

# **Substance Abuse Services under the Oregon Health Plan: Still Changing After All These Years**



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# RMC Research Corporation: Who Are We?

- A private, for-profit research, evaluation, training and technical assistance organization
- Headquarters in Portsmouth, NH
- Regional offices in Portland, OR; Denver, CO; Arlington, VA; and Long Beach, CA
- Portland office
  - Opened in 1990; 2 staff and \$200,000 in contracts
  - Now 35 staff and about \$6 M in grants and contracts
  - Evaluation and Policy Studies in: Behavioral health, School/Community-based Prevention, Math/Science Ed, Reading Comprehension



# And the Important Question: What Does “RMC” stand for?

□ *QUALITY*



# Other Members of RMC Research Team

- Kelly Vander Ley – Quantitative Analyst, Co-Occurring SA/MH Disorders; Behavioral Health and Primary Care
- Wyndy Wiitala – Quantitative Analyst, Administrative data
- Kathy Laws & Ryan D'Ambrosio – Qualitative Analysts, SA Prevention and Treatment, Evidence-based Practices
- Jeff Knudsen – Survey methodology, SA Tx Workforce, SA Prevention
- Jane Grover – Culturally Competent evaluation methods, American Indian Behavioral Health programs
- Matthew Carlson – alumnus



# RMC History of Research on OHP and Substance Abuse Services

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- ❑ 1996 – SAMHSA CSAT: Effects of Managed Care on Utilization and Outcomes of SA Tx Services for Medicaid Adults
- ❑ 1997 – SAMHSA CSAT: ...for Medicaid Adolescents
- ❑ 1999 – SAMHSA CSAT: Follow-up and Continued study on both populations
- ❑ 2000 – NIAAA (w/OHSU)
- ❑ 2000 – OR OADAP – Qualitative interviews w/providers and MCOs in all OR counties
- ❑ 2001 – SAMHSA CSAT – Effectiveness of Integrated COD Tx
- ❑ 2002 – NIDA – Effects of Different Financing Mechanisms on Methadone Maintenance Tx (Supplement in 2003 to focus on impact of cuts)
- ❑ 2004 – RWJ – Effects of Statewide Budget Reductions on Substance Abuse and Mental Health Services for Oregon's Most Vulnerable Citizens



# Key Elements of RMC Research on OHP

- Three-pronged methodology:
  - Construction, analysis of statewide analytic databases
  - Longitudinal follow-up studies of clients in Tx, using standardized instruments
  - Qualitative interviews of key stakeholders at state, county and local provider levels
- Comparisons w/state of Washington in most studies
  - Similar in demographics to Oregon, but very different in health/SA policies
- Partners, partners, partners
  - OR, WA state SA/BH agency, Medicaid staff
  - OHSU investigators (Depts of Psychiatry, Public Health & Preventive Medicine)
  - OHREC



# Brief Chronology of OHP Developments w/respect to Substance Abuse Services

<b>Date</b>	<b>Policy Change</b>
Feb., 1994	Expanded eligibility to all under 100% FPL
May, 1995	SA services integrated with medical care under managed care
Jan., 1996	Premium implemented for “Expansion” population in OHP (\$6-\$20 per mo. w/a number of waivers)
Oct., 2002	New CMS Waiver bifurcates OHP population into two sub-populations: OHP Standard (previous “Expansion”) and OHP Plus (categorical eligibles)
Feb., 2003	Co-pays implemented for OHP Standard (\$5) and OHP Plus (\$3) Premium payment rigorously enforced (disenrollment & 6-mo. “lockout”)
Mar., 2003	SA/MH benefit eliminated for OHP Standard
June, 2004	Co-pay requirement dropped for OHP Standard
July, 2004	No new OHP Standard enrollees permitted
Aug. 2004	SA/MH benefit reinstated for OHP Standard



# Administrative Data Studies

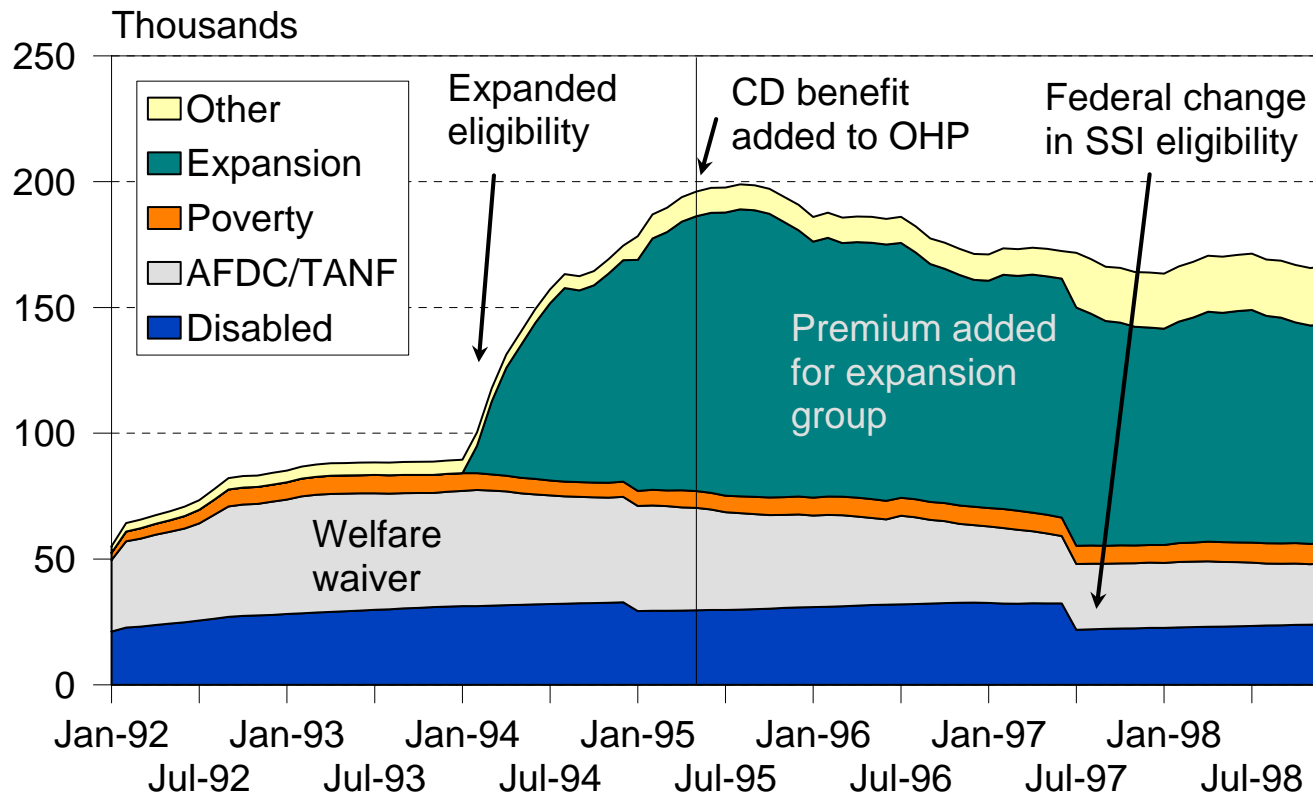
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- Trends in Medicaid enrollment and
- Substance Abuse Treatment access and utilization
  - By Medicaid eligibility groups
  - By adult and adolescent populations
- Development of treatment outcome measures, severity indicators



# Medicaid expansion in Oregon: Adults\* 1992–1998

## *Oregon Medicaid Enrollment Doubles in Mid-90's Under OHP & Federal Waiver*



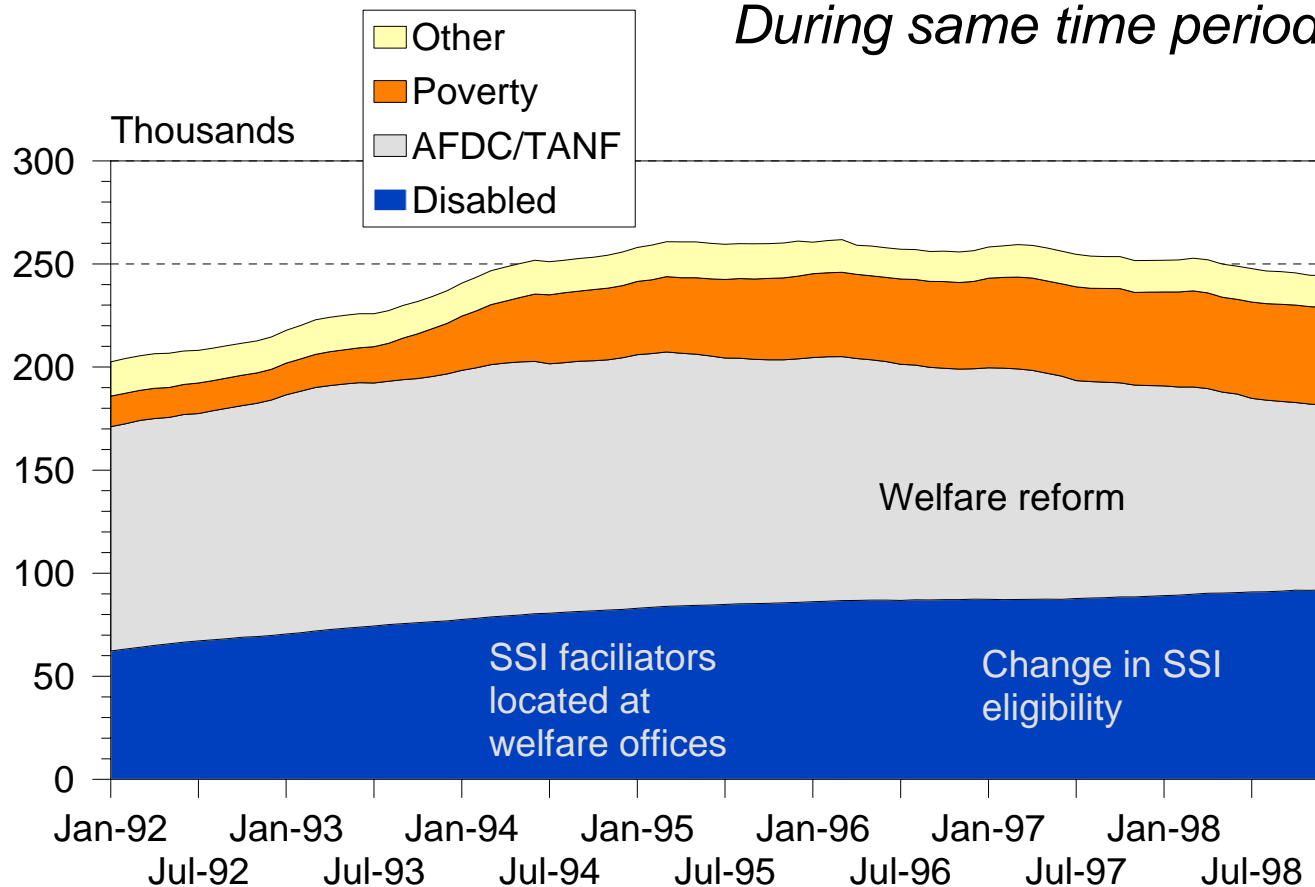
\* Age 18-64



# Medicaid expansion in Washington: Same time period

## Washington Medicaid-eligible Adults\*

*During same time period*

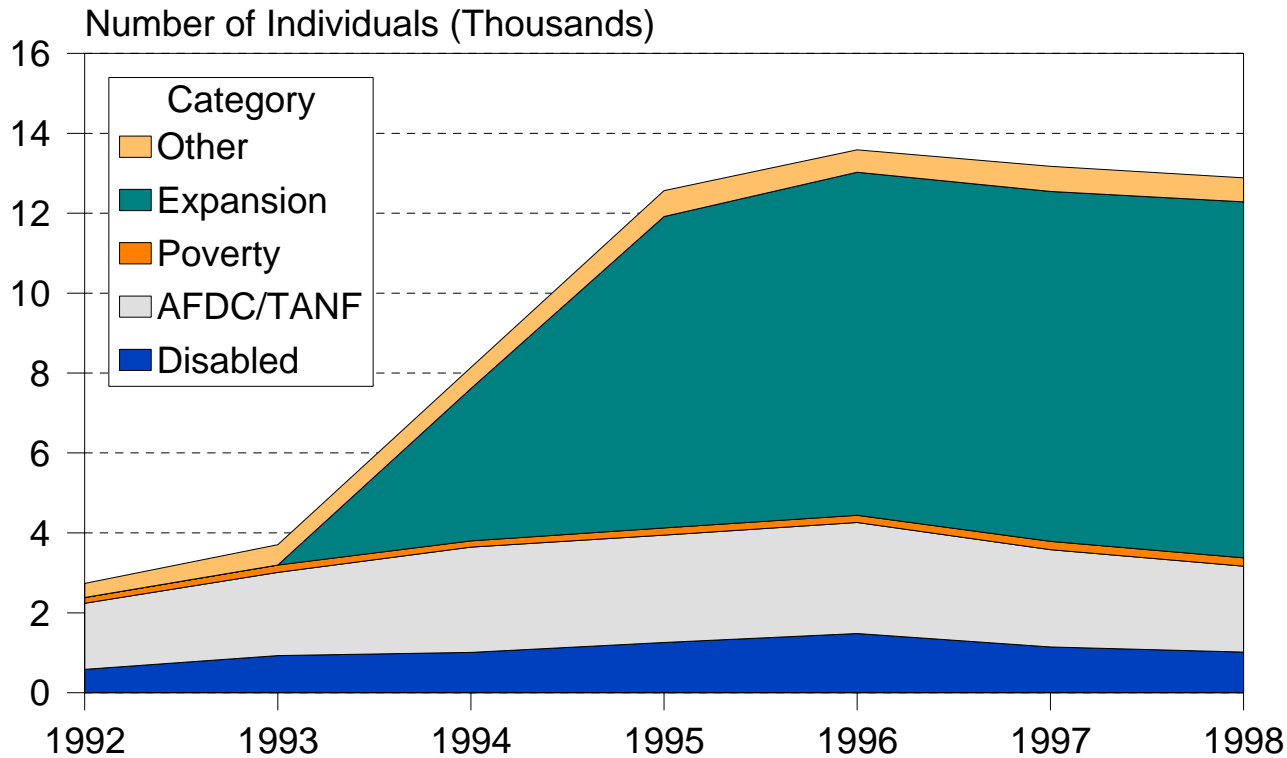


\* Age 18-64



# OR Admissions to SA Tx: 1992–1998 (Medicaid Adults)

## Oregon Admissions to Treatment *Number of Medicaid-eligible adults admitted to at least one treatment service during year*



Source: State treatment database (CPMS) and Medicaid eligibility files



# Sidebar: Publicly-funded SA Tx Services

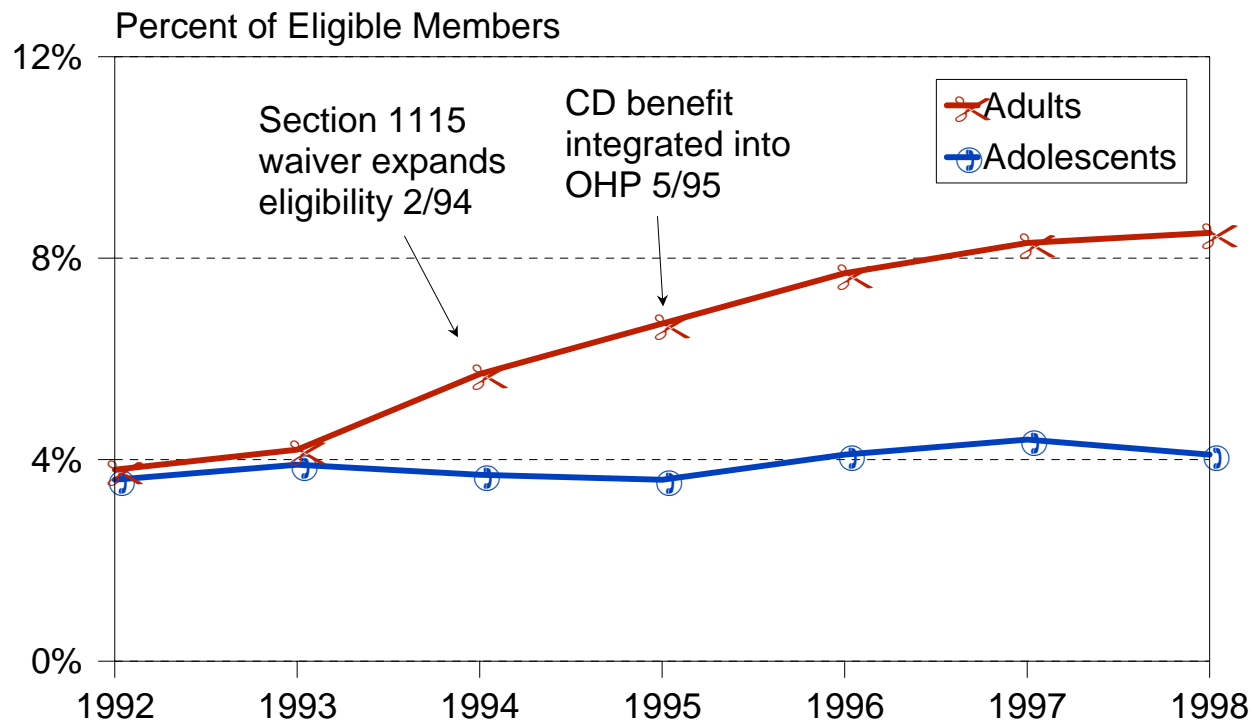
- About 30,000 adults received publicly-funded SA Tx in Oregon in 2000 – about 10,000 of them supported by Medicaid
- Major Tx modalities for OHP adults
  - Outpatient (60% – 70%)
  - Residential (10% – 15%)
  - Methadone Maintenance (5%)
  - Detoxification (15% – 20%)
- Distribution of modalities differs slightly for various Medicaid eligibility groups and for those supported by other public funded
- At the best of times, only 1 in 4 or 1 in 5 adults who need alcohol or drug treatment actually receive it (“Treatment Gap”)



# Rates of Access to SA Tx, 1992-1998: Oregon Adults and Adolescents

## Oregon Access Rates

*Eligible individuals admitted to treatment during year as percentage of average eligible members*

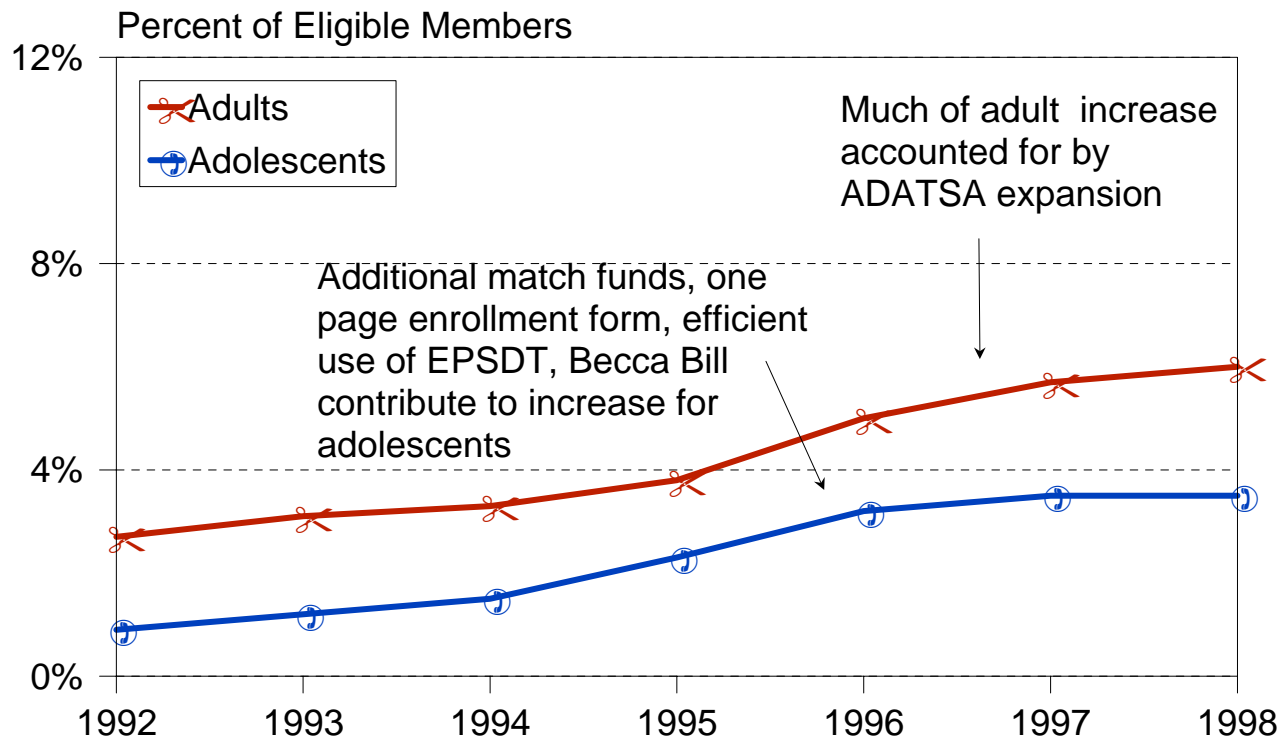


Source: State treatment database (CPMS) and Medicaid eligibility files

# Rates of Access to SA Tx, 1992-1998: Washington Adults and Adolescents

## Washington Access Rates

*Eligible individuals admitted to treatment during year as percentage of average eligible members*



Source: State treatment database (TARGET) and Medicaid eligibility files

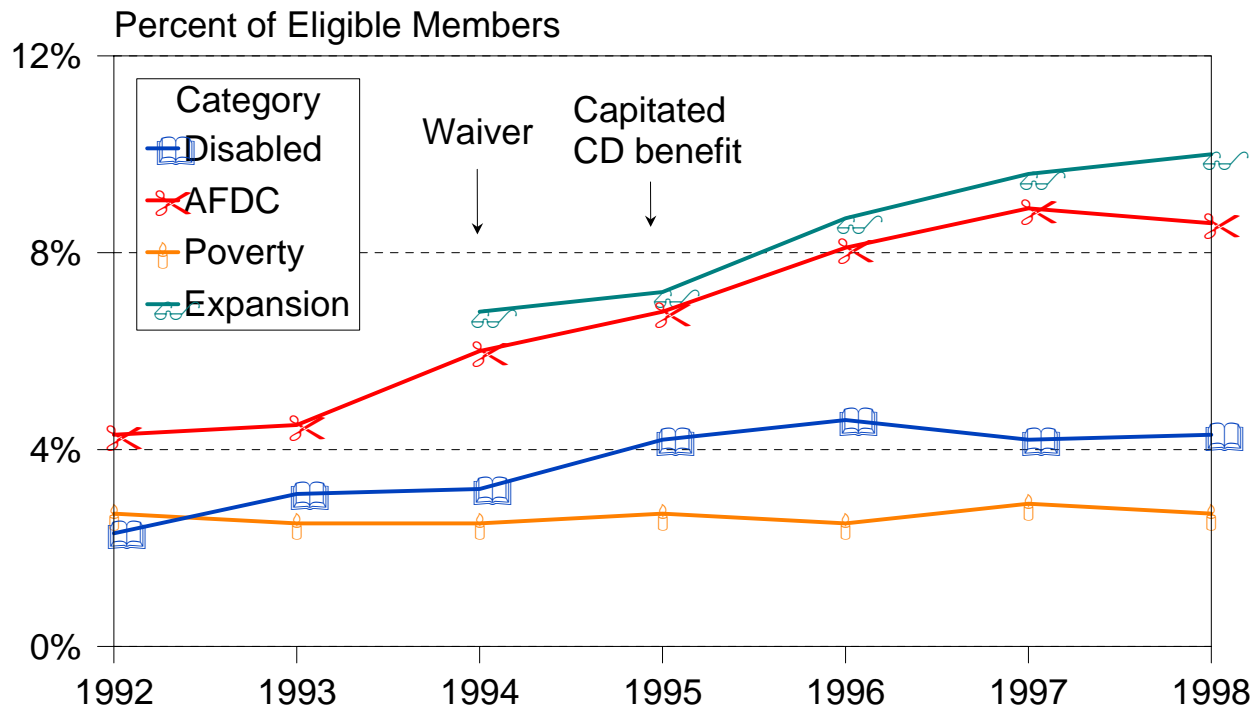
Deck (2000)



# Access to SA Tx by Medicaid Eligibility Group in Oregon

## Oregon Subgroup Access Rates

*Adults admitted to treatment during year as percentage of average eligible members*




Note. Rate for Other not shown, small group with changing composition  
Source: State treatment database (CPMS) and Medicaid eligibility files



# What We Learned about Access to Tx under the OHP

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- ❑ Contrary to concerns accompanying the shift to managed care, access to SA Tx did not decline; in fact it increased dramatically for adults under OHP
- ❑ No coincident reduction in access to Tx by other publicly-funded adults (i.e., not simply cost shifting)
- ❑ No difference in severity of clients treated under OHP vs. other public funds (i.e., not “skimming off the top”)
- ❑ Large variation in access to Tx for adults enrolled in different managed care organizations
- ❑ Little increase in access to Tx for adolescents



# What about Outcomes of SA Treatment?

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- Limited information available statewide from administrative databases. RMC formulation:
  - Retention in Tx (advantages over length of stay)
  - Tx Completion (clinical judgment at provider level)
  - Abstinence from AOD at discharge from Tx (self-report)
  - Readmission to Tx within year (a good thing? A bad thing?)
- More detailed, but less generalizable, information available from prospective sample studies
  - Addiction Severity Index (ASI): Degree of problems in alcohol use, drug use, mental health, medical condition, employment, criminal justice involvement
  - Global Appraisal of Individual Needs(GAIN): 8 outcome domains
  - Client Satisfaction with Tx Services
  - Interviews of client samples at Tx entry, 6 mos. and 12 mos. later



# Outcomes: Findings from Longitudinal Adult Study Samples

- ❑ Significant declines in all problem domains from baseline to 6 mo. follow-up. Improvement persisted, but did not continue, through 12 mo. follow-up
- ❑ Strongest difference with comparison state was in more significant improvement in mental and physical health among Oregon clients
- ❑ Greater, more lasting improvement among clients who were less severe, had fewer prior Tx episodes, and reported satisfaction with services received
- ❑ No differences in Tx outcome by gender, race/ethnicity, self-reported motivation/readiness for Tx, degree of integration in COD Tx



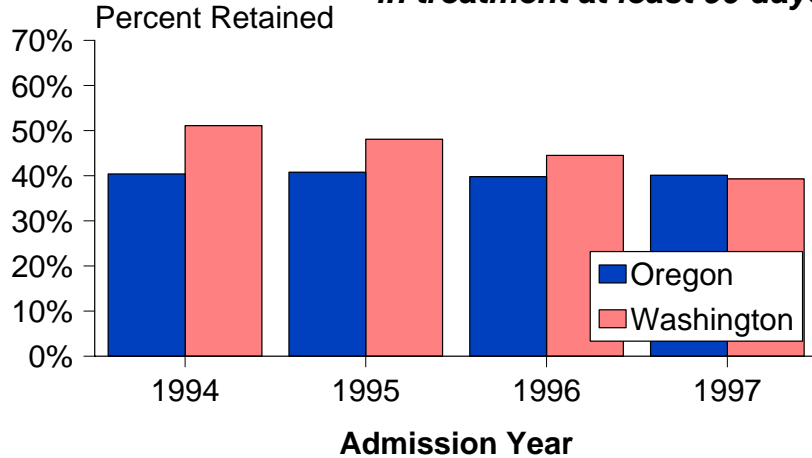
# What SA Tx Providers Told Us

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- ❑ Transition through Medicaid expansion and managed care included several phases and all were difficult. Providers had to become better “business people.”
- ❑ Objected to added layers of administration between funding and care; and alleged underwriting of financial losses on physical health care (fruits of integration)
- ❑ Different financing approaches across MCOs very influential in quality/consistency of care
- ❑ Mandating ASAM diagnosis and placement criteria significantly “professionalized” the field

## Retention in Outpatient Treatment

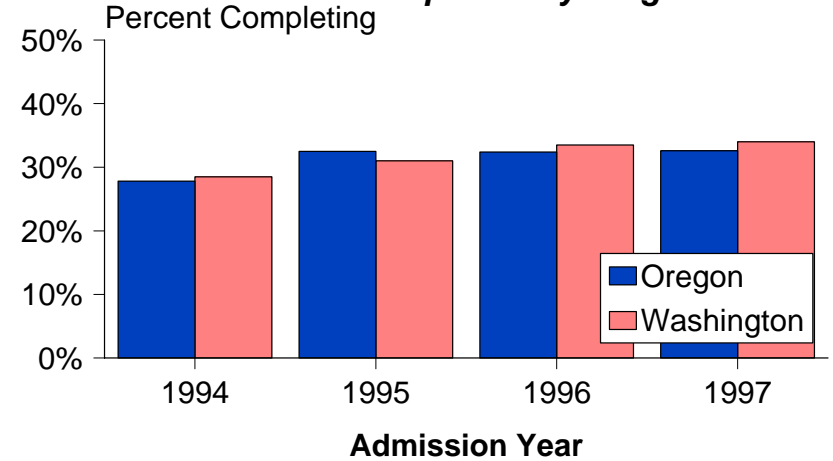
*Percent of eligible adults retained in treatment at least 90 days*



*Excluded deaths, incarceration, moves. Excluded outlier discharge dates.*

## Outpatient Treatment Completion

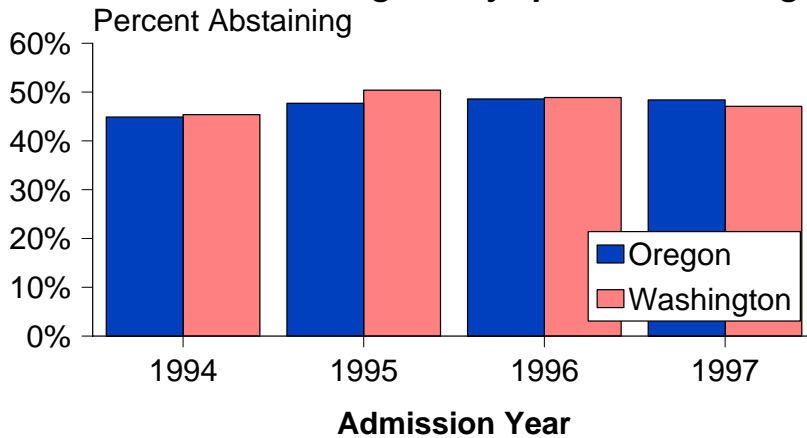
*Adults completing treatment as reported by drug counselor*



*Excluded deaths, incarceration, moves. Greater attention given to quality of outcome reporting in later years in both states.*

## Abstain at Discharge

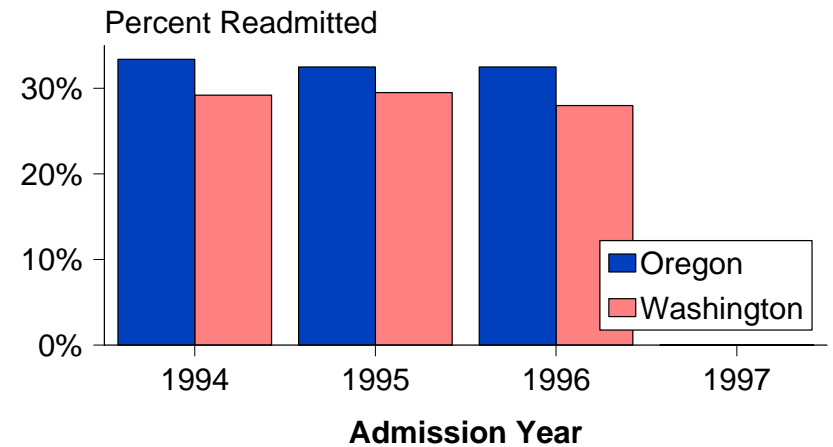
*Adults abstaining from use of primary drug during 30 days prior to discharge*



*Excluded deaths, incarceration, moves. Greater attention given to quality of outcome reporting in later years in both states.*

## Outpatient Treatment Readmission

*Adults readmitted to treatment within one year*



*Excluded transfers within 3 weeks of discharge, deaths, incarceration, moves. Part of difference may be due to multiple IDs for some clients in Washington.*

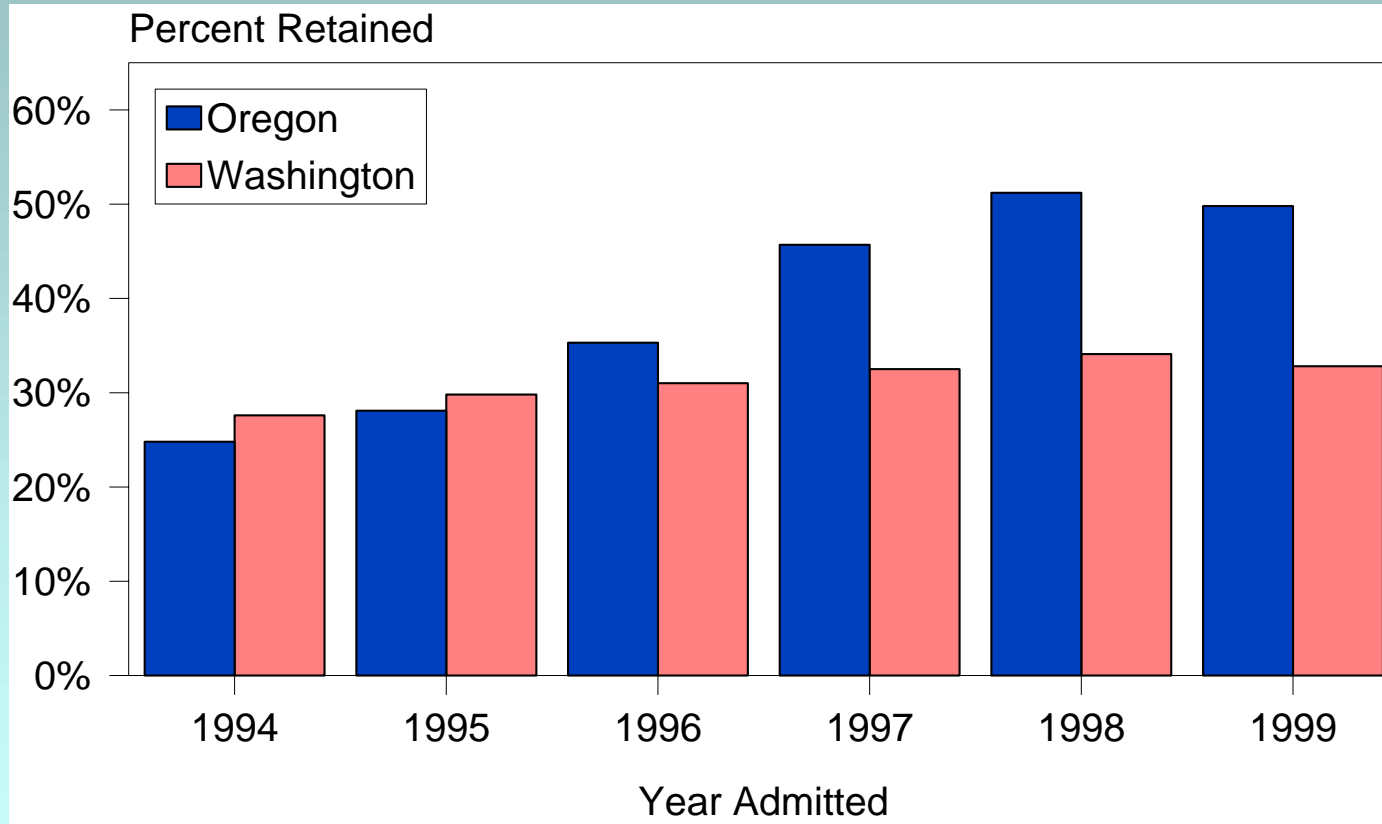


# Outcomes: Statewide Findings 1992-1998

- Little change in administrative data outcomes from pre- to post-OHP expansion; and similar trends to those found in comparison state, Washington
- For Outpatient Tx:
  - Retention inTx for at least 90 days: 40% to 50%
  - Tx Completion: 25% to 33%
  - Abstinence at discharge: 45% to 55%
  - Readmission to another Tx episode: 30% to 35%
- More positive outcomes for those who had longer continuity of Medicaid coverage and those with lower SA problem severity



# Methadone Outcomes: Retention (1 year)



Retention rates by admission cohort for adults (ages 18-64) entering methadone maintenance programs in Oregon (N = 6,863) and Washington (N = 5,308).



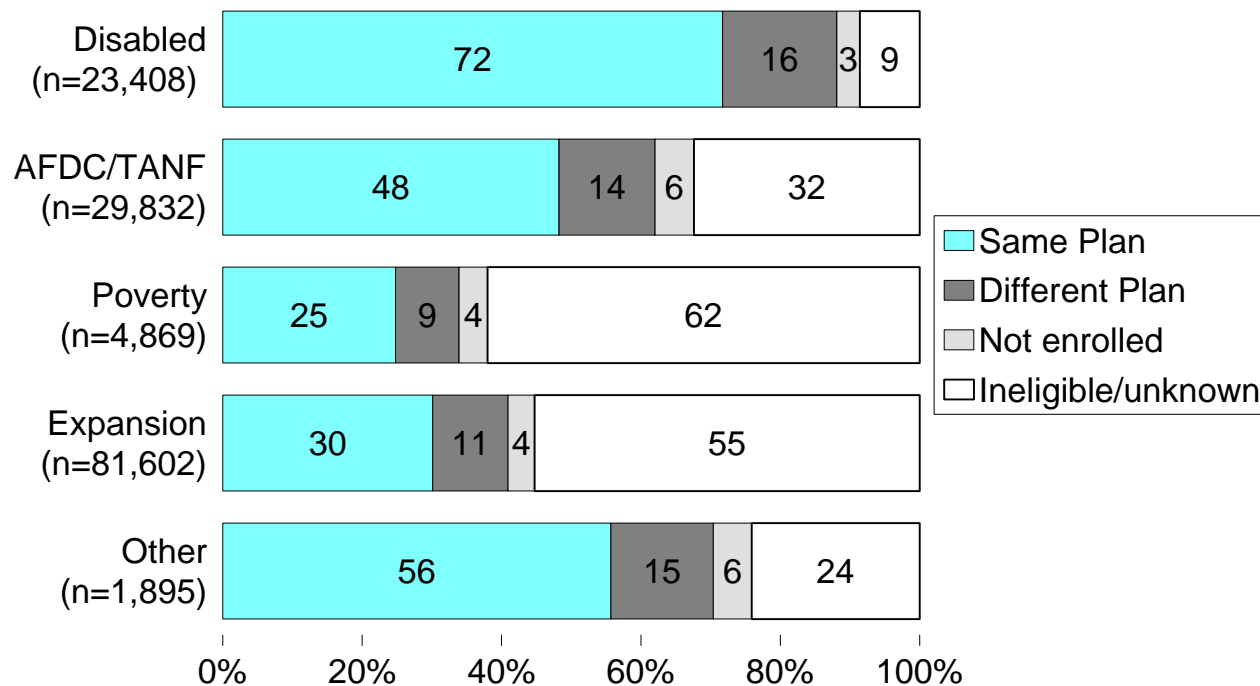
# Outcomes for Methadone: Retention (1 year)

- Increased retention in Oregon explains the dramatic increase in MMT utilization starting about 1997.
- Driving force appears to be more adequate financing in Oregon compared to Washington which led to state differences in provider behavior and ultimately better client outcomes.
- Forthcoming in Deck & Carlson (2005) JBHSR [Jan issue]
- We expect something of a reversal in the two states over the next year or two as the impact of cuts to OHPS in Oregon and expanded capacity and funding in Washington play out.

# Sidebar: Continuity of Insurance Coverage under OHP, the early years

## Stability of Enrollment

*Enrollment status of Oregon adults one year later by their eligibility category on 1/1/96*





# But That Was Then...

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- Changes in OHP since 2002 have affected SA services dramatically
  - Monthly premiums, co-pays
  - Elimination of SA/MH benefit for OHP Standard 3/03
  - 51% disenrollment in OHP beginning in 2003
    - Both voluntary and disciplinary
    - Disproportionate among lowest income, most medically needy
  - Decline in use of outpatient, methadone maintenance services since beginning of 2003 for both OHP Standard and Plus
  - Resumption of SA/MH benefit for OHP Standard, 8/03
  - Now what?



# RMC Continuing Study

## □ “Natural Experiment”:

Oregon Health Plan SA / MH Benefit Coverage  
by OHP Study Population and Time Period

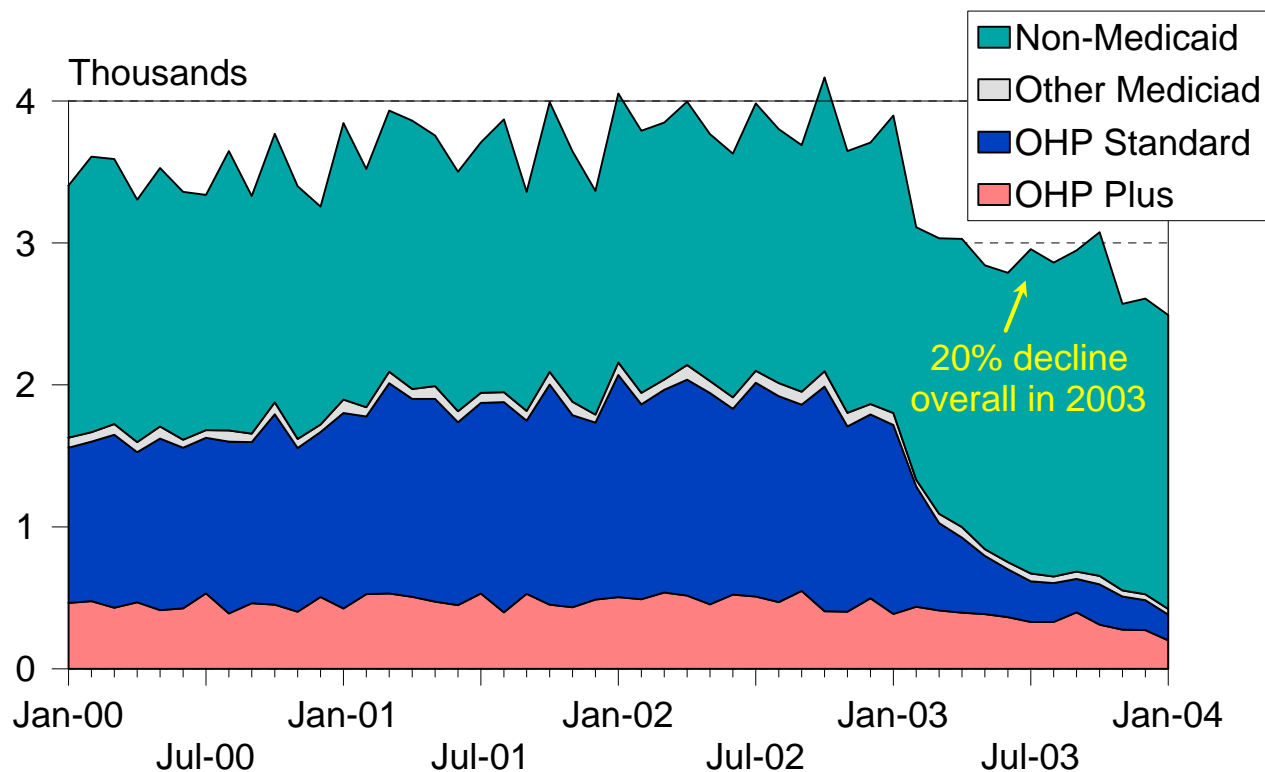
### OHP Policy-Relevant Time Period

	<b>Prior OHP (OHP: 1/00–12/02)</b>	<b>Restructured OHP (OHP2: 1/03–8/04)</b>	<b>Revised OHP<sup>1</sup> (OHP2: 8/04–)<sup>1</sup></b>
Medicaid: OHP Standard	Covered	Not Covered	Covered <sup>1</sup>
Medicaid: OHP Plus	Covered	Covered	Covered <sup>1</sup>
Non-Medicaid: Other Publicly Funded	N/A	N/A	N/A <sup>1</sup>



# Recent Trends: Access to Publicly Funded Tx

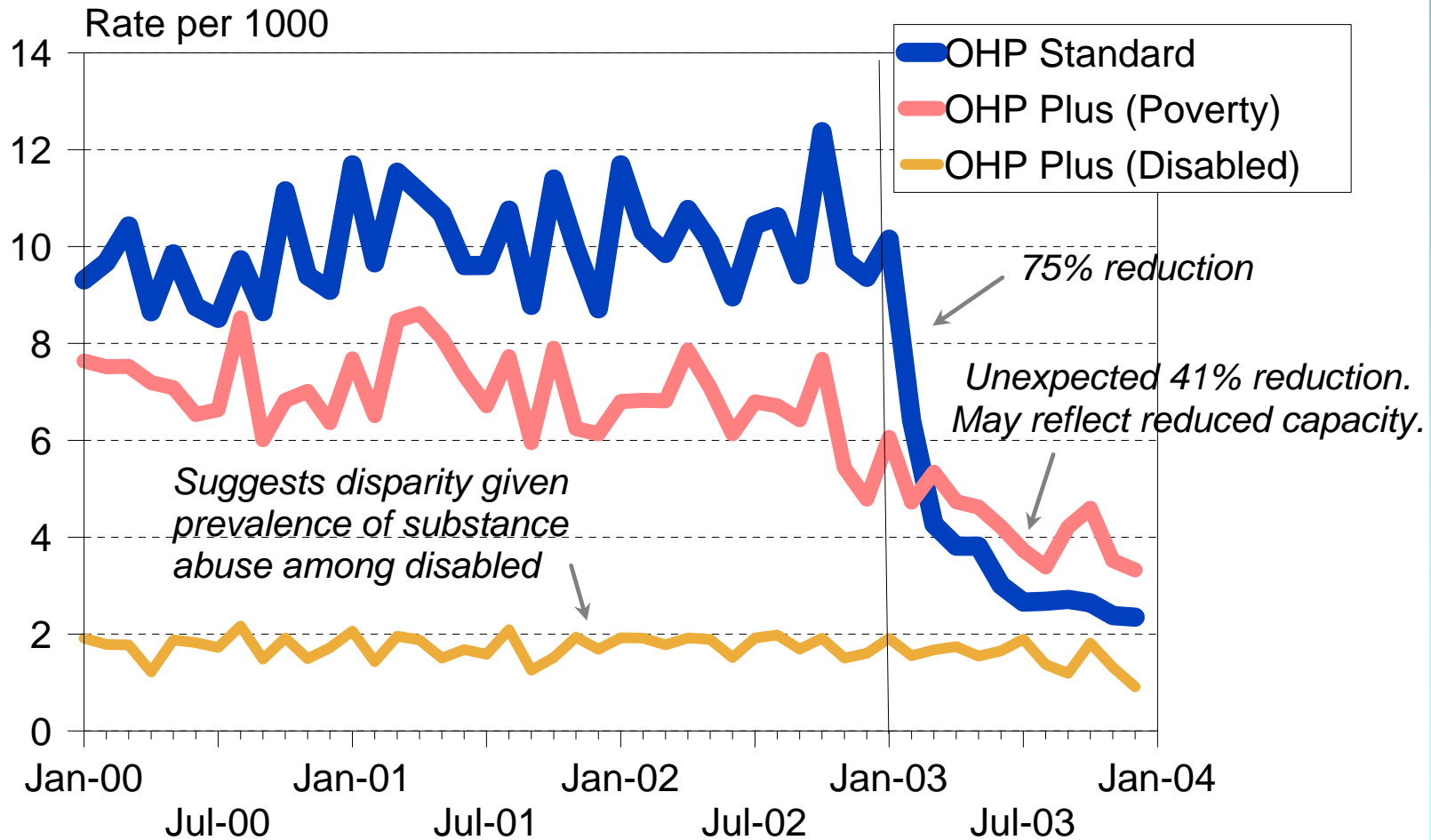
## Total Adults Admitted to any Publicly Funded Substance Abuse Treatment (including Residential Detox)



Unduplicated count by month. (% change based on 2002-03 averages)



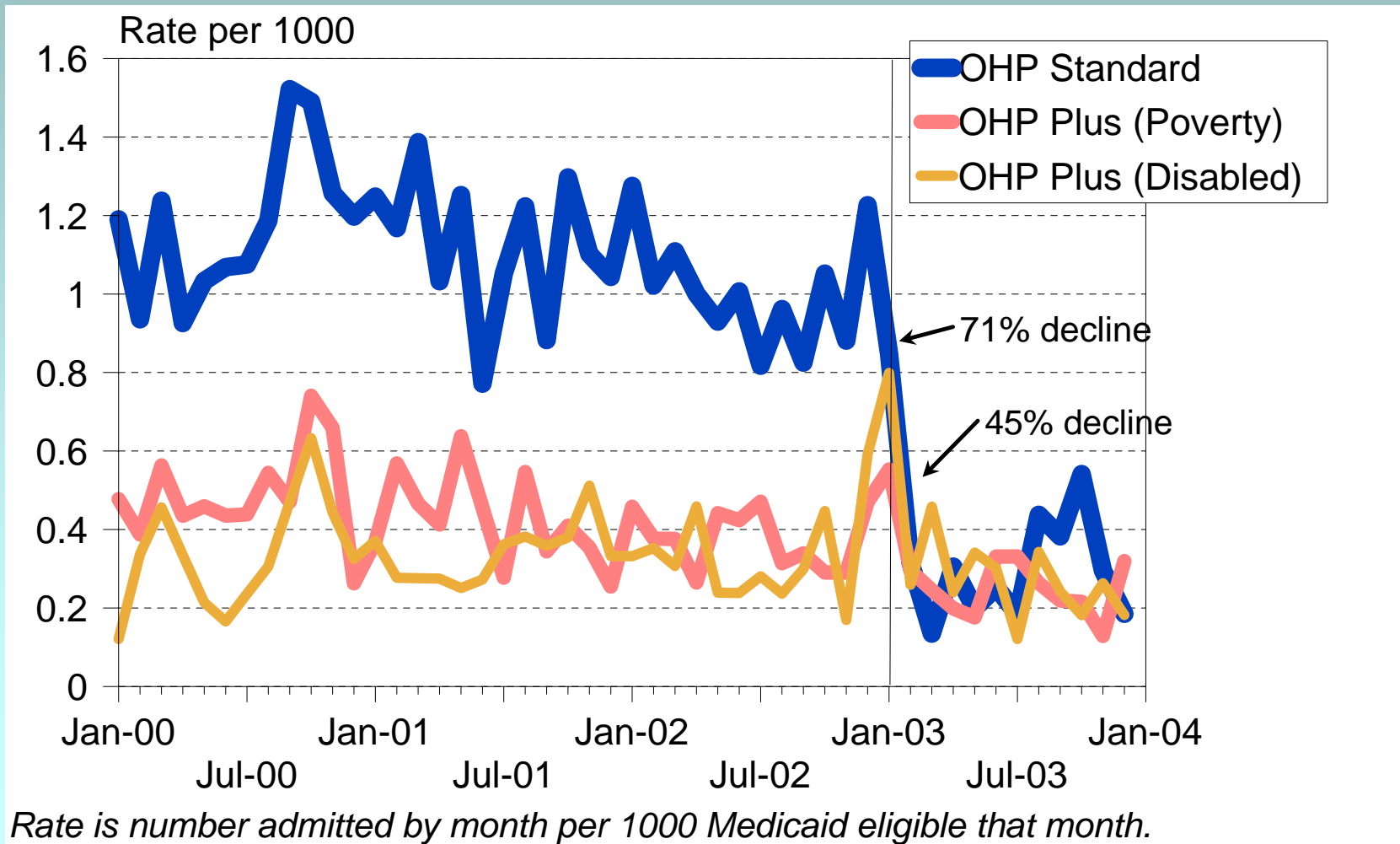
# Recent Trends: Outpatient Admissions



Number admitted by month per 1000 Medicaid eligible that month.



# Recent Trends: Methadone Admissions

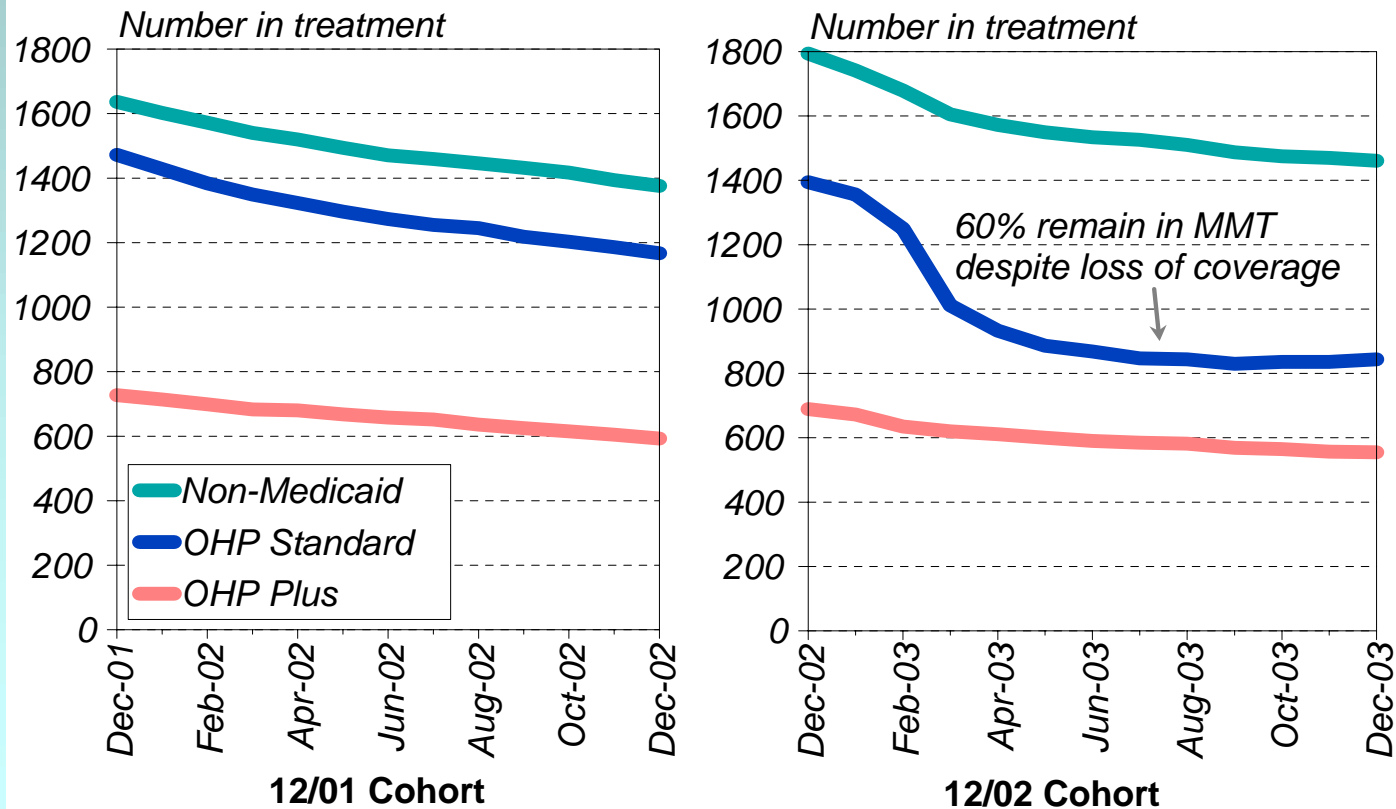




# Recent Trends: Impact on those in MMT

## Did those enrolled in MMT remain?

*Cohort Analysis: Follow continuous MMT enrollment (incl transfers) for two cohorts by Dec eligibility*

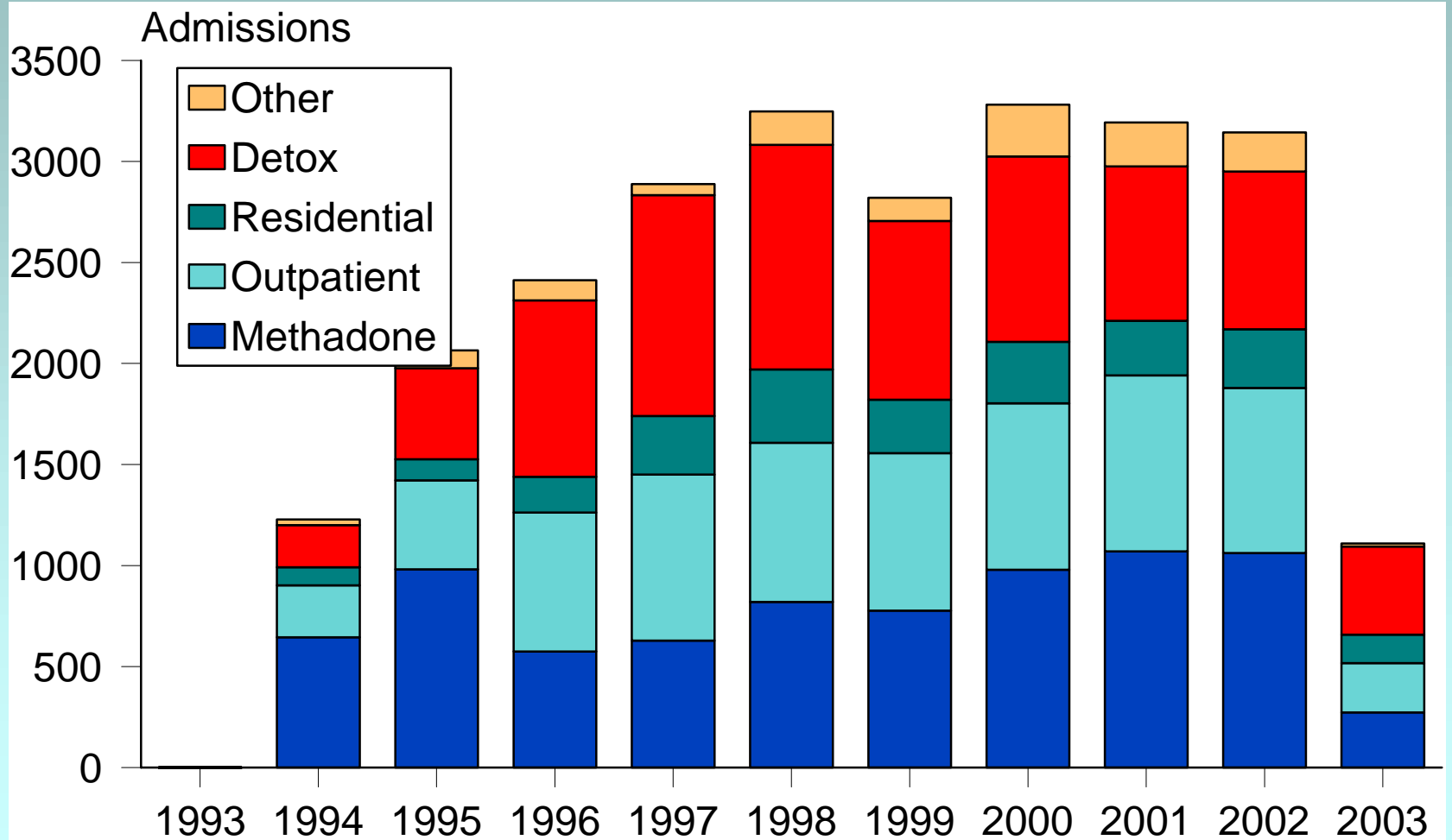




# Tentative Conclusion: General Impacts

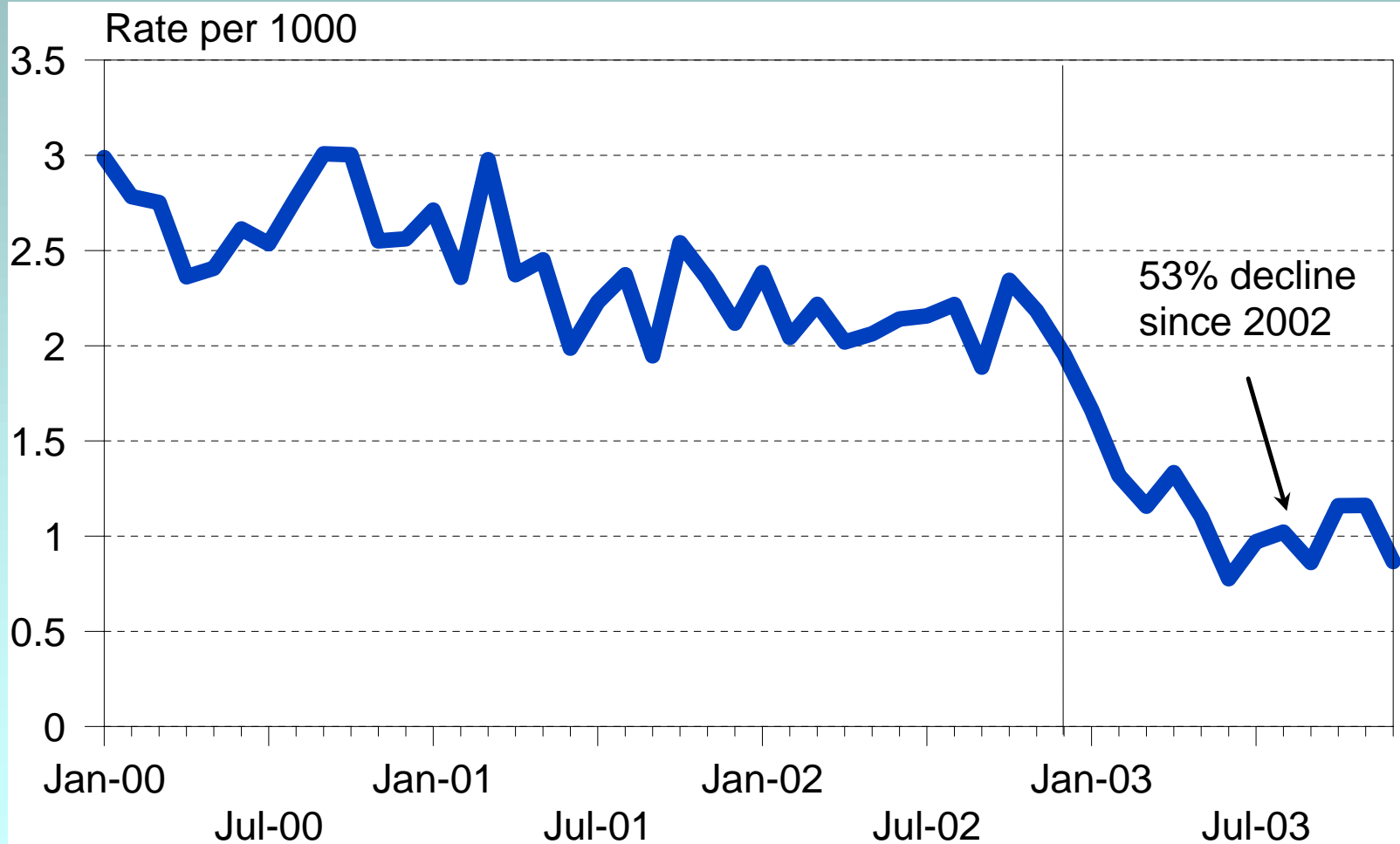
- The impact on OHPS was immediate and greater than can be explained by disenrollment from Medicaid.
- The impacts are not restricted to OHPS (or even Medicaid).
  - Our data suggests that there has been a broader decline in utilization, consistent with the provider reports of widespread layoffs and clinic closures.
  - Oregon faces potential penalties for failure to meet the Maintenance of Effort criteria for the SAPT Block Grant as a result of these declines.
- There is little evidence that those who lost coverage are getting treatment through alternative public sources or self-pay. There is only a modest increase in non-Medicaid admissions.
- The exception is that 60% of those enrolled in Methadone elected to self-pay (or payers/providers found stop gap funding to reduce impact). Who remains appears not to be a function of ability to pay but rather past history in MMT and severity.

# OHPS Admissions for Opiates





# Recent Trends: New opiate admissions (OHPS)





# Tentative Conclusions: Opiate addicts

- Opiate dependence is highly prevalent among OHPS (20% of those presenting for tx).
- In 2003, the rate of new admissions for OHPS opiate addicts dropped 53% (controlling for disenrollment) .
- Those who do present (controlling for disenrollment) are:
  - Less than half as likely to be placed in the most appropriate modality: a methadone maintenance program.
  - Usually have a past history of MMT.
- Thus we are no longer reaching many of the individuals we most want to get into treatment.



## So What? Why are we concerned about declines in participation in SA Treatment?

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- Individuals who need SA care and do not receive it will get help in hospitals, emergency rooms, or wind up in jail – all far more expensive than timely, effective SA Tx
- With all of its imperfections, SA Tx services for those who need them have been definitively shown to:
  - Reduce subsequent health care needs and costs
  - Reduce criminal behavior and incarceration rates
  - Increase employment rates and legal income



# Continuing Study Efforts

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- Tracking trends in SA and MH Tx access and utilization
- Interviewing samples of clients who expressed need for SA or MH Tx services or who had received these services prior to elimination of benefit 3/03.  
Retrospective inquiry into
  - Services received (SA/MH Tx, medical)
  - Employment, legal experience
  - Family relationships
- Interviewing administrators and providers at state, county and local levels
- Pushing results to policy forums



# Methodological Postscript

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- Believe strongly in complementary value of three-pronged methodology
  - Admin data comprehensive but full of developmental challenges and indicators are a bit blunt for program/system improvement purposes
  - Longitudinal studies provide sharper outcomes, but are very expensive and have limited generalizability
  - Key informant interviews and focus group provide unique insights and perspectives but not always accurate (“seldom right, but never in doubt”)



# Methodological Postscript (cont.)

- Longitudinal client sample studies suffer from absence of no-treatment control. Newly designed treatment vs “treatment as usual” studies are increasing, but ethical obstacles to having an equivalent “no treatment” group.
- Most convincing cost studies are those using administrative data, comparing over time:
  - Those who needed and received SA TX
  - Those with equivalent need but did not receive SA Tx