks, no more free COVID tests, and, in Colorado, plenty of marijuana in addition to the alcohol. Maybe we should take a closer look at why alcohol is considered so financially helpful to restaurants and stores (incidentally, the limit for alcohol-to-go in Colorado is two bottles of wine, 12 cans of beer, or one liter of spirits, and this is unchanged from the previous COVID-era rule).

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