DISABILITY RIGHTS OREGON

December 3, 2018

Sent via mail and email: patrick.allen@dhsoha.state.or.us

Patrick Allen, Director
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301-1097

Re: Concerns about KEPRO

Dear Director Allen,

On August 1, 2018, Disability Rights Oregon (DRO) wrote to the Oregon Department of Justice (our point of contact for the Oregon Health Authority) to request information about the Oregon Health Authority's contract with KEPRO.

> DRO's August 1, 2018 letter stated the following:
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> As you know, Disability Rights Oregon (DRO) has tracked progress relating to Oregon's compliance with the ADA's community integration mandate for people with mental illness through the benchmarks set forth in the Oregon Performance Plan. We are exceedingly supportive of the state's efforts to ensure that people who are held in Secure Residential Treatment Facilities (SRTFs) or other treatment facilities truly need that level of care. These facilities may lack pathways and opportunities for community engagement and, according to our clients, may feel just as institutional as the state hospital.
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> Concerns have arisen, however, regarding individuals' rights to due process and transition planning once it is determined that they no longer need the level of care at which they are currently housed. The Oregon Health Authority (OHA) has contracted with KEPRO to conduct utilization review across the spectrum of residential placements. DRO has received multiple complaints from individuals, guardians, and service providers who may support transition to a less restrictive setting but are concerned with how this transition is being conducted. We have received reports that individuals are not receiving notice of KEPRO's determinations (or that the notice is vague or misleading), that hearing rights are unclear, that the placement cannot be funded or preserved pending a hearing or adequate transition plan, and that individuals have been discharged to homelessness or hospitalized due to hasty, poorly planned transitions.

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In order to explore these concerns, DRO requested the contract between OHA and KEPRO, quarterly reports provided by KEPRO to OHA, sample copies of notices and transition planning documents, and dollar figures paid to KEPRO in incentive payments, and paid by OHA to residential service providers to maintain a placement after KEPRO denied eligibility. Much of the information we requested was provided. However, four months later, the most important question remains unanswered; *OHA has failed to account for the outcomes of individuals impacted by the KEPRO utilization review.*

In my August 1st letter, I asked how many people transitioned from a residential setting to homelessness (including a shelter or motel) and how many people had been admitted to a private hospital or the state hospital. Over the next few months, I engaged in dialogue with OHA representatives in order to attempt to obtain responsive information. I asked the following follow-up question: Is there any available information regarding whether KEPRO determinations of ineligibility for a current level of HCBS care are followed by any of the following:

- Emergency department visits/inpatient admission
- Arrest and/or "aid and assist" admission to OSH (Oregon State Hospital)
- Civil commitment and/or civil/voluntary by guardian admission to OSH
- Homelessness

On October 10th, OHA provided the following reply: "The agency does not have any documentation responsive to this portion of your request."

In recent weeks, OHA has attempted to find out where individuals have ended up subsequent to a move-out prompted by a KEPRO denial. We now know that:

- 1761 denials were issued for 524 individuals;
- 189 individuals have moved out of residential placements since KEPRO began its review (but the number of those prompted by KEPRO denials is not known);
- Of these individuals -
    - 5 have died,
    - 5 are homeless,
    - 1 is in jail,
    - 11 are in custody at the state hospital,
    - 64 have transferred to a lower level of residential care, and
    - 103 are "independent" (although, OHA acknowledges that a "deeper dive" is warranted in order to better understand the circumstances that are included in the "independent" category. "Independent" could include those who are simply unaccounted for).

Criticism regarding the KEPRO utilization review has appeared in the news, and DRO understands that OHA shares at least some of these concerns and has taken steps to rectify some serious problems, such as clarifying the denial notices and ensuring that individuals

understand how to appeal a denial. In this letter, DRO raises three systemic concerns with OHA and KEPRO's management of the continuum of residential metal health care in the state.

1. **Failure to track and incentivize long-term healthcare outcomes**

A strong healthcare delivery system should track and incentivize good long-term healthcare outcomes. DRO is concerned to learn that the Oregon Health Authority entered into a $27 million contract with a private company without instituting any mechanism for tracking whether the services provided contributed to positive health and quality of life outcomes for the individuals affected. Are they dead? Are they homeless? Or are they living more fulfilling and independent lives? OHA's core obligation is to allocate healthcare resources to maximize the health of Oregonians. Without information about outcomes, it is not possible to improve the system or to know whether we're dedicating our state resources to interventions that help, or harm.

Under its current contract, KEPRO receives a financial incentive to move a resident out of the Oregon State Hospital or an SRTF. However, the contract creates no effective corresponding financial incentive to ensure that individuals are appropriately moved to a more integrated setting, with appropriate supports and plans in place. An unbalanced financial incentive to reduce the level of care could induce KEPRO to discharge indiviuduals hastily or inappropriately.

2. **Failure to invest in lower levels of care and supports in order to facilitate the movement of people downwards through the continuum**

The system of residential care is a continuum. Secured facilities (SRTFs) are the most restrictive and should be reserved for the highest need or highest risk individuals. The system was originally conceived with the premise that, as people stabilized and learned skills and independence, they would "step down" through the levels of care, from secured facilities, to residential treatment, to group homes or adult foster homes, to supported housing or independent housing. In reality, most people did not move downward through the continuum. Instead, they stayed where they landed, unless a problem or crisis drove them into a higher level of care.

This stagnation can be explained in part because the system has not paved a path for transitions to less restrictive settings. First, there is little impetus among providers, guardians, and sometimes the individual themselves, to move absent a specific problem in the current setting.[1] Second, there continues to be inadequate supply of residential options at the bottom

[1] This is why DRO has advocated for a "step down in place" model, which involves services wrapped around an individual in their permanent home (which could be congregate or independent). Services and staffing can be increased or decreased as needed, without requiring the person to move to a different residential setting.

of the continuum: affordable independent housing and permanent supportive housing.[2] Third, the beds throughout the system are consistently full, which impedes movement.

DRO is concerned that OHA initiated movement from the highest level of care without developing capacity in the least restrictive settings. If this massive transition through the continuum had been thoughtfully planned, OHA would have begun by 1) developing capacity in permanent supportive housing, 2) offering supportive housing units (on a voluntary basis) to people in lower level congregate settings (such as group homes and adult foster homes), thereby creating openings at the bottom of the continuum, and finally 3) moving people from more restrictive residential settings (SRTFs) into lower levels of care.

Instead, OHA (through its contract with KEPRO) did the opposite; they began at the top of the continuum with the highest need/highest risk residents, and issued hundreds of denial notices. Because there are few beds available at lower levels of care, some were discharged to the streets or motels. Other residents did not move after a KEPRO denial and Oregon now pays for their continuing placement with state dollars (rather than federal Medicaid dollars). In these scenarios, the state pays much more without accomplishing the aim of moving the resident to a more integrated setting. $3 million has been paid out so far.

3. **Failure to implement the vision of person-centered planning**

KEPRO's contract with the OHA requires KEPRO to develop a "person-centered service plan" for all individuals who are eligible for some level of residential mental health services. The vision of person-centered planning is that the individual's wishes, desires, and needs drive the planning process regarding their services and living arrangement. This concept may sound intuitive, but it is actually a radical departure from the default approach to care planning, which is driven by availability of beds, funding, and eligibility criteria set by the state and providers. Person-centered planning is a time-intensive, individualized process that is led (to the extent possible) by the individual, but involves their healthcare providers and loved ones.

DRO questions how the vision of person-centered planning squares with KEPRO's approach to fulfilling its contract. Person-centered planning is the appropriate driver for transitions out of or between residential settings. DRO supported conducting a utilization review of residential

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[2] A recent report from the Corporation for Supportive Housing concluded that Multnomah County alone will need more than 2,000 additional supportive housing units over the next decade. It estimates that the total funding needed to add just 2,000 units is between $592 and $640 million dollars over the next ten years, and that ongoing operating and services investments after the first ten years are estimated at approximately $43-$47 million per year. *See* Corporation for Supportive Housing. *Scaling Smart Resources, Doing What Works: A System-Level Path to Producing 2,000 Units of Supportive Housing in Portland and Multnomah County*, p1 (Sept 11, 2018). The Corporation for Supportive Housing website reports that 12,388 supportive housing units are needed statewide (*https://www.csh.org/supportive-housing-101/data/*).

placements to identify and transition people who were stuck in a higher level of care than what they needed. But, rather than beginning with 1,761 confusing and alarming denial notices, the first step should have been talking to individuals about their needs and desires.

OHA's obligation now is to work with Community Mental Health Programs and local mental health providers to identify and locate people who are in untenable situations (homeless, or housed in temporary shelters, motels, hospitals, or jails) as a result of KEPRO denials, and to provide the services they need to stabilize.

We further recommend that OHA pause the KEPRO utilization review process in order to ensure that KEPRO is providing a person-centered planning process that meaningfully engages all involved parties, and that the resulting plan truly drives care decisions and transition planning. If transitions are to be made, start by moving those who are eager to do so.

Finally, the statewide long-term priority needs to be the development of permanent supportive housing. Access to supportive housing and a robust local crisis system would go a long ways towards reducing reliance on institutional and restrictive settings. Developing the bottom end of the continuum may be the perquisite to downsizing higher levels of care.

We look forward to continued dialogue with OHA about how to improve the quality of life and long-term health of Oregonians with mental health conditions.

Sincerely,

Sarah Radcliffe, Managing Attorney
Mental Health Rights Project
Disability Rights Oregon