



**Report to
Joint Committee on Ways and Means
Subcommittee on Human Services**

***Integrated Management and Service
Delivery Model
Version 1.2***

**Developed by:
Addictions and Mental Health Division
Department of Human Services**

April 23, 2009

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Executive Summary

A concept paper, based on the information, issues and recommendations of the Public Consulting Group and Human Services Research Institute reports was developed by the Department of Human Services, Addictions and Mental Health Division (AMH) staff at the request of the Ways and Means Human Services Subcommittee Co-Chairs, Senator Bates and Representative Kotek. There was invited testimony before the Ways and Means Human Services Subcommittee from organizations, physical health providers, mental health providers, alcohol and drug providers, consumers and advocates to discuss the concept paper in detail.

AMH recommends the establishment of two or three demonstration projects that meet the criteria described in the report. These will be collaborative demonstrations between each project and the state in order to solve problems as they occur and make adjustments in order to assure the continuous provision of services to the clients. As a result of the demonstrations, AMH expects to learn what is needed to better integrate the funding management and delivery of all services, including health care, to people with addiction disorders and to people with mental health disorders.

At the end of the demonstration, AMH expects to:

- Integrate the addictions, health and mental health service system;
- Develop an outcomes-based contracting and payment system;
- Develop a consolidated funding and management system;
- Understand the restrictions on funding services that must be changed to allow greater flexibility in service delivery while meeting federal requirements; and
- Identify a model to braid funding, including the use of federal waivers if necessary while identifying cost savings and efficiencies in service delivery.

A competent utilization management and quality improvement system will be necessary to manage the “right service at the right time for the right duration at the right cost” process, manage the front and back doors of inpatient and longer-term residential facilities, improve access to each level of care so that individuals are served at the time the need arises in the appropriate level of care, increase access to preventative services, screening, assessment, brief treatment strategies and to routine medical care for people with addictions and mental health disorders.

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Introduction

The concept of an integrated management and service delivery model was developed by AMH staff in response to a request from the Ways and Means Human Services Sub-committee Co-Chairs, Senator Bates and Representative Kotek. This proposed system change concept was based on the information, issues and recommendations found in the Public Consulting Group (PCG) and Human Services Research Institute (HSRI) reports. In addition AMH heard feedback from stakeholders, providers of mental health treatment services, addictions treatment services and physical health care services, consumers of mental health services, local government officials and legislators, all calling for improvements and efficiencies in the mental health and addictions service delivery system.

The focus of system change was on movement to an integrated service model (health, mental health and addictions services) and movement to an integrated service management and payment system. These two changes will result in a simpler, more efficient use of state, federal and local resources and better services to those in need.

Purpose Statement

Existing State, Federal, Other and Medicaid funds currently administered by AMH and the Division of Medical Assistance Programs (DMAP) will be managed through a limited number of managed care entities to purchase core health, mental health and addictions services. These services would include preventative, routine, acute and specialty medical care, acute mental health care, peer recovery services, detoxification, sub-acute mental health care, detoxification, residential addictions and mental health treatment, intensive outpatient, outpatient, and supportive housing as examples. For these core mental health and alcohol and drug services the state, AMH/DMAP, would consolidate administration of both federal and state service dollars through contracts with managed care entities on a regional/community basis. The managed care entity would purchase services through the current provider network combining the management of both Medicaid and non-Medicaid funds.

A major change within the managed care process will be to develop outcome-based financial incentives for selected outcomes to the extent feasible in a Medicaid-funded environment. Where possible, all payments through the managed

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care entities will be based on individual treatment outcomes so that providers have a high degree of accountability and financial motivation to move individuals through a continuum of services that maximizes outcomes in a cost-effective way.

A major change will be the integration of mental health and addictions services with primary health care services, both in delivery of service and payment through the managed care entity.

These major change elements in management of the health care, mental health and addictions service delivery systems would be demonstrated, in at least two regions/communities around the state, with those counties and regions who are interested and motivated to make this type of change. All non-demonstration services will continue to be delivered with existing funds in the current service delivery model.

Guiding Principles

The demonstration projects will be guided by the following principles:

- The goal of treatment and recovery is to provide services and opportunities for individuals to become self-sufficient.
- The array of treatment and recovery services must address the therapeutic needs of people in a holistic fashion. To the extent possible services need to be delivered in a seamless and integrated manner. Services include a continuum of core health, mental health and addiction services, as well as wraparound services for housing and employment/education assistance.
- The service delivery system must be managed in the most cost effective and individually focused manner. Funding for services should follow the shortest line from the state to community provider. The management structure used will consolidate all available funds, Medicaid and non-Medicaid funds, to pay for the array of core and wraparound services being provided with state funds.
- The service payment process will focus on achievement of measurable outcomes wherever possible.

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- Core mental health and addictions services must be geographically located to encourage access as close to home as possible. To avoid management and program duplication, services should be provided in a regional manner where possible.

Rationale for Demonstrations

Two recent legislatively funded reports from PCG (mental health) and HSRI (alcohol and drug) reports, recommended change to an integrated funding and service model that will:

- Provide consistent service throughout the state;
- Consolidate funding;
- Regionalize;
- Make the system more transparent; and
- Gain efficiencies in utilization of resources.

In addition, consumers, advocates, providers, counties and legislators are asking us to improve the way we provide addictions and mental health services around the following issues:

- To bring better balance to state investments. The system is currently more heavily invested in high cost institutional care for adults with mental illness.
- As a result of mixed responsibility for utilization management and a lack of identified incentives, the length of stay in mental health residential settings is too long. With the alignment of incentives for appropriate utilization and a single entity responsible for oversight of utilization, more people will be served in the least intensive and least expensive resources. The single entity needs to have clinical and program authority as well as financial accountability and needs to be capable of operating in a risk environment in less expensive community-based services.
- Understanding and knowing the major impact of health disparities for people with mental illness and addictions disorders, demands that we must move to an integrated system that delivers health care along with addictions and mental health services. Forging a more responsive integrated delivery system will be

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challenging but must be initiated now and is in keeping with State and Federal healthcare initiatives.

- The Legislature, advocates, consumers, and providers believe that we can manage this system more efficiently for the benefit of individuals with greater accountability and transparency. Shifting to an outcomes-based payment system will not only direct investments to achieve better outcomes for individuals but also provide system-wide measurable outcomes.

Work to Date

A concept paper, based on the information, issues and recommendations of the PCG and HSRI reports was developed by AMH staff at the request of the Ways and Means Human Services Sub-Committee Co-Chairs Senator Bates and Representative Kotek. There was invited testimony before the Ways and Means Human Services Sub-Committee and a series of three meetings with stakeholders to discuss the ideas contained in the concept paper on the following dates:

- Ways and Means Human Services Sub-Committee meeting March 25, 2009;
- Meeting with all interested consumer-survivors at DHS March 30, 2009 to discuss the March 25, 2009 Ways and Means Human Services Sub-Committee meeting and the concept paper;
- Large stakeholder meeting to identify concerns and solutions at Red Lion Hotel April 3, 2009; and
- Smaller self-selected stakeholder meeting to refine earlier concepts at the State Capitol April 10, 2009.

As the first step to develop a plan for integrated management and service delivery model demonstration projects AMH brought together interested stakeholders for a meeting on April 3, 2009. Approximately 150 people representing managed care organizations, physical health providers, mental health providers, alcohol and drug providers, consumers and advocates attended. During this time five topic specific subgroups focused on issues and solutions to develop an integrated system. The subgroup focus areas included:

- System structure;
- Performance-based contracting;

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- Financing and payment methodologies;
- Goals for an integrated addictions, mental health, and physical health pilots; and
- Essential services for recovery.

Information from these subgroups was compiled and used to inform the work in future meetings.

The smaller self-selected stakeholder meeting occurred April 10, 2009. There was a cross-section of individuals representing organizations with expertise in regionalization, managed care, and/or integration. Organizations were asked to self-select based on the following criteria:

- Existing viable working relationships locally between public health departments, FQHCs, MHOs, CMHPs, FCHPs and service providers;
- Services that support integration already exist in the proposed service area;
- An understanding that all services related to mental health, physical health and addictions are in the mix of the pilot;
- An understanding that consumers, people in recovery and families play a critical role in the management and delivery of care to individuals with substance use disorders or mental illness; and
- A serious intention to be an implementer in the demonstration project and be ready to contract by fall 2009.

This group refined issues raised in previous concept development meetings. The information generated in the stakeholder meetings and the initial model design meetings form the basis of this report.

Considerations

In order to maximize the quality, effectiveness, and efficiency of Oregon's mental health and addictions system and improve the integration of medical and behavioral health, a broad range of issues must be addressed. These issues range from identifying intended outcomes for particular populations to consolidating funding sources and designing regional accountable management structures.

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Natural tension exists between moving quickly and comprehensive redesign. AMH can, with legislative direction, solicit proposals and select demonstration projects by the fall of 2009. AMH and the demonstration projects will be accountable to reporting on outcome indicators and process improvements. Selection criteria will include sites that have already made some progress integrating medical and behavioral health and are able to propose an administrative and operational structure that can functionally consolidate funds from a variety of sources under one management structure. These regional management structures must also implement strategies for provider reimbursement that result in administrative simplification and provide incentives for achieving identified outcomes.

Making the changes described in these demonstrations constitute a major undertaking. AMH is confident these changes can be initiated within the current state and federal authority. The demonstrations will highlight any statutory changes that may be needed and what, if any, federal waivers are needed. State level oversight and technical assistance are critical to remove as many administrative barriers as possible and to assure compliance with existing requirements that cannot be flexed.

Other State Funding Integration Models

In preparing to do this work AMH approached the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) to learn where in the nation funding and management integration efforts have been successfully implemented. Many states responding to this question said they had not successfully integrated funding or management of these services.

Iowa and Kansas are two states identifying some success in efforts to “braid” funding from different sources. The Iowa Plan, administered by the Iowa Department of Human Services and the Iowa Department of Public Health, jointly manages specific, publicly funded treatment and related support services for mental health and substance abuse. Kansas placed all of the Medicaid and Substance Abuse Prevention and Treatment block grant funds with one management company. Kansas braided these funds to support substance abuse services but did not include funding streams that support mental health services. AMH will continue to communicate with these states to learn from their

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experiences. It should be noted that so far no other states appear to have successfully integrated funding and management for all three service domains: addictions, mental health and physical health/medical.

Recommendations

AMH recommends the establishment of two or three demonstration projects that meet the criteria described earlier. These will be collaborative demonstrations between each project and the state in order to solve problems as they occur and make adjustments in order to assure the continuous provision of services to the clients. As a result of the demonstrations, AMH expects to learn what is needed to better integrate the contracting, funding, management and delivery of all services, including health care, to people with addiction disorders and to people with mental health disorders.

At the end of the demonstration, AMH expects to:

- Identify cost savings and efficiencies in service delivery;
- Improve the management of services including utilization review, quality oversight, and involvement of consumers and family members;
- Assure improved access to services resulting in the right service at the right time, no more no less;
- Increase access to preventative services, screening, assessment, brief treatment strategies and to routine medical care for people with addictions and mental health disorders;
- Assure individuals are successful in the least restrictive setting possible;
- Provide a real time outcomes-based reporting system that reports agreed upon outcomes;
- Improve access to each level of care so that individuals are served at the time the need arises in the appropriate level of care;
- Increase variety of community-based services, (e.g., sub-acute treatment, supportive housing, intensive case management, and recovery supports including peer delivered);
- Reduce length of stay in the most restrictive and expensive levels of care;
- Understand the use of performance contracting;
- Reach agreed upon incentives for improved service delivery outcomes;

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- Understand the restrictions on funding services that must be changed to allow greater flexibility in service delivery while meeting federal requirements;
- Identify a model to braid funding, including the use of federal waivers if necessary; and
- Determine any changes that are needed in Oregon Statutes.

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	Additional Budget	Existing Central Support committed to project	09-11 Budget
Central Support *			
Principal Executive/Manager E	200,461	AMH Interim Director - 5% of time	18,141
Administrative Specialist 2	112,046	AMH Deputy Assistant Director - 10% of time	33,302
Operations & Policy Analyst 3	170,775	Adult Mental Health Services Administrator - 20% of time	51,681
Associated S & S	102,189	Program Analysis & Evaluation Mgr - 15% of time	34,001
DOJ - 200 hours/\$125	25,000	Addictions Program Administrator - 15% of time	37,109
		Medicaid Policy Manager - 20% of time	49,479
		Child & Adolescent MH Services Mgr - 20% of time	45,335
		2 - Program Analyst 2 positions - 100% of time	292,516
Total Central Support	<u>610,471</u>		<u>561,564</u>
Data Evaluation			
Research Analyst 4	170,775		
Research Analyst 2	124,933		
Associated S & S	68,126		
Independent Evaluation	<u>300,000</u>		
Total Data Evaluation	<u>663,834</u>		
Demonstration Staff and Start-up Costs	<u>485,000</u>		
Consumer Investment (Peer Delivered)	<u>125,000</u>		
OIS			
Principal Executive/Manager D	192,299		
Info Systems Specialist 8	222,349		
Associated S & S	70,576		
Vendor One-Time Costs (Includes SDC)	330,000		
Vendor Ongoing Costs (Includes SDC)	<u>200,000</u>		
Total OIS	<u>1,015,224</u>		
Grand Total	<u><u>\$2,899,529</u></u>		<u><u>\$561,564</u></u>

Current budget includes percentages of the 2009-11 budget for specific positions that will be responsible for tracking and oversight of the pilot projects.

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Budget Justification

Additions

Addictions and Mental Health Division Staff

AMH Project Manager (Principal Executive Manager E-PEME)

The manager will be responsible for developing and implementing the demonstration, including the development of priorities, criteria, policies, procedures and contracts. The manager will coordinate the activities associated with the demonstrations and manage staff hired to monitor the demonstration projects. This position will report to the adult mental health services administrator.

Administrative Specialist 2 (AS2)

This position will be responsible for interpreting laws, rules, policies, and procedures and for applying those interpretations to specific situations for this demonstration. The position will provide assistance for the manager with monitoring and or auditing, administrative research, and coordinating projects and program activities for this demonstration.

Operations & Policy Analyst 3 (OPA3)

The OPA 3 will be hired as lead technical consultant and monitor for the demonstrations. In addition, two existing AMH positions will be redeployed to be site-specific consultants, problem solvers, monitors, etc. These staff members will work directly with a given demonstration project. In addition, the OPA 3 will help coordinate any technical assistance needed by the demonstrations. These positions will report to the AMH PEM E.

Research Analyst 4 (RA4)

This position will be responsible for internal evaluation of the demonstration projects and help coordinate evaluation activities led by external evaluators. This position will report to the manager of program analysis and evaluation.

Research Analyst 2 (RA2)

This position will work directly with each pilot to ensure the entity is appropriately trained to submit necessary data and then coordinate its collection. The RA 2 will work closely with the OPA 3s and the RA 4 and report to the RA 4 and the manager of program analysis and evaluation.

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Office of Information System (OIS) Staff

Data System Project Manager (PEM D)

This position is responsible for ensuring the implementation of the proposed data collections system (described elsewhere) the pilots will use. The manager will work closely with AMH to make sure all information system needs are met and all DHS rules regarding software applications are followed.

System Analyst (IS8)

This position will work with the data collections system vendor to coordinate all technical issues related to the implementation and maintenance of the system. The position will report to the OIS PEM D.

Evaluation

While AMH will have the staff necessary to collect and analyze data associated with the demonstration, it is critical that an independent external evaluator be engaged to analyze the outcomes generated by the demonstrations in addition to collecting qualitative data from staff, providers, and stakeholders impacted by the implementation of the demonstration. The goal is to create an impartial review of the initial implementation, outcomes and sustainability of the demonstration in addition to providing a report to the appropriate legislative body, as well as AMH.

Demonstration Staff and Start-up Costs

These are new resources that will be available for approved demonstration projects to defray the costs associated with start-up and data reporting, as two examples. These are costs that are in addition to management costs that are associated with the services currently funded in the regions selected for the demonstration.

Consumer Investment

These are funds available to assist in training consumers, people in recovery, and family members to participate in the governance, quality assurance monitoring and oversight process of the demonstration projects.

Data System

To collect outcome information as well as other necessary data from the demonstrations, AMH will implement an open source web-based software known as WITS (web infrastructure for treatment services). WITS is a federally approved software that has been implemented in many other states and was designed to

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specifically meet the needs of clinicians, providers, state administrators, and the federal government.

The software itself is free. Costs are associated with its implementation and maintenance. The demonstration will serve as a good testing ground for the system that could open the door for statewide implementation if successful.

The alternative would require AMH in conjunction with DHS/OIS to develop a home grown tool to collect the data necessary to administer the demonstrations. This is not a very cost effective alternative and will not yield a sustainable system. The current systems for collecting data within AMH will not work under the model proposed for the demonstration.

Use of Existing AMH Staff

The budget reflects the dollar value of the time that key AMH managers will spend on the demonstration projects and the full dollar value of the two staff who will be redeployed to work full time on the demonstration providing consultation, solutions to barriers, monitoring demonstration projects, etc. In addition, AMH will use existing budget to reimburse travel costs for consumers, people in recovery and family members who are asked to be part of statewide meetings and who are not paid employees within the system.