

Addictions and Mental Health Division (AMH)
Integrated Pilot/Demonstration Project
Small Group Outcomes
April 3, 2009

Workgroup 1 - System Structure

The proposed demonstration pilot(s) need to be organized in a manner that ensures services and supports are identified and provided 24/7 based on an individual's needs and strengths with available funding so that people receive the identified services and supports in their communities within a recovery model context.

Themes for this workgroup have been consolidated and are identified as follows:

- Pilot entities must provide and pay for a service array beginning with prevention services and progressing through all levels of need including state hospitalization; e.g. outpatient, crisis, housing, education, employment. (“All-in” concept)
- All services must be consumer-driven based on a uniform assessment of need.
- Pilot entities must meet community/regional needs as defined by each involved community/region; must be flexible and innovative; must address cultural components within urban, rural and frontier communities.
- Pilot entity outcomes must be clear and measurable with a focus on evidence-based practices.
- Pilot entities must have a governance system linking the management of public health, mental health, addictions and physical health in a manner that promotes/includes consumers of public health, mental health services, addiction services and physical health services; the governance system must identify and mitigate risk and liability for demonstration failure.
- Adequate funding for the pilot entities must be secured from the legislature; AMH must provide comprehensive training for and monitoring oversight of pilot entities.
- Pilot entities must demonstrate administrative savings.
- State structure needs to reform and integrate using the values upon which pilot entities are based (e.g. integration of addictions and mental health services, dissolution of competing administrative rules, statutory changes as needed).

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Workgroup 2 - Performance Based Contracting

The goal was to follow up on the idea that the service payment process needs to focus on achievement of measurable outcomes. Some of the major themes from the discussion were:

- Individual outcomes vs. system outcomes
 - There was much discussion about the relative value of individual outcomes vs. system outcomes as a metric for performance based contracting. Most participants felt that system outcomes (reduced hospitalization, increased access, etc.) would be easier to track and implement in a pay for performance scenario—particularly when measuring the performance of a managed care type entity.
- AMH vs. Managed Care Role in setting outcomes
 - Individual outcomes were seen as more relevant to tracking the performance of specific providers or even services. It may be that the managed care organization could have an internal process to pay for performance based on different types of services/providers. Alternatively, the state could require specific outcomes among the package of service the managed care entity would be responsible for delivering.
- Base payment plus incentives vs. other methods
 - There was concern about how the payment system would work. Most assumed that there would need to be a base payment. Achievement of outcomes/goals would create incentive payments or “bonuses” doled out on a regular basis.
- CMS concerns
 - There was concern about how we would balance a requirement for the submission of claims along with outcome information, while conceding that some outcomes can be derived from claims information. Several suggested DHS re-examine its rate setting process, noting that DHS not CMS dictates the FFS emphasis of the current methodology. CMS requires an actuarially supported methodology. There are other methodologies that could fit better into a performance-based system.

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- Start Simple
 - The process used for performance reimbursement should start simple, be based on currently available data, and the provider should be held harmless for the initial period(s) of the contract.
- Internalize performance incentives
 - Several times it was stated that the system could be set up so providers' performance was "self-rewarding". In other words, if they do what they are supposed to do they will have more funds available for a broader array of services and be more successful. If not then they will not remain financially viable for long.
- Avoid gaming of the system
 - Be sure to build in a mechanism that rewards the Entity for treating "difficult" clients, otherwise it is too easy to avoid them in order to maintain good performance.
- Investment upfront
 - There needs to be an investment upfront on making sure that the managed care entity has the infrastructure to track and supply needed outcome information in a timely manner. Similarly, AMH needs to be able to process the information and work with the Entity in a timely manner so good and poor performance can be dealt with swiftly.
- The managed care entities need to work with AMH during the contracting process to set up an agreed upon set of outcomes.

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Workgroup 3 - Financing and Payment Methodologies

- Reviewed summary of current fund sources and payment methodologies:
 - OHP Medicaid, Capitation payments to MHO, and FCHP,
 - Non-OHP Medicaid, Fee for Service to providers,
 - State General Fund, monthly payments
 - Block Grants: monthly payments
 - Federal Substance Abuse Treatment and Prevention
 - Mental Health Block Grant
 - Lottery Funds for Treatment of Problem Gambling, monthly payments
 - Oregon State Hospital, Legislatively Approved Budget
- Use experience from other states.
- Recommendation to use braided, rather than blended funding in pilots.
- Clarify the regulatory requirements of each fund source.
- Require local sites to include as many local funds as are available under the same management structure.
- Include as broad a range of services as possible, “all in.”
- Allow the design of the regional pilot and to some degree the financing to be determined by the locality or region, bottom up to maintain flexibility.
- Expectations should be realistic considering available resources.
- There are costs to transforming a system that cannot be generated through efficiencies, consider providing sites with initial start up funds as an incentive.
- Guard against unintended cost shifts by tracking outcomes in Child Welfare, Juvenile Justice, Adult Criminal Justice, as well as Primary Care, Emergency Rooms and Hospital.

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Workgroup 4 - Goals for Integrated Addictions, Mental Health, and Physical health pilots

- An integrated system of healthcare should be focused on prevention and holistic care at the community level, focused on the reduction of high end services, and focused not just on episodes of treatment, but should follow someone throughout their life span.
 - Invested in the use of Evidence Based-Practices
 - Use of a standardized, integrated assessment process
 - Coordinated, single treatment plan
 - Integration of co-morbidities treatment such as addiction and chronic pain
 - Coordination with other social service departments serving the same individuals such as CAF as a way of reuniting families
 - Coordination with criminal justice
 - A variety of on-site resources with the capacity to meet multiple health needs
 - A flexible system that offers integrated, culturally specific programs and services
- The integrated system should have the level of sophistication necessary to streamline administrative costs and an ability to collect and analyze data for a variety of quality measures
 - An ability to track utilization and outcomes recognizing that there may be different outcomes associated with different sub-populations
 - An ability to demonstrate administrative savings
 - An ability to demonstrate medical cost-offsets related to access to appropriate addictions and mental health services
 - Elimination of redundant paperwork
 - Standardization of billing codes
 - The use of standardized methodologies to track outcomes
- A system that is integrated with the community and emphasizes prevention, resilience, and recovery as well as treatment
 - Promoting the recovery model to the community through community education and outreach
 - Promoting mutual understanding and common language among the three primary spheres including physical health, mental health and addictions
 - Promoting safe and stable housing supports
 - Utilization of peer-delivered services
 - Utilization of supported employment

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Workgroup 5 - Essential Services to Support Recovery

The purpose of this workgroup was to identify essential services in primary health care, mental health care and substance use disorder care that need to be considered in an integrated system. The discussion included other considerations in integrating an array of services. Key themes that emerge from the discussion include the following points.

- Identified Services
 - Housing and associated supports
 - An array of crisis services for both mental health and addictions services
 - Prevention
 - Early intervention
 - Trauma informed services
 - Services that consider address developmental, cultural and gender issues
 - Civil commitment investigations
 - Outreach services
 - Supports to access services such as transportation and child care
 - Family inclusive services
 - Dental care
 - Smoking cessation
 - Services for person in or entering the corrections system
 - Education and employment supports
 - Medication management

- Other considerations
 - Peer delivered services and supports in the continuum of care
 - Workforce development, cross training
 - Community education to combat stigma
 - Move away from a system that focuses on discreet episodes of care
 - Provide an exit from the services
 - Have mental health providers consider physical causes of distress and primary care providers consider a mental health or addictions basis for symptoms
 - Shift from a system of care that is based on the age of consumers
 - Families and consumers to be involved in system planning and oversight
 - Electronic records
 - Self-directed care