Oregon

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DATE: **March 24, 2009**

TO: **All Interested AMH Stakeholders**

FROM: **Richard Harris**
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RE: **Elements of an Effective Mental Health Addictions Treatment and Care Delivery System**

The following concept 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. The system change concept is based on the information, issues and recommendations found in the PCG and HSRI reports as well as the experience in the Children's Change Initiative.

I. Guiding Principles for Mental Health and Addiction Treatment System

1. The goal of treatment and recovery is to provide services and opportunities for individuals to become self-sufficient. The service system needs to provide appropriate services for individuals, neither more or less than she or he needs to achieve self-sufficiency.

2. The array of treatment and recovery services needs to 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 or core health, mental health and addiction services, and wraparound services of housing and employment/education assistance.

3. The service delivery system should be managed in the most cost effective and individually focused manner. Funding for services needs to follow the shortest line from the state to community provider

services that benefit the person. The management structure used to manage Medicaid funds needs to manage a blend of Medicaid and non-Medicaid funds for the array of core and wraparound services being provided with state funds.

4. The service payment process needs to focus on achievement of measurable outcomes wherever possible not on fee-for-services methodology. Provider payment needs to incent services that help individuals become self-sufficient in the least restrictive setting possible, with the least cost possible.

5. Core Mental Health and Addictions services be geographically located to encourage access closest to home as possible. Where possible services be provided in a regional manner to avoid management and program duplication.

II. Current Addictions and Mental Health System

The current Mental Health and Addictions system is based on a State, County and private provider model. The State contracts with counties and counties mostly contract with non-profit providers to deliver services, or deliver the services with County employees. Laced in between, some service elements are Medicaid reimbursed through AMH/DMAP. For example AMH manages the state and federal block grant funds through contracts with the counties who are responsible for the delivery of services. The Federal Medicaid funds through AMH/DMAP are managed two different ways. For Addiction services the OHP health plans manage and pay for some addiction services on a fee-for-service basis. Other services flow through county contracts. Mental Health services, which are carved out of the OHP, are managed by a variety of County MH/Managed Care Organizations, both single County organizations and regional County consortium organizations.

The continuum of the Mental Health and Addictions Services being provided at the local level has been built up over the years to include an array of outpatient, residential and supportive housing programs. This

provider infrastructure though not sufficient in capacity to meet all the need is sufficient in operation and capacity to meet the demand in the current funded system.

III. New Mental Health & Addictions Management System

What needs to change is the management and payment of the service delivery system. Two major changes would provide a simpler, more efficient and cost effective delivery system.

1. State, Federal and Medicaid funds administered by AMH/DMAP be managed through a limited number of managed care entities to purchase the core mental health and addictions services. These services would include acute mental health care, detoxification, sub-acute mental health care, residential addictions and mental health treatment, intensive outpatient, outpatient, peer recovery services, and supportive housing. 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 Organizations on a regional/community basis. The managed care company would purchase services through the current provide network combining the management of both Medicaid and non-Medicaid funds.

   For county mandated services such as crisis and civil commitment and other non-core services that are County driven AMH would continue to contract directly with the County. Counties would also be free to develop and pay for custom services that were important to their communities.

   Where possible Mental Health and Addictions services be integrated with primary healthcare both in delivery of service and payment through Managed Care Organizations.

2. The second major change would be to develop an outcomes-based payment system in lieu of the current fee-for-service system. This

Medicaid based system relies upon paying for therapeutic encounters as the payment ticket. This methodology results in poor utilization outcomes. Where possible all payments through the Managed Care Organizations be based on individual treatment outcomes so that providers have a high degree of accountability and a financial motivation to move individuals through continuum of services that maximizes outcomes in a cost effective way.

This change in compensation methodology would require case rates or some type of capitated care agreements. The move to Managed Care Organization management of combined core addictions and mental health services would require a business-oriented relationship through performance-based contracts between AMH/DMAP. The move from fee-for-service to individual outcomes-based payments would also require establishing and resetting rates and outcomes with providers.

The result will be more cost effective utilization of service components in the community, based on people's need. Service providers would need to invest in individualized treatment and services that would support individual clients to remain in their homes and receive only the service they need.

These are the two changes that could be demonstrated in three regions of the state. Only those counties or regional county groups who are motivated to make these changes would pilot and demonstrate the elements of this concept.