**State Report**

Integration And Its Discontents: Substance Abuse Treatment In The Oregon Health Plan

Oregon’s goal of integrating substance abuse treatment with physical health care remains elusive and may well be impossible.

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**ABSTRACT:** With the creation of the Oregon Health Plan (OHP) in 1994, Oregon placed its Medicaid program under a managed care system. This paper examines the managed care practices of seven health plans serving OHP enrollees between 1996 and 1998. Results indicated that the original vision of integrating substance abuse treatment services with physical care for OHP enrollees evolved into a multilayered, carved-out approach. Factors working against integration included changes in the administration and management of the chemical dependency benefit, financial losses by health plans, and lack of training and incentives for physicians to refer clients to substance abuse treatment.

**Medicaid reform** began in Oregon in 1987 and resulted in state laws that paved the way for the establishment of the innovative Oregon Health Plan (OHP) in February 1994. A Centers for Medicare and Medicaid Services (CMS, then HCFA) 1115a Medicaid waiver granted in 1993 nearly doubled the size of Oregon's Medicaid population and placed the responsibility for administering the health benefit under a managed care system. Some nineteen fully capitated health plans negotiated contracts with the state Medicaid agency and became responsible for the delivery of health care services. By April 1998 almost 85 percent of Medicaid clients were enrolled in one of these plans. However, through mergers, reorganizations, and discontinuation of services, only thirteen plans were serving OHP enrollees by the end of 1998.

Outpatient substance abuse treatment for Medicaid clients was included in the basic OHP benefit package and was placed under managed care in May 1995. Funding for the treatment (including methadone maintenance) was assigned to health plans as part of their capitation payments. Inpatient (including residential) treatment, not a covered benefit, was funded by a federal block grant.

Integration of substance abuse treatment within the OHP physical health benefit was a fundamental aspect of the plan, to ensure continuity of care and contain (or reduce) medical and surgical costs. Drawing on the perceptions of key stakeholders involved in the provision of substance abuse treatment for OHP enrollees, this paper describes the outcome of Oregon's effort to form an integrated system under managed care.

**Study Methods**

Data were obtained from three qualitative...
studies conducted in 1999, each with its own survey and sampling scheme. Respondents were selected for broad geographic representation and to include organizations serving the majority of publicly funded clients.

- **Study 1: survey of treatment providers.** As part of a larger study on the organization and financing of substance abuse treatment under managed care in Oregon, a survey was mailed to forty-five of the largest treatment providers in Oregon, each of which served at least 100 Medicaid clients in 1996—70 percent of Oregon's Medicaid client population receiving substance abuse treatment services that year. In all, thirty-five treatment providers (78 percent of the target sample) completed the survey. The survey asked respondents about their experiences with managed care and how it had affected their ability to provide treatment.

- **Study 2: telephone interviews of key stakeholders.** Sixty-seven key stakeholders across the state were interviewed via telephone in a second study that was commissioned by the state substance abuse agency to document experiences with and perceptions of Medicaid managed care and the substance abuse treatment system. The sample included sixty treatment providers, ten state agency staff representing six agencies serving the Medicaid population, and eight health plan and managed behavioral health organization staff. Forty-nine of the treatment providers (81 percent) in the sample and all eighteen of the state agency and health plan staff participated in the interviews. The number of Medicaid clients served by the sampled treatment providers in 1998 ranged from 9 to 1,077.

- **Study 3: interviews with health plan staff.** In a third study, face-to-face interviews were conducted to obtain the opinions of fourteen key health and managed behavioral health plan staff about the provision of outpatient substance abuse treatment services to their Medicaid clients from 1996 through 1998. Because a definable sampling frame within these health plans was lacking, key informants were identified using a modified snowball sampling procedure. The respondents held such positions as contracts manager, director of network development, substance abuse treatment managed care coordinator, chief operating officer, accountant, executive director, and program manager. Seven health plans were chosen because they enrolled 80 percent of Oregon's Medicaid population and were representative of the wide variations in organizational structures, payment mechanisms, and utilization management (UM) approaches used by health plans to manage the OHP's substance abuse treatment services. The interview questions focused on the plans' financial and risk arrangements with treatment providers and other subcontractors, UM practices, and quality-of-care oversight.

**Barriers To Integration**

Integrating substance abuse treatment with physical health care was hindered by several factors, as described below:

- **Plans' use of managed behavioral health care.** In the early stages of implementing the OHP's chemical dependency benefit, health plans were directly involved with the administration and management of substance abuse treatment for their Medicaid clients. All of the plans contracted directly with substance abuse treatment providers and also (in some service regions) with managed behavioral health care organizations. Over the course of the three-year study period, the health plans did less and less direct contracting with the former and relied more heavily on the latter to manage the treatment provider panels and networks, payment policies, and UM services. During the study period all seven health plans subcontracted with one to four managed behavioral health care organizations across the state to manage some or all of their substance abuse treatment services.

When asked if their health plan carved out the OHP's chemical dependency benefit, most of the health plans' key respondents maintained that these services were integrated with physical health services, not carved out. Nomenclature was challenging when discussing these issues with health plan staff. They readily agreed that the terms *integrated* and
carve-out were not always used in the same way by those in the insurance industry. Health plan respondents maintained that the fully capitated health plans were ultimately responsible for the provision of those services, were at financial risk, and had the final say in any decisions regarding the provision of treatment services. Therefore, they believed that their services were integrated.

The treatment providers asserted that the devolution of management of services to managed behavioral health care organizations had fragmented service provision, adding another layer of bureaucracy. Also, according to the providers, the organizations’ administrative fees, in addition to the health plans’ administrative fees, consumed already scarce resources for substance abuse treatment.

Health plans maintained that they contracted with the organizations because it was more cost-effective to do so than to employ in-house staff with the expertise to manage the program. Some plans already had established relationships with managed behavioral health care organizations because these organizations managed the behavioral health benefits for the plans’ commercial clients. The organizations were also attractive because some had their own treatment provider networks and staff that had expertise in substance abuse treatment. Substance abuse treatment providers viewed the use of these organizations as evidence of health plans’ lack of commitment to providing high-quality substance abuse treatment by shuffling responsibility to other organizations and thereby fragmenting further the continuum of care.

Mental health carve-outs. Two key aspects of the organization of mental health services under the OHP hindered the integration of substance abuse treatment with physical health care. First, Medicaid mental health services were carved out from physical health services, and second, they often involved a different set of managed care organizations than those used for substance abuse treatment. Mental health services were originally slated to be integrated into physical health services along with substance abuse services, but the mental health community fought integration, fearful that the community mental health programs that had provided the majority of public mental health care prior to the OHP would lose their authority and funding. Also, many health plans were not interested in providing mental health services.

The Oregon state legislature mandated that mental health care services be provided by carved-out mental health organizations or health plans under a managed care system. After a phase-in period, mental health services were fully incorporated into the OHP statewide in January 1998. The carve-out system for mental health services created a confusing array of mental health organizations, health plans, community mental health programs, and a consortium of rural mental health providers. Depending on their county of residence, OHP enrollees could have a single fully capitated health plan handling all of their physical and behavioral health care needs; a health plan for their physical care and chemical dependency treatment but a community mental health plan for their mental health needs; or a health plan with a mental health contract but not in the county where they reside, requiring them to go to a community program.

Substance abuse treatment providers had great difficulty referring their clients to mental health services because of the separate and multilayered systems. Providers who offered both mental health and substance abuse treatment services experienced difficulty securing payment for the mental health services, as there were two separate reimbursement systems. Unfortunately, neither system had a payment category for dually diagnosed persons. Structuring OHP mental health services as a carve-out derailed attempts to link primary care physicians, substance abuse treatment providers, and mental health care providers in a more integrated, coordinated, and holistic treatment system for enrollees.

Health plans’ financial losses. Another barrier to integration was financial. Administrative costs were high because of Medicaid’s extensive contractual require-
ments and the exceedingly high turnover rate among enrollees.\textsuperscript{14} Statewide data show that nearly 60 percent of Oregon’s Medicaid population either switches health plans or loses Medicaid eligibility in a calendar year.\textsuperscript{15} A state-commissioned actuarial review of the four largest health plans showed that these plans had lost money on both their Medicaid and commercial lines of business, mirroring a nationwide trend.\textsuperscript{16} Also, a financial report for 1996–1998 found that five of the seven health plans included in our study incurred net losses.\textsuperscript{17} Prescription costs were among the greatest contributors to these losses, with more than 3.7 million prescriptions dispensed in 1998 alone, at a cost exceeding $102 million.\textsuperscript{18} Many plans left the OHP because of these losses: In 1994 there were twelve plans serving OHP members in the state’s largest urban county; now there are three.

One of the drawbacks to an integrated model is the opportunity for health plans to cover physical health care costs with money designated for behavioral health care services.\textsuperscript{19} Indeed, treatment providers complained that the OHP capitation for the chemical dependency benefit was used by health plans to offset medical or surgical costs. Some health plan respondents acknowledged that this shift happened in the OHP’s early years because use of substance abuse treatment services had not increased as rapidly as use of medical and surgical services had. However, as substance abuse treatment expenses increased over time and began to approach the capitated amount, plans no longer had this funding flexibility. In fact, the chemical dependency capitation, which averaged $3.41 per member per month between 1995 and 1997, amounted to a small percentage of the total capitation payment from the state (approximately $150 per member per month).\textsuperscript{20} The use of unspent substance abuse dollars to offset financial losses did little to reduce plans’ losses and only served to increase ill will and mistrust among their substance abuse treatment providers.

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\textbf{Physician referrals for substance abuse treatment.}\ Another barrier to integration was the lack of substance abuse treatment referrals by physicians. Data from the state substance abuse agency show that in the seven health plans, physician-initiated referrals accounted for only 3 percent of all referrals to substance abuse treatment during the three years studied. Two of the seven plans offered substance abuse treatment services by clinicians affiliated with the plan. These two plans had slightly higher physician-initiated referral rates (averaging 3.5 percent of substance abuse treatment clients across the three years) than the other five plans had. This rate, however, still falls far short of the state’s aspirations and is four to eight times lower than referral rates from the legal or social service systems.
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When substance abuse treatment services were placed under managed care in 1995, the state substance abuse agency required health plans to ensure that their panels of primary care physicians would identify and screen their patients for substance abuse problems during routine physical exams. Although OHP members can refer themselves to substance abuse treatment, the state agency believed that primary care providers could play an important role by encouraging patients to seek out and follow through with treatment.

Health plan and managed behavioral health care organization staff reported that they made some attempts to encourage physicians on their panels to refer OHP clients for substance abuse treatment. Respondents admitted that the task was difficult because, as they stated, “physicians are a breed unto themselves.” Some health plans periodically sent newsletters containing information about substance abuse treatment issues to their physician panels. Other respondents mentioned that the state had created a course for physicians about recognizing the signs and symptoms of sub-
stance abuse. However, the course lasted for six hours and was offered on Saturdays, which made it unappealing to busy physicians. Other obstacles cited by health plan and managed behavioral health care organization respondents included getting physicians to meet with them or read the mail they sent about substance abuse treatment issues. Only one health plan respondent said that the plan offered incentives to physicians to increase substance abuse referrals. However, there was no change in that plan’s referral rate, which averaged 3 percent across the three years studied (the same rate as in the other health plans). After these initial efforts at increasing physician referrals failed, health plans and the state agency directed their efforts elsewhere.

An Uncertain Future

As the OHP enters its seventh year of providing capitated substance abuse treatment under a managed care system, the vision of its integration with physical health care is at best elusive and may well be impossible to achieve in the current climate.

All health plan respondents stated that they wanted to participate in the OHP, that they wanted to provide high-quality care to all of their members, and that they were not expecting to make a profit but could not sustain indefinitely the large losses on the medical-surgical side of the plan. Consequently, three of the largest health plans in the study left the OHP.

Integrated health care was not a high priority for health plans, as evidenced by their meager efforts in working with primary care providers and by their shifting the management of the chemical dependency benefit to managed behavioral health care organizations. Although integration was important to the state substance abuse authority, other concerns diverted its attention elsewhere. Having mental health services carved out from physical health care further weakened any efforts to provide a continuum of care for OHP members.

Oregon’s governor, the chief architect of the OHP, and its legislators are revamping the plan to distribute the burden of financing health care for uninsured Oregonians more equitably. Some of the cost-sharing strategies suggested include reducing the basic benefit package for some Medicaid clients, expanding coverage to the uninsured, using copayments, having employers contribute toward premiums for low-income workers, and leveraging federal dollars, all of which will require a new federal waiver. How behavioral health benefits will fare during this revamping process is uncertain. States are not required to pay for mental health or substance abuse treatment, and although there are no plans to remove these benefits from the OHP, there is concern among treatment providers that requiring copayments could create barriers to substance abuse treatment.22

The OHP’s future is yet to be determined. The vision of an integrated health care system is still embraced by state leaders, and there is a desire by the state Medicaid office to bring back private insurers to cover OHP members.23 Whether or not there is renewed effort by the private and public sectors to develop a plan for integrated health care remains to be seen.

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NOTES


3. Lierman, *The Oregon Health Plan*.

4. Office of Medical Assistance Programs, *Oregon Health Plan*.


10. Ibid.


13. Ibid.


17. Lierman, *The Oregon Health Plan*.

18. Ibid.


22. Ibid.

23. Ibid.