Journal of Substance Abuse Treatment 94 (2018) 24–28

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

Access to treatment for alcohol use disorders following Oregon's health care reforms and Medicaid expansion

Dennis McCarty[a,b,*], Yifan Gu[c], Stephanie Renfro[c], Robin Baker[a], Bonnie K. Lind[c,d], K. John McConnell[a,c,d]

[a] OHSU – PSU School of Public Health, Oregon Health & Science University, Portland, OR, United States of America
[b] Department of Psychiatry, Oregon Health & Science University, Portland, OR, United States of America
[c] Center for Health Systems Effectiveness, Oregon Health & Science University, Portland, OR, United States of America
[d] Department of Emergency Medicine, Oregon Health & Science University, Portland, OR, United States of America

ARTICLE INFO

Keywords:
Alcohol use disorders
Medicaid expansion
Pharmacotherapy
Healthcare reforms

ABSTRACT

The study examines impacts of delivery system reforms and Medicaid expansion on treatment for alcohol use disorders within the Oregon Health Plan (Medicaid). Diagnoses, services and pharmacy claims related to alcohol use disorders were extracted from Medicaid encounter data. Logistic regression and interrupted time series analyses assessed the percent with alcohol use disorder entering care and the percent receiving pharmacotherapy before (January 2010–June 2012) and after (January 2013–June 2015) the initiation of Oregon's Coordinated Care Organization (CCO) model (July 2012–December 2012). Analyses also examined changes in access following Medicaid expansion (January 2014).

Treatment entry rates increased from 35% in 2010 to 41% in 2015 following the introduction of CCOs and Medicaid expansion. The number of Medicaid enrollees with a diagnosed alcohol use disorder increased about 150% from 10,360 (2013) to 25,454 (2014) following Medicaid expansion. Individuals with an alcohol use disorder who were prescribed a medication to support recovery increased from 2.3% (2010) to 3.8% (2015). In Oregon, Medicaid expansion and health care reforms enhanced access and improved treatment initiation for alcohol use disorders.

1. Introduction

The 2010 Affordable Care Act (ACA), in combination with the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA), set the stage for large-scale improvements in access to treatment for alcohol use disorders. Together, the two acts created policies that support integration of addiction treatment into primary care (Abraham et al., 2017; Barry & Huskamp, 2011; Buck, 2011) and, potentially, end the long-standing separation of treatment for substance use disorders from routine medical care (Institute of Medicine, 2006). Systematic tests of integrated treatment for opioid use disorders find reduced use, increased engagement in care, enhanced quality of life, and improved quality of care (Altice et al., 2011; Fiellin et al., 2001; Fiellin & O'Conner, 2002; Korthuis et al., 2011). The advantages of integrated care could extend to patients with alcohol use disorders because specialty addiction centers often operate without a physician on staff or access to a prescriber. In addition, the Affordable Care Act's 2014 Medicaid expansion added millions of individuals to state Medicaid plans, including many with alcohol and drug use disorders. The expansion may improve access to care for alcohol use disorders because the ACA defined addiction treatment as an “essential benefit” for anyone with private or public insurance (i.e., individuals eligible for Medicaid under the Medicaid expansion) coverage (Barry & Huskamp, 2011; Buck, 2011).

1.1. Oregon's health care transformation

Oregon transformed its Medicaid program in 2012 and authorized regional Coordinated Care Organizations (CCOs) (a form of Accountable Care Organizations) to manage and provide care for Medicaid beneficiaries. CCOs, locally governed community coalitions of health care providers and community stakeholders, assume financial risk and use preventive services and disease management to limit increases in cost of care to 3.4% per year and improve population health and quality of care (McConnell, 2016; Stecker, 2013).

CCOs receive a per-person global budget that integrates funding

* Corresponding author at: OHSU – PSU School of Public Health, Oregon Health & Science University, Portland, OR, United States of America.
E-mail address: mccartyd@ohsu.edu (D. McCarty).

https://doi.org/10.1016/j.jsat.2018.08.002
Received 4 February 2018; Received in revised form 3 July 2018; Accepted 6 August 2018

streams that were traditionally separated or carved out and includes funding for mental health care, substance use disorders, primary care, specialty medical care, transportation, durable medical equipment, and oral health care. Theoretically, this approach incentivizes CCOs to encourage the use of primary care in place of emergency department and inpatient hospitalization services. Global budgets were expected to promote integrated behavioral health and primary care because the most expensive members tend to rely on emergency care for mental health and substance use disorders. The CCO model also included incentive measures to promote improvements in the quality of care.

One incentive measure encouraged routine screening for alcohol and drug use and brief interventions when individuals appear to be at elevated risk of developing a disorder. CCOs and care settings trained practitioners and adjusted work flows to substantially increase screening and brief intervention for potential substance use disorders (Rieckmann, Renfro, McCarty, Baker, & McConnell, 2018). An additional performance metric monitored initiation and engagement in treatment for alcohol and drug use disorders (National Committee for Quality Assurance, 2018). CCOs encouraged primary care clinics to add licensed practitioners trained to address mental health and substance use disorders to their primary care teams to facilitate screening and initiate care.

CCO implementation was associated with reductions in health care expenditures due to declines in inpatient utilization and emergency visits (McConnell, Renfro, Chan, et al., 2017; McConnell, Renfro, Lindrooth, et al., 2017). There is evidence, moreover, of reductions in preventable hospital admissions, enhanced access to preventive care, and improved appropriateness of care (McConnell, Renfro, Lindrooth, et al., 2017).

1.2. Focus on alcohol use disorder

Alcohol use disorders are among the most prevalent and undertreated behavioral health problems. The 2016 National Survey on Drug Use and Health estimated that 14.8 million individuals 18 years of age and older (6.1% of the population) met criteria for diagnosis of an alcohol use disorder and needed care for the disorder. Most (14.2 million) who needed care, however, did not enter care. The study examined change over time in access to care for alcohol use disorders and the use of pharmacotherapies to support recovery from alcohol use disorders The analysis may illuminate the influences of health care reforms and Medicaid expansion on treatment for alcohol use disorders.

2. Methods

To assess CCO and Medicaid expansion effects on services for alcohol use disorders, the study team analyzed 5 years of de-identified Oregon Medicaid encounter data from before (January 2010–June 2012) and after (January 2013–June 2015) CCO implementation and Medicaid expansion (January 2014–June 2015). Because of the introduction of ICD-10 coding in October 2015, more recent data were unavailable for an extended analysis. The Oregon Health & Science University's Institutional Review Board reviewed and approved the protocol. A data use agreement with the Oregon Health Authority permitted access to Medicaid data.

2.1. Study population

The study population included individuals aged 18–64 years, continuously enrolled in Oregon Medicaid during a given half-year observation (described in more detail below). Recipients who were dually eligible for Medicaid and Medicare (because Medicare claims were not available) and individuals not assigned to a CCO (because of special health needs) were excluded from the analysis.

2.2. Measures

The study operationalized measures of a) alcohol use disorder, b) treatment entry, c) use of outpatient, emergency, hospital, or residential care, and d) pharmacotherapy. ICD-9 diagnostic codes for alcohol abuse, alcohol dependence and alcohol-related co-morbid conditions identified individuals with alcohol use disorder. Members were categorized as having an alcohol use disorder if they had one or more claims with an ICD-9 diagnostic code reflecting alcohol use disorders during the half-year observation period.

To determine treatment settings (i.e., outpatient clinics, primary care clinics, emergency departments, inpatient hospital care, and detoxification and rehabilitation services in addiction treatment centers), the analysis used the Current Procedural Terminology (CPT) code set, the Place of Service code set, Revenue codes, and the Healthcare Common Procedure Code System (HCPCS). Pharmacotherapy included medications with Food and Drug Administration approval to support recovery from alcohol use disorders: acamprosate (Campral®), disulfiram (Antabuse®), oral naltrexone (Revia®), and extended-release naltrexone (Vivitrol®). Codes used are detailed in Supplementary Table S1.

2.3. Analysis

Medicaid enrollment, claims and encounter data from Oregon's Health Systems Division covered 30 months prior to CCO implementation (January 1, 2010 to June 30, 2012), a six-month early implementation period (July 1, 2012 to December 31, 2012), and 30 months following CCO implementation (January 1, 2013 to June 30, 2015). Data were aggregated by semi-annual observations (January–June and July–December). The unit of analysis was the person half-year. These records were paired with pharmacy claims to determine the number and percent of persons with an alcohol use disorder who filled a prescription with medication that can support abstinence or reduced alcohol use. Medicaid recipients with an alcohol use disorder diagnosis were also paired with treatment claims to determine the percent who received care for alcohol use disorder.

Logistic regression models adjusted for age, gender, race/ethnicity, the presence of co-occurring psychiatric disorders (yes/no), residential geography (urban/rural) and time trend. The association of CCO implementation and Medicaid expansion with change in the percent of members diagnosed with alcohol use disorder and subsequent treatment for alcohol use disorder in a a) emergency, b) hospital, c) residential, d) primary, or e) specialty addiction treatment setting was analyzed. Pharmacotherapy for alcohol use disorder was also assessed. Models included an indicator for the post-intervention periods for CCO implementation (2013 to first half of 2015) and Medicaid expansion (2014 to first half of 2015) to test for immediate program effects and an interaction between time and post-intervention indicators to assess intervention effects on the time trend (i.e., sustained effects). To facilitate interpretation of logistic regression models with two interruptions (one for CCO implementation and one for Medicaid expansion), regression coefficients calculated a combined estimate of the change in odds over the 2.5-year intervention period given both reforms versus expected change in the absence of either reform (Taljaard, McKenzie, Ramsay, & Grimshaw, 2014). Standard errors were clustered at the individual level to address the correlation between the longitudinal observations for members with multiple observations. Models were not run for the use of acamprosate and extended-release naltrexone because the percent of patients using the medications was too small for stable models. Data management and analysis used R version 3.3.2 software.

3. Results

The number of members eligible for the analysis (met study inclusion criteria) grew from about 149,000 (2010) to 210,000 (2013) and,