Oregon's Coordinated Care Organizations Integrate Care for Drug Use Disorders

Project Summary/Abstract

The innovative Oregon Health Plan (Medicaid) is a national leader in healthcare reform. State legislation (passed with bipartisan support) authorized Coordinated Care Organizations (CCOs) to manage care for Medicaid recipients. In May 2012, Oregon received a five year $1.9 billion federal/state demonstration grant to transform care and the Centers for Medicare and Medicaid Services approved the changes in the Oregon Health Plan July 5, 2012. Eight CCOs began August 1, 2012 and six more September 1, 2012. Oregon is an ideal setting to assess the impact of healthcare reform on treatment for drug and alcohol use disorders.

CCOs integrate physical and behavioral health care in a single point of accountability (a patient centered primary care home) to increase access to care, control healthcare costs and improve health outcomes. Assertive preventive and disease management services seek to reduce unnecessary emergency and hospital care. Global budgets and shared savings promote quality of care. A major goal is to improve access to and utilization of services for alcohol and drug use disorders through integration with primary care.

The study compares and contrasts the integration of addiction treatment services within CCOs. Variations in integration and financing strategies are described and coded to assess associations with healthcare utilization. Oregon's All Payer All Claims (APAC) database provides a comprehensive description of utilization and permits counts of the numbers of patients a) screened, b) counseled, c) prescribed medications for alcohol or opioid use disorders, and d) tested with HIV rapid testing. The APAC data, moreover, record emergency visits and inpatient admissions. The study has three specific aims.

Specific Aim 1: Year 1—review and code approved CCO applications, interview CCO stakeholders to assess a) behavioral health integration strategies, b) outcomes monitoring, and c) system redesign for behavioral healthcare, and select eight CCOs for intensive study during Years 2 through 5; the 8 study sites serve urban and rural communities and vary in integration and financing strategies.

Specific Aim 2: Extract utilization data from the APAC data and a) compare CCOs, b) track change in spending and utilization on study measures (i.e., screening, counseling, pharmacotherapy prescriptions for substance use disorders, HIV rapid testing), and outcomes (i.e., use of emergency and inpatient care among individuals with diagnoses of drug and alcohol use disorders), and c) assess relationships between spending on and utilization of drug and alcohol services and expenditures for and rates of emergency and inpatient care.

Specific Aim 3: Complete a mixed methods assessment integrating qualitative (e.g., key informant interviews, observations) and quantitative data (utilization rates and expenditures) to identify individual, organizational, and contextual variables associated with use of addiction treatment services in patient centered primary care homes.