Oklahoma Department of Mental Health & Substance Abuse Services
Oklahoma Department of Rehabilitation Services
Oklahoma Health Care Authority

Improving the System of Care for Individuals with Mental Health and Substance Abuse Treatment Needs

Request for Information
November 4, 2002

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Introduction

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the Oklahoma Department of Rehabilitation Services (DRS) and the Oklahoma Health Care Authority (OHCA) are jointly issuing this Request for Information (RFI) on how best to reform the mental health and substance abuse treatment system for adults with low incomes.

The RFI is being released at an early stage in this multi-agency collaboration in order to garner maximum public input into the decision making process and ensure consideration of a broad array of options.

Once the program design is finalized, the State intends to implement a sub-state pilot in a specific region (yet to be determined) of rural Oklahoma. The State anticipates that the pilot program will include treatment and related services to individuals currently eligible for services provided through the Medicaid program, by ODMHSAS, and by DRS. For the pilot being considered, the State intends to explore changes in the current delivery system to maximize the use of Federal and State funding resources. If successful, the pilot program may be extended to other parts of the State.

The three collaborating agencies welcome input from all interested parties, including consumers, providers, behavioral health organizations, consultants, advocacy groups, academicians, and other governmental entities.

The last two sections of the RFI include instructions for submission of responses and a series of questions. Any interested party is encouraged to submit responses to any or all of the written questions. Written responses will be compiled and made available to the public. All who submit written responses will be invited to participate in a follow-up meeting to discuss the responses to this request and the pilot project. Please submit responses by close of business (COB) on Wednesday, November 27, 2002.

Section 1: Overview of the Collaborative Project

The Oklahoma Department of Mental Health and Substance Abuse Services and the Oklahoma Health Care Authority are responsible for purchasing treatment services on behalf of low-income adult Oklahomans with mental illnesses and substance abuse disorders. In each case the primary goal of the services is recovery, to improve the functioning of the individuals served through decreasing the symptoms of the particular disorder and increasing the individual's ability to function in the community. In a system with recovery as the primary goal, employment services should be a core service. The Oklahoma Department of Rehabilitation Services provides vocational services to persons with a mental illness in order to fill this essential service need.

ODMHSAS, DRS, and OHCA staff and leadership believe that collaborative planning, purchasing, administration and oversight offer the opportunity to put existing resources to more efficient use and improve the quality of care. To this end, an interagency effort has been undertaken to develop a framework that achieves the following objectives:

1) The structure, policies, financial arrangements and services provided in this system will reflect a primary commitment to a consumer empowerment and recovery model of care.

2) The financial structure must facilitate provision of an evidence based set of services and encourage the efficient use of resources. To the extent possible, sources of funding will be invisible to the consumer. It is hoped that a delivery system can be achieved that cares for the Medicaid and ODMHSAS funded recipients under the same guidelines and policies for all services purchased by the State.

3) Where possible, the administrative burden and requirements to the providers of care should be simplified and reduced, while permitting appropriate oversight of the delivery system and ability to measure program performance and individual treatment outcomes.

4) Consumer, provider, and system wide outcome data will be developed, monitored and analyzed in order to provide comprehensive and useful information to consumers, purchasers, and providers.

5) The service system will be responsive to the needs of the larger community of health care, social services and legal systems.

Section 2: Overview of the Current System

Currently, mental health and substance abuse services for adults who have low incomes are primarily provided by either ODMHSAS operated or contracted facilities or the OHCA through contracts with a variety of providers. Through these arrangements, each state agency purchases an array of substance abuse and mental health care including counseling, rehabilitation, crisis and case management services, residential treatment, and inpatient hospitalization. Recently, ODMHSAS implemented the Program of Assertive Community Treatment (PACT) teams in several locations in Oklahoma. Consumer and family organizations such as the Oklahoma Mental Health Consumer Council, the National Alliance for the Mentally Ill and the Mental Health Association offer varying types and amounts of support, educational, and advocacy services.

Data on persons served and funding provided for the services for SFY2001 are included in the attached tables.

A more specific description of mental health and substance abuse services provided or purchased by each of the major public funding entities follows.

The Oklahoma Department of Mental Health and Substance Abuse Services

The following services provided through the ODMHSAS system are generally available to persons in need of those services who have incomes of 200% of the Federal Poverty Level or less.

Substance Abuse Services. ODMHSAS is the designated state agency to receive federal substance abuse funds, such as Substance Abuse and Prevention and Treatment Block Grant funds. Additionally, ODMHSAS receives state appropriations to

further develop and provide substance abuse treatment. ODMHSAS plays a critical role in developing and implementing an integrated substance abuse prevention and treatment strategy for the state. ODMHSAS currently contracts with over 40 substance abuse treatment centers across the state of Oklahoma. Some of the programs are designed to meet the needs of special populations such as Native Americans; Temporary Assistance to Needy Families (TANF) recipients; women with children; adolescents and people with co-occurring mental illnesses and substance abuse disorders.

The continuum of care for alcohol and other drug treatment services include outpatient, detoxification/crisis stabilization, residential and Halfway House.

Mental Health Services. ODMHSAS is also the designated agency to receive Federal Mental Health Block Grant Funds. State appropriations for mental health are also allocated to ODMHSAS. With these funds, ODMHSAS primarily arranges for mental health services through the eighteen (18) Community Mental Health Centers. Thirteen (13) of the CMHCs are private non-profit organizations under contract with ODMHSAS. The remaining five (5) CMHCs are state operated. The minimal range of services provided by CMHCs in Oklahoma includes: crisis intervention, assessment and referral, case management, counseling services, medication and physician services, and psychosocial rehabilitation. Most CMHCs offer other services in addition to those listed.

During FY2001, ODMHSAS also purchased or provided hospital based mental health services and residential care services. Additional mental health services were purchased through other providers that offer specialty programs in the area of crisis stabilization, employment, housing and community based services for homeless individuals. At present, most coordination between providers occurs at the local level. To an extent, ODMHSAS mandates a systemic approach through required linkages for individuals who transition from hospital or crisis stabilization services. Regardless, the Department envisions a more integrated and inter-provider network will develop pursuant to the project being proposed.

The current ODMHSAS system lacks an integrated model in treating clients with co-occurring disorders. Instead, the current system tends to be a sequential model of treatment where the client is treated by one system and then by the other (mental health, substance abuse). ODMHSAS as well as the other partners of OHCA and DRS intend to more fully develop an integrated treatment approach, in conjunction with the pilot being considered to better serve those with co-occurring disorders.

The Oklahoma Health Care Authority

The OHCA is the state's designated Medicaid agency. Behavioral Health Services are a significant component of the Oklahoma Medicaid benefits. Although the exact numbers are not available it is believed that approximately one third of the adults who qualify for Medicaid due to a disabled status have a serious mental illness (SMI). Many of the adults on Medicaid who have a serious mental illness also have one or more co-existing additional chronic disorders. It is thought that a high percentage of people with chronic serious mental illnesses end up qualifying for Medicaid due to a lack of employment related health insurance and financial resources accompanied by qualifying for Supplemental Security Income.

The adults who are receiving Medicaid due to a Temporary Assistance to Needy Families (TANF) or related status (which includes low income adults and pregnant and postpartum women) are less frequently in need of behavioral health care services. However, some individuals with a serious mental illness are in this category of Medicaid recipients. In both populations of recipients, substance abuse disorders are predicted to exist with prevalence at least equal and likely higher than the rate for the general population of Oklahoma. However, a relatively low number of individuals appear to receive substance abuse treatment under their Medicaid benefits.

The following mental health or substance abuse treatment benefits are provided to eligible individuals as part of the state's Medicaid Plan:

- Inpatient Psychiatric Hospitalization – Adults who receive Medicaid have a hospital benefit which is currently twenty four days per year. There is a reduction in this benefit scheduled for November 1, 2002 to fifteen days per year. This benefit includes but is not limited to psychiatric care. The benefit limitation applies to all medically necessary inpatient days for the fiscal year. The psychiatric hospital care purchased through the Medicaid program is available only through general hospitals due to Title XIX prohibitions against paying for psychiatric services in institutions for mental diseases (unless permission is granted through a waiver process). In SFY 2002 approximately $5,200,000 was spent for this service for adults over 21 years old. This service does not appear to be highly over utilized, however the connection and transition between inpatient and outpatient care is often lacking or tentative, and resulting in poor or haphazard community based outpatient support.

- Statewide, in the fee for service Medicaid program for SFY 2002 approximately $38,000,000 was paid to contracted providers of outpatient behavioral health services. This amount includes the state match and federal share. The providers include private not for profit and for profit entities as well as community mental health agencies. Some providers serve a focused population of seriously mentally ill adults predominately providing full or part day programming. Others may be predominately serving residents of nursing facilities including Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) and still others serve a wider spectrum of the adult Medicaid recipients.

- While substance abuse diagnoses are included as appropriate diagnoses to be treated, few substance abuse providers are currently contracted with Medicaid and the few that are provide only a small amount of Medicaid compensated care.

- Case management is another Medicaid benefit for SMI adults. This service accounted for approximately $800,000 in payment in SFY 2002.

The Oklahoma Department of Rehabilitation Services

The Oklahoma Department of Rehabilitation Services (DRS) provides assistance to Oklahomans with disabilities through vocational rehabilitation, employment, independent

living, residential and outreach education programs. The DRS Division of Vocational Rehabilitation serves consumers with all types of disabilities, except persons with visual disabilities who are served by the Division of Visual Services. The Division of Vocational Rehabilitation offers employment services, independent living programs, and transition from school to work and supported employment services. Supported Employment services help individuals with severe physical, mental, emotional or multiple disabilities learn job duties on site so they can successfully reach the employers performance standards. DRS counselors arrange for and coordinate services, such as skill assessment, job placement assistance, and work site job training and follow-up. These services are provided to consumers by community based organizations under contract with DRS.

Section 3: Pilot Program Design

This section provides a summary of the initial framework for pilot program design. This framework is not intended to represent the final thinking of the three agencies; rather, it is offered so that respondents to the RFI can have a "baseline" proposal against which to offer comments and recommendations.

Delivery System Structure

In the current behavioral health care system in Oklahoma, assessment is conducted routinely from the viewpoint of determining eligibility or fit with the services offered by the provider where the client initially accesses care. The resulting assessment and treatment planning can be highly influenced by funding streams and provider capacity. This arrangement also may fail to properly engage the consumer in his or her treatment, thereby negatively affecting motivation and treatment effectiveness.

It is a core and unifying belief of the participating agencies that assessment and treatment planning should be conducted with a sole focus on the client's individual needs, strengths, preferences and recovery. The State seeks to develop a framework which promotes assessment and treatment planning based on the individual's needs, embracing a recovery and empowerment philosophy. One option under consideration separates the assessment and treatment planning processes from the actual provision of services. Under such a design, assessment and treatment planning will be carried out by an entity with limited fiscal or organizational connection to the provision of any of the treatment services. For purposes of this RFI, this entity is referred to as a Service Facilitating Team (SFT).

The functions of the SFT can be closely aligned with concepts included in the Center for Medicaid Services (CMS) Independence Plus Initiative for Individually Directed Community Based Services. CMS refers to this as support brokerage and defines it as a function to assist participating families and individuals to make informed decisions about what will work best for them, consistent with their needs and circumstances. SFTs will assist the consumer identify immediate and long-term needs; develop options to meet those needs; and, access preferred supports and services. This will be documented and guided by a person centered written plan of care.

In the model, the consumer will be actively involved with SFT functions. The selection of services should be consumer directed, with guidance, assistance and support from the team. The consumer will have choice of service and provider to the extent providers

are available and under contract with one of the participating state agencies. The SFT team will be expected to recruit new contractors where service choice is limited. This team will authorize the chosen services from the selected provider as directed by the consumer with the advice of the team.

In addition to the consumer, each SFT will include:

1) A trained consumer specialist;
2) A Licensed Mental Health Professional;
3) A Certified Alcohol and Drug Counselor; and,
4) A Vocational Rehabilitation Specialist.

The entire SFT will not need to access every individual. It is assumed, though, the entire team will review assessments, and each consumer will receive ongoing assistance from at least one member of their designated SFT. In addition to the direct assistance functions, the team will continually monitor progress and focus on specific consumer outcomes.

The team will routinely report data regarding client demographics, outcomes, critical incidents, indicators, expenditures, and conduct service authorizations. This will require access to the OHCA Medicaid Management Information System (MMIS), the ODMHSAS Integrated Client Information System (ICIS), and the Oklahoma Rehabilitation Management Information System (ORMIS) for authorizations and other necessary reporting, billing and client information.

In summary, all functions of the SFT are intended to:

- ✓ optimize the likelihood that the client successfully accesses and completes the authorized treatment services;
- ✓ assist the client to identify, select, and access needed social, educational or other community based services that may improve their ability to function optimally in their community;
- ✓ assess client satisfaction with services and their recovery progress;
- ✓ ensure coordination and collaboration between behavioral health treatment services;
- ✓ provide collaboration with Primary Care and other medical providers of physical health services;
- ✓ evaluate treatment outcomes and progress; and,
- ✓ authorize the substance abuse and community based mental health services.

Coordination of Care

Services provided by physicians will be adjunctive to the treatment services described above. The SFT will seek input from and will coordinate with the psychiatrist or primary care physician (PCP) treating the client during the initial assessment phase as well as at other regular intervals and at other critical times. If the client has no physician treating their behavioral disorder(s), SFT team will assist the client to obtain needed medical services for the purpose of additional assessment and diagnostic information, as well as physician input regarding treatment recommendations, and pharmacological treatment services for non-behavioral health medications. Medicaid-eligible adults will typically have a primary care provider/case manager assigned to them through the ***SoonerCare***

Choice program. Coordination of care with the PCP by the team will also be routinely performed.

Additional supportive services will be essential for many persons served by this integrated system. Individuals on Medicaid will have access to the SoonerRide program as needed. Financial resources will be identified to buy into the SoonerRide program for individuals whose care is supported by ODMHSAS and/or DRS funding. A significant number of the prospective enrollees into this system of care will at some time benefit from assisted living, supported, or transitional housing. It will be important that these options are available and appropriately funded to provide quality services.

Individuals Served

The target population for inclusion in the pilot will be qualifying low-income adults in need of substance abuse treatment and/or in need for services for SMI who live in the selected geographic area. It has been determined that certain counties will not be considered for a pilot at this time. Those are Cimarron, Roger Mills, Beaver, Ellis, Harper, Dewey, Grant, Harmon, Alfalfa, Woods, Jefferson, Greer, Texas, Tulsa, and Oklahoma counties. Although the counties presently in the ***SoonerCare* Plus** (Health Maintenance Organization – HMO) program are not excluded from consideration for the potential pilot, (with the exceptions of Oklahoma and Tulsa counties) only individuals not enrolled in ***SoonerCare* Plus** would be able to included in the pilot. Most adult Medicaid recipients living in the SoonerCare Plus counties who are not enrolled in a ***SoonerCare* Plus** are primarily individuals who are classified as "dually eligible" (Medicaid and Medicare recipients) or individuals residing nursing facilities.

Participants must be eligible for Medicaid or meet the income and eligibility requirements established by ODMHSAS for adults (note: the current income maximum is 200 percent of the Federal Poverty Level).

Participants will also have to be in need of treatment for any of the following:

1) Substance abuse disorders
2) Serious mental illnesses
3) Both substance abuse disorders and serious mental illnesses (co-occurring disorders)

The current framework anticipates that the following populations will *not* be part of the pilot program:

1) Individuals under the age of 18
2) Individuals enrolled in the Medicaid *AD*vantage waiver program
3) Individuals enrolled in the DDSD waiver program
4) Individuals enrolled in the ***SoonerCare* Plus** managed care program
5) Residents of non-psychiatric and non-substance abuse treatment state facilities

There has been an ongoing discussion regarding the population of Medicaid with specific mental health treatment needs who are not generally classified as seriously mentally ill. This group of individuals may be affected by a mood disorder, adjustment disorder or other condition that qualifies as a mental illness under the DSM-IV criteria, but is not one of the major mental illnesses and generally has not significantly impacted

the individuals' ability to function in their communities. It is anticipated that these persons will continue to be treated outside of the collaborative system of care. They will be provided a fee-for-service benefit to include appropriate counseling services with a mental health professional that will be required to collaborate with the individual's primary care physician to improve coordination of care. If an individual exhausted the standard benefit and was thought to require more treatment, s/he will be evaluated for SMI designation.

Services to Be Provided

Substance Abuse Treatment. Treatment will be delivered across a continuum of care that reflects both the varying type and severity of illnesses as well as the intensity of the level of care required. American Society of Addiction Medicine (ASAM) Patient Placement Criteria will be used to assess and evaluate the treatment needs of this population. The goal of utilizing ASAM is to move from program driven assessments to clinically appropriate and outcomes-driven assessments and treatments.

At a minimum the services will include:

1) Detoxification and stabilization services
2) Inpatient/residential services
3) Intensive outpatient treatment
4) Other outpatient treatment services
5) Employment services
6) Case management
7) Integrated substance abuse and mental health services for persons with coexisting disorders.

The State also anticipates prioritizing services for the special populations below, and will provide culturally relevant treatment programs:

1) Pregnant injecting drug users
2) Pregnant drug users
3) IV drug users
4) Persons with HIV/AIDS
5) Women with dependent children
6) Minorities

Mental Health Services. There exists a clear consensus among the OHCA, ODMHSAS and DRS as well as representatives of consumer organizations that have participated in the planning process, that the recovery-oriented services to be emphasized in the community based treatment of the seriously mentally ill population will be the following:

1) Family to Family educational support
2) Wellness Recovery Action Plan (WRAP) self management training
3) Clubhouse model of psychosocial rehabilitation
4) Programs of Assertive Community Treatment (PACT)
5) Supported Employment
6) Integrated substance abuse and mental health services for persons with coexisting disorders
7) Case management

8) New generation antipsychotic and anti-depressant medications utilization (including algorithms for prescriptive practices)
9) Inpatient acute psychiatric care
10) Crisis assessment, intervention and stabilization

Services for Individuals with Co-occurring Disorders. The individuals who have coexisting substance abuse and mental illness disorders will have available the full range of services. Their treatment will be managed by staff who are skilled in serving this population, including the sequencing and timing of receipt of needed treatments and services. In addition, the approach for treating clients with co-occurring disorders will include acute crisis intervention and stabilization that focus on the severity of the presenting problems, not on one specific disorder, e.g. substance abuse versus mental illness.

Financial Structure

The SFT will be authorizing all ODMHSAS and OHCA non-medical behavioral health treatment services. At this point, it is assumed that the medical services to treat behavioral disorders (physician, medication, emergency, and inpatient care) will not be managed by an authorization process. SFT functions (assessment, treatment planning, case management and service facilitation) will be reimbursed under a capitated case rate arrangement with performance and outcome-based incentives. In addition to the case rate, there are envisioned financial incentives and disincentives connected with exceeding or falling short of established performance targets. The performance targets will be developed in several areas including achieving client outcomes and recovery milestones.

It is anticipated that the non-medical community based treatment services will be supported and compensated through a monthly budgeting system. A target amount will be established that will be available for each enrollee to cover the costs of the non-medical mental health and substance abuse treatment services. The enrollee will receive access to these services as desired and indicated during the service planning and facilitation process, within the allowed target amounts. It is not anticipated that the SFT will be at risk for these services.

It is expected that the assessment/service planning/facilitation process must reflect a recovery philosophy and consistently communicate an expectation of improvement in functioning and quality of life. Consumer empowerment, choice, and education will be emphasized throughout the processes.

As previously mentioned, this project is not designed to reduce the current overall amounts of state funds being spent to provide treatment, employment services, or related services. It is the intent, however, to rearrange how the state dollars are utilized so those resources can be used more effectively. It is also believed that the use of evidenced based and emerging practices will improve treatment outcomes. This, in turn, will result in less dependence on the treatment system in a shorter period of time than is currently experienced.

Section 4: Response Instructions

Interested parties are encouraged to submit written responses to any or all of the questions provided below. Please reference the question number in your written response.

Responses should be sent to the contacts listed below. Responses may be forwarded to the State via email, fax or regular mail, as follows:

Email: CollaborationProject@odmhsas.org

Fax: Collaboration Project c/o (405) 522-3650

Or mail to: Collaboration Project
PO Box 53277
Oklahoma City, OK 73152-3277

Section 5: Questions

1) From what perspective are you responding to this RFI? – provider, potential service facilitator, consumer, advocate or other (please specify)?

2) What is your overall opinion of the need to reform the existing service delivery system to increase collaboration among ODMHSAS, DRS and the OHCA? If you see a need, what should be the primary objectives of such collaboration? (Limit your response to the counties described on page 4 of this RFI.)

3) Please comment on the "Delivery System Structure" section of the RFI. Do you agree with the proposed separation of assessment and treatment planning from service provision? If not, what alternative(s) will you propose for addressing the state's concerns regarding conflicts of interest in the current system?

4) Please comment on the "Individuals Served" section of the RFI. Are the target populations the right ones? If not, describe who you believe should be targeted, and why.

5) Please comment on the "Services to be Provided" section of the RFI. Is the service mix the right one? If not, explain how the mix should be restructured, and why.

6) Is the scope of responsibility outlined for the Service Facilitation Team (SFT) appropriate? If not, how should it be revised?

7) Is the make-up of the proposed SFT appropriate? If not, how should it be revised?

8) How should the SFT team be compensated? For potential service facilitation entities: What information will you need to formulate a per member per month or case rate price proposal?

9) A financing approach is being considered whereby a monthly budget amount will be established for enrollees. Do you think establishing a monthly maximum and minimum budget range will be an effective mechanism to assure the quantity and

scope services needed for enrollees? Should this be done on a tier or leveling system, based on anticipated services needs of the enrollees? Should the SFT be at risk financially if actual expenditures exceed the cost of reimbursement for the SFT activities? What other incentives will encourage the appropriate level of service delivery?

10) What types of incentives could be offered to SFT to encourage improved treatment outcomes? For example, in addition to case rates, will incentive payments for recovery milestones, such as improving housing or employment status, facilitate a recovery focus?

11) What other challenges do you envision beyond those already identified in your response? Do you have any suggestions regarding either the size (number of participants) of the pilot program or particular region(s) that may be potential pilot sites?

12) What specific measures should be considered as indicators of improved treatment outcomes?

13) What advantages or concerns would you see with a system in which individuals direct more decisions about the services they wish to receive?

14) Would you recommend different (more restrictive or expanded) roles for the service facilitator teams, other than that described in this document?

15) Do you have any suggestions or comments regarding the program design that are not addressed by the preceding questions?
