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Drug treatment program ownership, Medicaid acceptance, and service provision

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Abstract

The Institute of Medicine noted that effective substance abuse treatment (SAT) programs integrate individual therapeutic approaches with transitional/ancillary services. In addition, research suggests that type of ownership impacts SAT services offered and that Medicaid plays a key role in SAT access. Data from the National Survey of Substance Abuse Treatment Services for the years 2000 and 2002–2006 were used to examine relationships among SAT program Medicaid acceptance, program ownership, and transitional/ancillary service accessibility. Multivariate logistic regression models controlling for state- and program-level contextual factors were used to analyze the data. Nonprofit SAT programs were significantly more likely to offer transitional/ancillary services than for-profit programs. However, programs that accepted Medicaid, regardless of ownership, were significantly more likely to offer most transitional/ancillary services. The data suggest that Medicaid may play a significant role in offering key transitional/ancillary services related to successful treatment outcome, regardless of program ownership type.

Keywords: Substance abuse treatment centers; Medicaid; Treatment outcome; Health care

1. Introduction

Significant effort has been put into documenting evidence-based treatment methods associated with improved substance abuse treatment (SAT) outcomes (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). As part of such efforts, there has been a focus on the importance of transitional and ancillary services. Transitional/ancillary services have been found to be essential to successful SAT access and retention as well as short- and long-term treatment outcomes (Institute of Medicine [IOM], 2006; SAMHSA, 2009). It is the purpose of this article to examine how the accessibility of specific SAT program transitional/ancillary services relates to two other key SAT issues: treatment program ownership and program acceptance of Medicaid payment for SAT services. A more thorough discussion of transitional/ancillary services in the context of SAT will be provided, followed by a discussion of program ownership and Medicaid acceptance.

1.1. SAT transitional/ancillary services

SAT in the United States involves a wide variety of services including core components of assessment, screening, testing, pharmacotherapies, and various forms of counseling. Along with such services, two other main forms of services may be offered: transitional and ancillary services (SAMHSA, 2009). Ancillary services are those that give added support to clients, such as substance abuse education, case management, and social services assistance. Transitional services are those that aid in an individual

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successfully transitioning out of treatment and back into the community. This includes services such as discharge planning and aftercare or continuing care. Research has indicated that ancillary services are related to treatment program retention (Krupski, Campbell, Joesch, Lucenko, & Roy-Byrne, 2009) and long-term outcomes (Comiskey & Stapleton, 2010). Asche and Harrison (2002) found generally that those with higher substance abuse problem severity were more likely to need and receive ancillary services. Transitional/ancillary services have been shown to be particularly important for successful outcomes in specific populations such as drug-abusing females (Morgenstern, Hogue, Dauber, Dasaro, & McKay, 2008; Lewandowski & Hill, 2009) and female criminal offenders (Oser, Knudsen, Staton-Tindall, & Leukefeld, 2009), as well as criminal justice populations in general (Taxman, Byrne, & Thanner, 2002). The National Institute on Drug Abuse (NIDA, 2009) specifically noted that a key principle of effective drug addiction treatment is to include ancillary/transitional services as a core part of treatment services.

In its 2006 Report entitled "Improving the Quality of Health Care for Mental and Substance-Use Conditions," the IOM made a number of specific recommendations noting the importance of transitional/ancillary services that directly link treatment services with important community resources. For example, Recommendation 3-1 called for "maintaining effective, formal linkages with community resources…" (p. 12). The IOM report went on to note that mental health and SAT providers need to "coordinate their services and education agencies, such as schools, housing and vocational rehabilitations agencies, and providers of services for older adults" (p. 17). Community service linkages have shown themselves to be a core part of programs that successfully monitor proven treatment outcomes (Rush, Corea, & Martin, 2009). One method of ensuring service coordination is the ancillary service of case management. In 1998, SAMHSA issued a Treatment Improvement Protocol outlining core elements of effective case management in an attempt to move the SAT field toward implementing coordinating services (Cook et al., 1998). Comprehensive case management has been shown to be an important SAT component (Siegal et al., 1996), and clients with such case management have been found to receive significantly more transitional/ancillary services and to have significantly higher abstinence rates (Morgenstern et al., 2009). Overall, research and IOM/NIDA policy positions make the case for the importance of SAT transitional/ancillary services.

1.2. Medicaid payment acceptance for SAT

As Aday, Begley, Lairson, and Balkrishnan (2004) have argued, access is a key health care system goal. Medicaid has played a major and increasing role in SAT service access as private insurance involvement has decreased (Mark et al., 2007). A recent study illustrated that Medicaid is more likely to be accepted by outpatient SAT programs if the program is publicly funded (e.g., nonprofit) and located in a state that allows SAT coverage under its Medicaid policy (Terry-McElrath, Chriqui, & McBride, 2011). State policy allowing Medicaid SAT coverage has been shown to strongly and positively relate to both SAT admission rates (Deck & Gabriel, 2011; Deck, Wiitala, & Laws, 2006) and pharmacotherapy access (Heinrich & Hill, 2008; Ducharme & Abraham, 2008). However, no research has examined if treatment program-level acceptance of Medicaid for SAT significantly relates to the accessibility of transitional/ancillary SAT services.

1.3. Treatment program ownership

Health care facility ownership varies significantly across the United States. The federal government has a long history of providing health care through government-owned hospitals for veterans and Native Americans and through the Public Health Service (Jaffe, 2009). In addition, a variety of state, county, and city hospitals have provided care for the poor. The private nonprofit sector also has had a long tradition of providing hospital care (see Powell & Steinberg, 2006). However, with the increasing availability of capital to build hospitals under the Hill-Burton Act of 1947[1] and the emergence of a cost pass through reimbursement system where hospitals and physicians are able to obtain reimbursement from public and private insurance based on their documented costs (Morey & Dittman, 1996), the private for-profit sector also has became a significant provider of health care in recent decades. There has been considerable debate about differences in the quality of services offered and treatment outcomes between for-profit systems (that must please investors and return profit) compared with private nonprofit providers (that have often been perceived to focus on care quality). An important study by Sloan, Picone, Taylor, and Chou (2001) argued that there were no significant differences in survival or many other quality of life indicators by hospital ownership. However, other researchers have argued that the for-profit sector is less likely to serve the poor (Crampton et al., 2004) and that, overall, the nonprofit sector delivers higher quality care for Medicaid and Medicare patients (Aaronson, Zinn, & Rosko, 1994; Amirkhanyan, Kim, & Lambright, 2008). Schlesinger, Gray and Bradley (1996) found that the nonprofit sector was more likely than the for-profit sector to be involved in community prevention, education, and linkages. In a major attempt to analyze two decades of studies examining quality differences between for-profit and nonprofit health care systems, Roseanau and Linder (2003) concluded that nonprofits were superior to for-profit health care facilities in providing charity care, service access and quality, and cost-efficiency.

Although much of the discussion of the comparative impact of organizational ownership has focused on health

[1] Public Law 725, Hospital Survey and Construction Act.