Mercer

Government Human Services Consulting

Integrated Co-Occurring Disorders Reimbursement Study

On behalf of

Oregon Health Authority

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Section 1

Executive Summary

In 2021, House Bill (HB) 2086[1] was passed by the Oregon Legislature. HB 2086 directs that: "The Oregon Health Authority shall conduct a study of reimbursement rates for co-occurring disorder treatments, including treatment of a co-occurring intellectual and developmental disability and problem gambling disorder."[2] To complete this report, the Oregon Health Authority (OHA) contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct a study of reimbursement rates for co-occurring disorder (COD) treatments. Oregon defines COD as an individual having two or more behavioral health disorders, including a mental health (MH) disorder and either a substance use disorder (SUD) or problem gambling (PG); or a behavioral health disorder and an intellectual or developmental disability (I/DD). HB 2086 includes individuals with PG and I/DD as part of a study of reimbursement rates for co-occurring disorder treatments.

The study is intended to provide support to achieve higher quality treatment outcomes for individuals experiencing COD (including I/DD and PG) as evidenced by: greater retention of member engagement in services, lower rates of recidivism/repeat treatment episodes, member reported higher quality of experience during treatment episode, and member reported quality of life at conclusion of treatment episode. For this study's purposes, the analysis of co-occurring disorders includes any combination of SUD, MH Disorders, PG, and I/DD. This study focused on the integration of these areas using a comprehensive approach to treatment that can include two or more of the above-mentioned categories.

Improvements in the integration of services for people experiencing I/DD and/or PG are integral to ensuring equitable COD service delivery in Oregon. This report identifies issues that should be addressed to support this effort. Challenges posed by integration in Oregon include: divisions within the health and human service system, issues with access specific to individuals with I/DD, and Oregon's diverse geographic landscape and population distribution.This report uses examples of individuals experiencing a variety of co-occurring conditions to demonstrate some of these challenges. To fulfill the aims of this study, Mercer performed a review of MH, SUD, PG, and I/DD services available in Oregon, conducted Subject Matter Experts (SME) interviews, analyzed financial datafrom OHA and the Oregon Department of Developmental Services (ODDS), and reviewed best and promising practices being used in other states. SME interviewes were conducted with 20 SMEs from across Oregon who have relevant expertise at different levels in the areas of focus for this study. Interview questions aimed to gather perceptions of the current state of COD integration across individuals with MH or SUD support needs, I/DD, and individuals requiring assistance with PG, as well as ideas about what integration could look like in the future. Financial data analysis reviewed the current cost of services relating to COD, COD and PG treatment, and COD and/or PG treatment for people with I/DD.

Key findings from this report include:

[1] House Bill 2086, 81st Oregon Legislative Assembly. (2021) https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/HB2086/Introduced

[2] It bears note that I/DD is not a "treatable" condition. The term "treatment" here refers to the treatment of mental health conditions and/or substance use disorders in people with I/DD.

- Data analysis showed a variance between the national prevalence rates of MH, SUD, I/DD, and PG and the penetration rate of service engagement and retention for members in Oregon. The current ICD (Integrated Co-Occurring Disorder) work that Oregon has in process should continue and where possible receive continued and increased financial support to reduce and close this gap.
- SME interviews revealed areas where integration is going well, including efforts over the last year with OHA that allowed for people to receive services under one roof for a combination of conditions. Interviews demonstrated that while Oregon has a strong array of MH, SUD, and PG services available to people with MH, SUD, PG, and I/DD, the ability of individuals with these different conditions to obtain these services, and in ways which best meet their needs, varies widely.
- Challenges to integration were also uncovered through SME interviews and the review of the Oregon service landscape. Challenges included the siloed nature of services, difficulties in billing for dually credentialed providers, issues with access including provider shortages, discrimination of individuals with I/DD, and insufficient provision of accomodations, and differences in service experience based on where an individual is served in the State.
- Financial data analysis revealed a total of 53,143 Oregon Medicaid members with co-occurring disorders in 2021. A prevalence comparison showcases the disparity between national studies of prevalence to Oregon data, indicating gaps in services for members with co-occurring disorders. The current Medicaid Behavioral Health spend is estimated to be $117.23 per month for Dual-eligible members and $293.98 per month for Non-dual eligible members.
- Oregon has begun taking many positive steps toward the integration of COD to include MH, SUD, I/DD, and PG, but still has several challenges to overcome to achieve it. Oregon displays commitment to strengthen its efforts to make PG increasingly more accessible and to include extension of these services to persons with IDD.
- To address the challenges and barriers to integration that are discussed in this report, recommendations for additional efforts include:
  - Initiation of stakeholder roundtables for each COD population group (MH, SUD, I/DD, and PG) in effort to glean the perspective of persons served beyond the SME interviews conducted as part of this paper
  - A comprehensive review of policies and administrative rules identified in the SME interviews which present barriers to COD progress in Oregon
  - Analysis of all services in each of the MH, SUD, I/DD, and PG programs with the goal of identifying specific services which could support further integration efforts (e.g., case management, care coordination, and services where service coordination is embedded)
  - Additional analysis to understand over and underspending across Oregon service regions
  - Develop timeline and resources needed to complete all areas of study

Section 2

Introduction

Mercer is contracted with the Oregon OHA to conduct a study of reimbursement rates for co-occurring disorder (COD) treatments, authorized by HB 2086 (d. 2021). To accomplish this, Mercer and OHA mutually agreed upon a scope of work that included the following:

1. Data Collection and Landscape Analysis
    A. Gather and review appropriate claims data.
    B. Conduct a review of the current MH, SUD, I/DD, and PG landscape in Oregon.
    C. Conduct a review of literature on the integration of MH, SUD, I/DD, and PG.
2. Convening of Meetings of Interested Parties
    A. Conduct SME interviews with representatives with expertise in MH, SUD, I/DD, and PG, including administrators and providers.
    B. Develop and vet through OHA a series of SME interview questions, with focus on the extent of integration at present, potential cost impacts and training needs, and perspectives on reimbursement.
    C. Create a summary of interview results was prepared based on findings from SME interviews.
3. Aggregate Input and Present Final Report
    A. Draft Final Report to include cost analysis based on claims data review, review of current Oregon landscape, review of integration literature, and SME interview summary.

The Mercer project team undertook this work between September 2022 and November 2022. Meetings with OHA were conducted on a bi-weekly schedule to enable Mercer to report progress and findings to OHA.

Section 3
Purpose

OHA indicated that this study should provide support to achieve higher quality treatment outcomes for individuals experiencing COD (including I/DD and PG) as evidenced by: greater retention of member engagement in services, lower rates of recidivism/repeat treatment episodes, member reported higher quality of experience during treatment episode, and member reported quality of life at conclusion of treatment episode.

OHA works with behavioral health system partners to improve services to Oregonians with co-occurring disorders by developing funding strategies and competencies, providing training and technical assistance to staff on program integration and evidence-based practices, conducting fidelity reviews, and revising the Integrated Services and Supports Oregon Administrative Rule.[3]

While maintaining a focus on the treatment of COD, the study aims to focus on how individuals who experience PG and/or I/DD could be better incorporated into COD treatments. The study does not include review of how I/DD or PG services are paid for. Rather, this study focuses on the integration of these areas using a comprehensive approach to treatment that can include two or more of the above-mentioned categories.

Payment and delivery systems for integrated care efforts can be on a fee-for-service (FFS), through managed care plans, or both. For FFS, fee schedules for the integrated care service treatments would need to be established to ensure payments are sufficient to provide access to the general population. With managed care, the fee paid to the managed care plans would be consistent per member per month regardless of actual utilization and would be easier to budget. The efficiency and quality of care provided by the contracted managed care plans would become integral for successful integration. Rate incentives based on quality metrics can be implemented to promote quality and efficient care, but the metrics would likely need to be developed specific to the integrated COD system.

OHA has already begun initiatives related to creating an integrated COD system, nominally referred to in Oregon as the ICD initiative. This includes accepting applications for proposals for startup grants.[4] Criteria to apply for this grant includes adhering to Oregon Administrative Rule (OAR). A draft, updated OAR has been created, which amends OAR 309-019-0145, requiring services to align with best practices in the treatment of Co-Occurring MH, SUD, and Gambling Disorder by utilizing an integrated model of treatment.[5] These initiatives aim to create additional credentialing by allowing provider organizations to seek a co-occurring Disorder Certificate of Approval (COA).

[3] Oregon Health Authority. "Co-occurring Disorders," available at https://www.oregon.gov/oha/HSD/AMH/Pages/Co-occurring.aspx

[4] Oregon Health Authority. (n.d.) Integrated Co-occurring Disorders. Oregon Health Authority Behavioral Health Services. Retrieved from https://www.oregon.gov/oha/HSD/AMH/Pages/Co-occurring.aspx

[5] OAR Draft to amend 309-019-0145

Section 4

Complexities and Challenges

Improvements in the integration of services for people experiencing I/DD and/or PG are integral to ensuring that COD services are delivered equitably in Oregon. There are, however, a number of factors that must be addressed in order to achieve this. To understand these, Mercer reviewed information about systems in Oregon that provide services to people with MH, SUD, I/DD, and PG, reviewed available information about gaps in these services, and conducted interviews with a number of SMEs suggested by OHA. From these sources, Mercer gathered that complexities to integration of I/DD and PG into COD services are born from a variety of factors outlined in this section.

A key issue that became apparent through the review of service systems and SME interviews is the division of Oregon's service system. Oregon's health and human service system is structurally divided, with OHA administering physical and behavioral health services, and Oregon Department of Human Services (ODHS) administering other human services, including I/DD. While these systems do regularly work together, they include different programs, language, payment structures and reporting, eligibility rules, and even service orientations. Adding additional complexity, services for MH and SUD are reimbursed through managed care organizations called Community Care Organizations while PG and I/DD are funded through lottery appropriations and a combination of Medicaid waivers and a Community First Choice state plan option, respectively. A SME in billing for these services reported that differences in payment method result in different reimbursement codes not easily cross-referenced and add confusion among providers about who they can serve and what is billable.

A report[6] mandated by SB5529 and provided to the Oregon legislature in February 2022, co-authored by OHA and ODHS, extensively outlined barriers specific to people served by the offices of Aging and People with Disabilities (ADP) and ODDS to receiving MH services. Although aging individuals are not specifically included in the study mandated by HB 2086, strategies for better connecting people with I/DD to MH services still provide important context for this report. The SB5529 report suggests seven different action items to improve access to MH services for people with I/DD, including:

1. Enforcing existing policies that would help to prevent discrimination across provider systems.
2. Developing stronger communication pathways between ODDS, OHA, and Community Mental Health Programs.
3. Developing processes and procedures to ensure mental health services are person-centered.
4. Supporting efforts to address the ongoing workforce shortage.
5. Developing methods to coordinate services for people with complex needs.

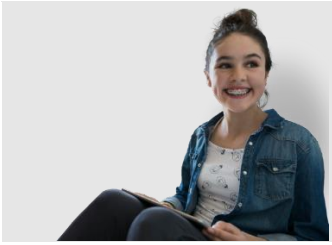
[6] Oregon Department of Human Services, Oregon Health Authority. (2022) SB5229 Report: Barriers to Mental Health Services for Older Adults and People with Disabilities. Retrieved from https://www.oregon.gov/dhs/ABOUTDHS/LegislativeInformation/SB%205529%20Barriers%20to%20Mental%20Health.pdfSubstance Abuse and Mental Health Services Administration

6. Exploring strategies to coordinate different Medicaid authorities to ensure all individuals receive appropriate services.
7. Requesting ongoing discussion with the legislature and community partners about the prioritization in state statute for mental health services.

In addition, Oregon has a diverse geographic landscape with similarly diverse population distribution. Urban centers typically have a larger network of providers from which to seek services and treatment whereas rural communities may have limited networks and in some cases service gaps. Telehealth may provide relief to service access challenges but may not be appropriate for all individuals. Treatment professionals and services teams should evaluate the appropriateness of telehealth in a person-centered way. The PG provider network that has been established since 1992 and which continues to develop offers at least one provider for each county. Further study would be required to provide a more detailed analysis by county of service access.

Some SMEs anecdotally suggested larger population centers may have more service providers available; this can mean that individuals with more than one type of service need may see many different providers. While this is not inherently negative, it can be burdensome for individuals to have multiple appointments and providers to coordinate. SMEs from more rural areas described scenarios and/or models that suggest that individuals in more rural areas may, in turn, see fewer providers due to a greater necessity for providers to wear multiple “hats” by being dually credentialed, or otherwise supporting multiple populations. This, however, creates higher risk of becoming disconnected from services should a provider close or leave the service market. Oregon’s commitment toward dual credentialing across disciplines is universally offered across all areas of Oregon and is a viable remedy to disparities or variances in professional training and practice expertise.

The following sample of fictional case scenarios attempts to further illustrate the complexities that people with COD experience:

Julietta	Dmitri	John
		
Julietta is a 14-year-old girl living in Harney County. Julietta was diagnosed with Autism at an early age and is now experiencing depression and problems with alcohol and marijuana use. Julietta receives services through the OR Children's HCBS waiver, which also makes her eligible for OHP. The Community Developmental Disabilities Program (CDDP) in Harney County is Symmetry Care. Symmetry Care creates an individual service plan (ISP) for Julietta that connects her to services offered through the OR Children's HCBS waiver and OHP that can best meet her needs including different employment services to her Julietta with early steps toward job training and a life with greater independence. In addition to acting as the CDDP in her county, Symmetry Care also offers mental health and addiction treatment services, not included in the OR Children's HCBS waiver. Therefore, when Symmetry Care evaluated Julietta when she first entered their care, they determined through assessment that her support needs extended beyond I/DD services and were able connect her with individualized therapy for her depression, and outpatient services to help her with her struggles with alcohol and marijuana use. All of Julietta's services are managed by Symmetry Care and are coordinated together to minimize her need to come in for appointments. Julietta currently is connected to providers that understand how to integrate her developmental disability, mental health and substance abuse needs. However, Julietta and her family are worried that she is at risk of losing some of her services if any of her providers move on or retire. Julietta and her family know that no other providers in their county are trained to understand how to manage all three of her service needs concurrently.	Dmitri is a 52-year-old Russian-born man living in Gresham, in Multnomah County. He has lived in the US for many years, and obtained his citizenship 5 years ago, but he is still working on English proficiency, and is closest with the Russian community in which he lives, socializes, and worships. Dmitri began to struggle with his alcohol use several years ago after taking a job at a construction company where he is the only Russian speaker. Feeling disconnected from his colleagues, Dmitri began stopping by bars on the way home from work to unwind. There, he discovered that playing video poker machines gave him something to do while he was in the bar and enabled him to not have to worry about speaking with others. Over time, he began spending more and more time in bars, and playing video poker machines. This has caused tensions with his family and friends, leaving Dmitri feeling more ostracized, anxious, and depressed. In addition, the cost of routinely purchasing alcohol and playing video poker is creating financial burdens for Dmitri and has resulted in two months of late rent payments. Recently, Dmitri was issued a DUI while returning home one evening and is now completing court-mandated addiction and mental health treatment. The mental health service provider that Dmitri was referred to does not specialize in addiction treatment, and so referred him to an addiction treatment provider in his area who they think may speak Russian. Dmitri's mental health service provider was not trained to assess for problem gambling, and so did not address this issue. Overwhelmed with providers and feeling confused and ashamed, Dmitri did not call the addiction treatment provider. While he found some of what he learned from his mental health service provider helpful, and sees that he may be drinking too much, he did not continue to see them after completing his court-mandated sessions.	John is a 38-year-old man living in Medford. John has always heard voices that tell him things that scare him. He finds that if he consumes enough alcohol or drugs, that the voices quiet down somewhat. John grew up in the foster care system and has been alone without family since he was 18. He has held jobs intermittently, but struggles with following complicated, multi-step directions, and feels like a failure when he loses a job. One day, while intoxicated, John falls down his stairs and hurts himself badly enough that he has to go to the hospital. The stress of the hospital brings out the voices, and the doctor who is treating him for a fall asks John if he has ever been diagnosed with a mental health disorder like schizophrenia. John does not know what schizophrenia is, but feels insulted by the doctor, who he believes is unintelligent. Nevertheless, the doctor orders a psychiatrist to meet with John while he is in the hospital. The psychiatrist meets with John and learns about his history by hearing voices, and his struggles to maintain a job. Based on what they learn, the psychiatrist makes a formal diagnosis of schizophrenia. The hospital team connects John with a community mental health service provider. The community mental health service provider does another intake screening and determines that John meets diagnostic criteria for schizophrenia and SUD. This provider happens to be dually-credentialed and can support John's mental health and SUD service needs. At no point in his service journey, however, is he assessed for I/DD, and so the intellectual disability that has played a large part in John's struggles at work goes undiagnosed and unsupported.

Oregon's ICD initiatives were developed in response to the challenges presented in these fictitious case examples, recognizing that individuals may have a variety of support needs, and

that the identification and treatment of these needs must be available through as many points in the system as possible. Oregonians living with co-occurring disorders require a highly skilled and well-coordinated service system that can be easily accessed and which does not shift the burden of care management and service coordination to the person served.

Integrated care can improve access to care, increase person-centeredness, promote equity, and increase availability of treatment.[7] It may be described as a “no wrong door” approach to service, or when a variety of services can be accessed through one point of entry, or as a singular service which encompasses all support needs. As such, integrated care can use a variety of models, including multi-disciplinary teams, which can contain multiple providers from different areas of practice, and dual-credentialing, which allows a single provider to support an individual with more than one diagnosis and support need.

[7] Minkoff, K., Covell, N.H. (2021) Recommendations for Integrated Systems and Services for People with Co-occurring Mental Health and Substance Use Conditions. Psychiatric Services. 73(6), 686-689. doi: https://doi.org/10.1176/appi.ps.202000839

Section 5
Methodologies

In an effort to best understand and to accurately represent the complexity of the COD population and its current service system, Mercer engaged in three research strategies. These included conducting SME interviews with key Oregon stakeholders, completing a financial analysis including claims review and the study of all service lines and reimbursement structures, and finally completing a national research study to understand both the relationship between prevalence rates of targeted groups (MH, SUD, I/DD, and PG) and the subsequent engagement rates with community based provider organizations as well as promising practices which promote improved integration for persons living with COD.

SME Interviews

Mercer conducted virtual interviews with SMEs across Oregon. To determine interviewees, OHA provided Mercer with a list of 20 pre-selected SMEs to include in the initial request for interviews. OHA also gave background information on this project to some SMEs before the interview request. Mercer scheduled interviews with SMEs via email and held a virtual orientation/training for the SMEs on the project prior to the scheduled interviews. The orientation included an overview of the ICD initiative and the reimbursement rate study, Mercer's role in supporting OHA, and expectations of interviewees. Between October 19, 2022 and October 28, 2022, Mercer conducted 15 interviews with 20 SMEs. Some of the interviews were conducted with small groups of SMEs from the same practice or from the same geographic region. Each interview was scheduled for 60 minutes, and interviewees were given the option to submit additional information to the Mercer team via email by November 1, 2022.

Interviews were conducted by Mercer staff using a 10-question interview instrument (see Appendix A), created by Mercer, and vetted by OHA staff. Interview questions aimed to gather perceptions of the current state of COD integration across individuals with MH or SUD support needs, I/DD, and individuals requiring assistance with PG. SME Interviewees (referred to here as SMEs/Interviewees) represented a range of experiences at many levels in the Oregon service system. SMEs included administrators and providers in MH, SUD, or both COD, I/DD, and PG, Coordinated Care Organization (CCO) administrators, and others in education, training, program evaluation, primary care integration, policy, and practice (See Appendix B).

Financial Data

Mercer completed an analysis of the current cost of services relating to COD, COD and PG treatment, and COD and/or PG treatment for people with I/DD. The following three data sources were utilized for the financial analysis:

- Calendar year (CY) 2021 CCO encounter data
- I/DD specific data obtained from the ODDS with enrollment and cost information for Medicaid members enrolled in I/DD services as of November 2022 Statewide (Medicaid plus Non-Medicaid) encounter data related to PG for the July 2021 through September 2022 period

In addition, known fee schedule increases that will become effective January 2023 related to co-occurring disorder treatment services were accounted for in the cost calculation.

Diagnosis codes used to identify members with MH/SUD and I/DD diagnoses were applied on the encounter data to isolate members with co-occurring disorders. The Category of Service (COS) field created by OHA was then used to bucket claims into physical health, MH, and pharmacy. This information was used to develop the 2021 unit cost, utilization, and Per Member Per Month (PMPM) cost metrics to analyze cost discrepancies and gaps in care by region and targeted cohorts. A crosswalk of the diagnosis coding and COS mapping logic is provided (see Appendix C).

For I/DD, the member list from ODDS was matched against the 2021 CCO eligibility data, and a total of 28,485 members were identified as having I/DD in 2021 and included in this report. Below is the breakdown of the I/DD members included in the report:

Region	IDD Only	PG+ IDD	SUD+ IDD	MH+ IDD	SUD+ PG+ IDD	MH+ PG+ IDD	MH+ SUD+ IDD	MH+ SUD+ PG+ IDD	Total
North Coast Basin	525	0	2	158	0	5	12	0	702
Lower Willamette Basin	12042	9	76	4433	3	137	283	10	16993
Central Coast/ Upper Willamette Basin	2781	2	41	1918	1	59	156	0	4958
Southwest Oregon Basin	2106	2	11	907	0	28	55	0	3109
Deschutes Basin	889	1	10	387	0	12	39	0	1338
High Desert Basin	187	0	2	204	0	6	29	0	428
John Day Umatilla Basin	384	0	0	87	0	3	6	0	480
Snake River Basin	337	0	5	122	0	4	7	0	475
Total	**19253**	**14**	**147**	**8216**	**4**	**254**	**587**	**10**	**28485**

Amongst the 28,485 members, only 9,232 were identified as having co-occurring conditions. The prevalence highlights the additional barriers experienced by members with I/DD to access the services they need. In addition to the members included in this report, another 4,000 I/DD members were identified as being in the developmental disabilities system, but are not part of Medicaid due to the limited network and lack of accessibility to independent providers, and are therefore not included in the report.

Regarding Problem Gambling, because PG treatment is currently not covered under the CCO Managed Care program within the Oregon Health Plan, another separate data source was needed to incorporate PG costs into the financial analysis. Statewide (Medicaid plus Non-Medicaid) encounter data related to PG for the July 2021 through September 2022 period was used as the basis for the development of the PG prevalence and costs shown in the financial analysis. The detailed assumptions developed using the statewide PG encounter data are consistent with what was used in the CY23 CCO rate development process, and are listed below:

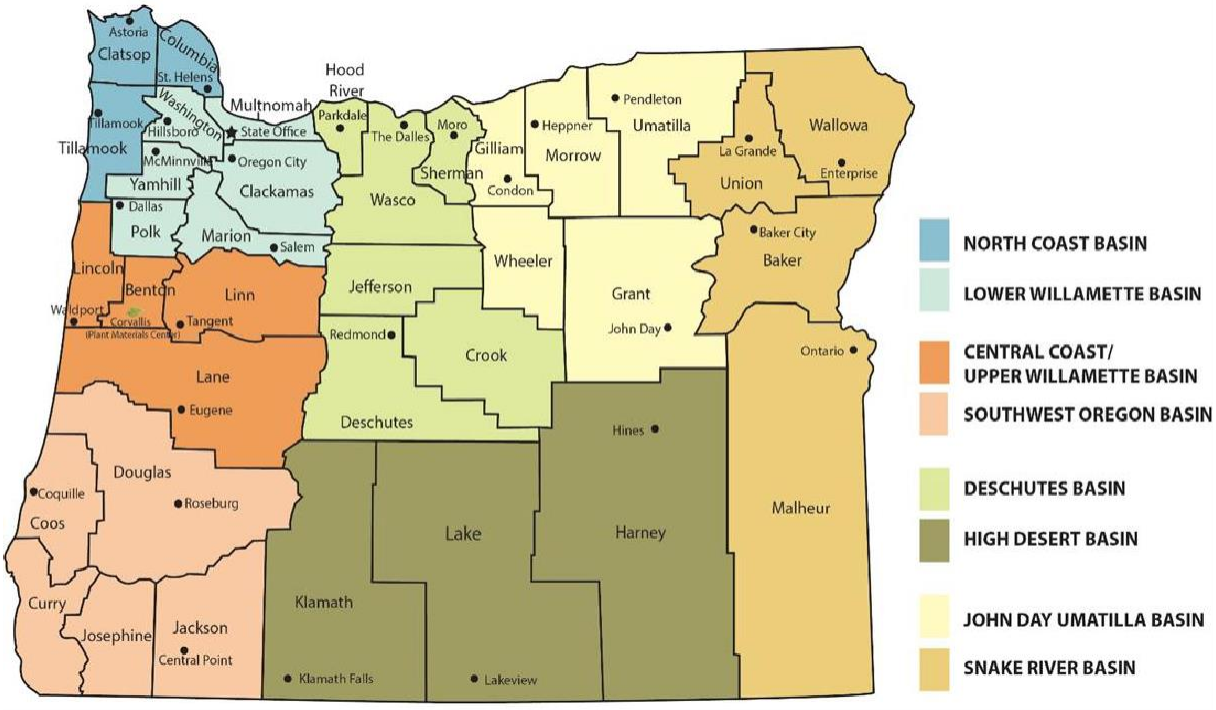
- At-Risk Rate of 2.6%
- Treatment Rate of 3.0%
- Annual Treatment Cost of $1,743
- Annual Units per Utilizer of 90.27

The at-risk rate above considers the fact that only a portion of the Medicaid population would be at-risk of developing a PG disorder. Members with co-occurring behavioral health conditions are assumed to be at-risk, so the at-risk rate is not applied for them in the analysis. With the above methodology, 1,740 PG utilizers were identified. The calculated annual claim cost related to Problem Gambling treatment services is around $3.0 million.

In addition to incorporating the PG assumptions, another adjustment was made to the base data to account for the fee schedule increase that would impact co-occurring disorder treatment services. Starting in CY23, mental health treatment services for certain co-occurring disorders provided by qualified providers will receive a uniform dollar increase add-on. The rate add-on is accounted for in the financial analysis and can be summarized as follows:

- Add-on rate is equal to 15% of the FFS State Plan rate for applicable services rendered by qualifying residential providers.
- Add-on rate is equal to 20% of the FFS State Plan rate for applicable services rendered by a provider with a Master's degree or higher in an applicable behavioral health field.
- Add-on rate is equal to 10% for all other qualifying providers rendering treatment for COD.

With the goal to identify drivers of gaps in care and discrepancies in cost, the adjusted data was analyzed at a granular level. In particular, the cost and utilization metrics were developed separately for each of the Oregon regions in order to account for potential provider network and contracting differences. The below Oregon state map illustrates how the regions were defined in the financial analysis:



In addition to looking at differences by region, the Dual eligible population (meaning individuals who are Medicaid eligible but also have another form of insurance, such as Medicare) and the Non-dual eligible population were separated in the analysis. Since a sizable portion of the Dual eligible MH cost is subsidized by payers other than Medicaid, bucketing the two populations together would skew the unit cost and cost PMPM calculations.

Finally, to provide an overview of the distribution of cost by the various disability groups, 11 targeted integrated sub-populations were examined. The table below shows combinations of two or more co-occurring conditions:

	Condition 1	Condition 2	Condition 3	Condition 4
Cohort 1	Mental Health	Substance Use Disorder	Problem Gambling	I/DD
Cohort 2	Mental Health	Substance Use Disorder	Problem Gambling	
Cohort 3	Mental Health	Substance Use Disorder		I/DD
Cohort 4		Substance Use Disorder	Problem Gambling	I/DD
Cohort 5			Problem Gambling	I/DD
Cohort 6	Mental Health		Problem Gambling	I/DD
Cohort 7	Mental Health			I/DD
Cohort 8		Substance Use Disorder		I/DD
Cohort 9	Mental Health		Problem Gambling	
Cohort 10	Mental Health	Substance Use Disorder		
Cohort 11		Substance Use Disorder	Problem Gambling	

By developing the unit cost, utilization, and PMPM cost metrics by various disability groups and by region, Mercer was able to highlight cost variances between identified members and provide clarity on the prevalence of the targeted cohorts. A summary of these findings is shown and discussed in the Financial Analysis section of this report. Analysis includes view of Dual eligibles (people eligible for both Medicaid and Medicare or Medicaid and other private insurance policy) and Non-dual eligibles (people eligible for only Medicaid).

Financial analysis also included physical health costs for the same cohort of people receiving MH, SUD, I/DD and PG services. Physical health claims were included to illustrate the total cost of care for the people supported with specialty ICD services. Total integration of care should consider both ICD specific services as well as physical health costs across multiple payer systems.

Research Efforts

To ensure that Mercer staff have a holistic understanding of the systems in Oregon that serve individuals who will be impacted by integration of COD, Mercer first undertook a scan of Oregon programming and services for MH, PG, SUD, and I/DD. To maximize the reach of research efforts, Mercer staff split up populations to that staff could dive more deeply into available materials and reduce overlap in research focus.

To manage this research, a common template was created to allow Mercer staff to capture programmatic information such as service name, target population, service code, eligibility criteria, service description, required credentials of service providers, focus on children/adults, published rate tables, and questions/comments the team member reviewing the service had. These were completed to the degree possible for 1915k, 1915b(4), Adult DD 0375, Children DD 0117, Behavioral 40194, Behavioral Rehabilitation Services Program, Intensive In-Home Behavioral Health Treatment, Diversion Services, Behavioral Health Crisis System and 988, Peer Delivered Services, Residential Treatment Homes, Residential Treatment Facilities, Secure Residential Treatment Facilities, and a host of services available for PG and SUD.

This research allowed Mercer staff to understand the system broadly and more thoughtfully develop questions for SMEs for the interviews conducted.

As SME interviews were taking place, Mercer staff also conducted a national environmental scan for any information on integrated co-occurring disorder services including PG and I/DD. Particular emphasis was placed on searching for reimbursement rates for such integrated services. Mercer project staff again divided this research by population. Results of both research efforts are discussed in the Trends and Gaps section of this report.

Section 6
Summary of Findings

SME Interviews Summary

To get a sense of how integration efforts have occurred so far in Oregon and what the future of integration looks like, Mercer conducted interviews with SMEs across Oregon. Upon completion of all the interviews, responses were summarized, and key themes were identified.

The following themes were selected to summarize SME feedback regarding ICD:

- Assessment
- Workforce Development and Certification
- Multi-Disciplinary Teams
- Intellectual and Developmental Disabilities
- Problem Gambling
- Financing
- Diverse Voices

SMEs described areas in which integration is going well in Oregon, such as efforts made over the last year toward integration through collaboration with OHA. For example, individuals receiving services under one roof for a combination of conditions, such as SUD and MH, are benefiting from integrated care efforts in Oregon. However, SMEs also described the systems in Oregon as quite siloed, particularly regarding PG and I/DD, resulting in less effective care and more struggles for providers. The detail of the SME interviews is provided (see Appendix D).

The SME interview responses clearly reflected that integration is not achieved exclusively by adjustment in reimbursement rates but requires thorough study and consideration across the aforementioned themes. Further analysis of policy and regulations which may be competing with the mission of integration is needed.

Financial Analysis

Mercer began the analysis of funding by comparing the rate of service engagement in Oregon with national prevalence rates by disability category:

	Age Group	MH	SUD	IDD	PG
National	Adolescent	46.2%	27.2%	17.8%	2.1%
	Adult	21.0%	23.8%	1.5%	3.0%
Oregon	Adolescent	16.9%	0.8%	3.4%	0.3%
	Adult	24.5%	9.4%	2.7%	0.3%

The MH, SUD, and PG national prevalence rates above are from the National Institute of Mental Health,[8] while the I/DD national prevalence rates are from Zablotsky et al.[9] and Larson et al.,[10] respectively. It is worth noting that the national I/DD adult rate is from 1994/1995 so may not be a true representation of the current national prevalence, while the available data for I/DD adolescent includes kids from ages three to 17, which is a wider inclusion criterion than for the other adolescent rate groups which only includes members aged 10 and older.

One last disclaimer regarding the comparison is that the Oregon rates are developed using identified members who were billed for care, while the national metrics are based on assessment rates, not individuals in service. The lower prevalence rates for Oregon, while expected, also show that there are members with mental health conditions that are not receiving the care they need.

Oregon's ICD initiative works to address these gaps in care through the development of improved access systems and specialized treatment approaches to improve engagement and retention in treatment and support services. Oregon should expand available funding to continue efforts which will decrease and eventually close the gap between national prevalence rates for the identified populations and Oregon's service penetration rate.

The exhibits which follow illustrate further analysis by region, including member count, total cost, utilization and per member per month payments for various cohorts receiving MH, SUD, I/DD, and PG services.

The 2021 unit cost, utilization, and Medicaid PMPM cost metrics for the members identified is summarized in the below exhibit:

Region	Cohort	Member Count	Member Months	MH PMPM	MH Util	MH UC	PH PMPM
North Coast Basin	Dual	197	2247	$ 44.28	1.41	$ 31.33	$ 53.98
	Non-Dual	1378	15157	$ 163.09	2.89	$ 56.45	$ 355.31
Lower Willamette Basin	Dual	3855	44415	$ 135.87	3.33	$ 40.84	$ 44.09
	Non-Dual	21833	244308	$ 331.82	5.68	$ 58.38	$ 328.90
Central Coast/ Upper Willamette Basin	Dual	1632	18826	$ 109.07	3.15	$ 34.67	$ 30.38
	Non-Dual	9267	103910	$ 314.10	5.81	$ 54.11	$ 333.40
Southwest Oregon Basin	Dual	995	11342	$ 68.83	1.88	$ 36.57	$ 23.55
	Non-Dual	6605	73989	$ 184.65	3.63	$ 50.91	$ 302.84
Deschutes Basin	Dual	390	4423	$ 156.92	3.69	$ 42.48	$ 40.52
	Non-Dual	3416	37795	$ 373.69	6.40	$ 58.42	$ 177.13
High Desert Basin	Dual	154	1761	$ 179.71	2.04	$ 87.90	$ 110.07
	Non-Dual	1209	13067	$ 247.41	3.48	$ 71.05	$ 253.53
John Day Umatilla Basin	Dual	98	1124	$ 54.77	0.86	$ 63.70	$ 35.92
	Non-Dual	823	9032	$ 142.77	2.01	$ 70.95	$ 357.19
Snake River Basin	Dual	179	1976	$ 29.38	0.55	$ 53.23	$ 109.26

[8]National institute of Mental Health. (n.d.) Mental Illness. National Institute of Mental Health: Mental health information. Retrieved from www.nimh.nih.gov/health/statistics/mental-illness

[9]Zablotsky, B., Black, L.I., Maenner, M.J., Schieve, L.A., Danielson, M.L., Bitsko, R.H., Blumberg, S.J.,…Boyle, C.A. (2019) Prevalence and Trends of Developmental Disabilities among Children in the US: 2009-2017. Pediatrics. 144(4). doi: 10.1542/peds.2019-0811

[10]Larson, S. A., Lakin, K. C., Anderson, L., Kwak, N., Lee, J. H., & Anderson, D. (2001). Prevalence of mental retardation and developmental disabilities: estimates from the 1994/1995 National Health Interview Survey Disability Supplements. American Journal on Mental Retardation, 106(3), 231-252. No doi.

Region	Cohort	Member Count	Member Months	MH PMPM	MH Util	MH UC	PH PMPM
	Non-Dual	1112	12386	$ 108.39	1.51	$ 71.84	$ 318.86
Total	**Dual**	**7500**	**86113**	**$ 117.23**	**2.95**	**$ 39.81**	**$ 41.17**
	Non-Dual	**45643**	**509644**	**$ 293.98**	**5.16**	**$ 57.01**	**$ 313.91**

Overall, the Dual-eligible identified members incurred MH costs amounting to $117.23 per month while the Non-dual eligible members incurred MH costs amounting to $293.98 per month. North Coast Basin, John Day Umatilla Basin, and Snake River Basin stood out as having significantly less MH spending and utilization than other regions. Another interesting finding is that Deschutes Basin has much lower physical health spend than other regions, but has the highest MH spend.

The table below further splits out the mental health costs by the 11 targeted cohorts:

Region	Cohort	MH+ SUD+ PG+ I/DD	MH+ SUD+ PG	MH+ SUD+ I/DD	MH+ PG+ I/DD	SUD+ PG+ I/DD	MH+ SUD	MH+ PG	MH+ I/DD	SUD+ PG	SUD+ I/DD	PG+ I/DD
North Coast Basin	Dual	$0.00	$199.80	$27.52	$156.62	$0.00	$54.55	$0.00	$11.37	$0.00	$0.00	$0.00
	Non-Dual	$0.00	$313.96	$150.18	$179.56	$0.00	$168.71	$204.87	$34.31	$213.61	$0.00	$0.00
Lower Willamette Basin	Dual	$0.00	$312.26	$217.71	$229.43	$164.05	$167.01	$226.87	$84.18	$222.42	$18.80	$159.19
	Non-Dual	$948.15	$480.75	$802.90	$396.50	$218.78	$335.50	$276.01	$251.25	$290.30	$73.53	$162.89
Central Coast/ Upper Willamette Basin	Dual	$0.00	$282.27	$103.53	$199.59	$0.00	$137.02	$205.89	$54.34	$0.00	$71.46	$152.68
	Non-Dual	$0.00	$468.11	$456.47	$375.48	$240.89	$322.86	$280.09	$230.23	$274.30	$95.64	$164.60
Southwest Oregon Basin	Dual	$0.00	$227.75	$98.00	$170.11	$0.00	$82.50	$184.74	$24.86	$0.00	$115.48	$149.84
	Non-Dual	$0.00	$331.29	$222.85	$268.41	$0.00	$186.04	$237.41	$123.16	$228.83	$8.93	$154.82
Deschutes Basin	Dual	$0.00	$334.74	$158.24	$210.15	$0.00	$189.49	$194.58	$64.90	$0.00	$90.84	$0.00
	Non-Dual	$0.00	$524.18	$472.53	$417.53	$0.00	$378.93	$290.15	$272.28	$291.44	$23.57	$165.67
High Desert Basin	Dual	$0.00	$369.86	$562.36	$227.61	$0.00	$224.61	$0.00	$82.36	$0.00	$0.00	$0.00
	Non-Dual	$0.00	$367.98	$434.81	$503.56	$0.00	$222.73	$241.04	$358.31	$0.00	$43.64	$0.00
John Day Umatilla Basin	Dual	$0.00	$221.21	$3.07	$149.53	$0.00	$75.96	$0.00	$4.28	$0.00	$0.00	$0.00
	Non-Dual	$0.00	$287.67	$44.63	$233.17	$0.00	$142.42	$172.79	$87.92	$193.72	$0.00	$0.00
Snake River Basin	Dual	$0.00	$178.50	$3.33	$151.16	$0.00	$33.25	$0.00	$5.91	$0.00	$12.63	$0.00
	Non-Dual	$0.00	$254.28	$24.73	$184.29	$0.00	$109.03	$175.05	$39.04	$174.27	$0.00	$0.00
Total	**Dual**	**$0.00**	**$287.30**	**$170.33**	**$212.06**	**$183.32**	**$142.05**	**$209.95**	**$66.81**	**$200.18**	**$38.07**	**$155.88**
	Non-Dual	**$948.15**	**$441.34**	**$591.36**	**$372.41**	**$215.81**	**$296.09**	**$266.69**	**$227.16**	**$267.81**	**$70.56**	**$161.81**

As expected, an increase in cost associated with increase in severity is apparent. Members identified with all four conditions are the most expensive, followed by members with three conditions.

The prevalence rate of co-occurring mental health disorder were studied by grouping members into the following categories:

- Members incurred no MH claims

- Members with incurred MH claims in only one of the four conditions (MH, SUD, PG, I/DD)
- Members with incurred MH claims in two of the four conditions
- Members with incurred MH claims in three of the four conditions
- Members with incurred MH claims for all four conditions

The exhibit below shows the prevalence rate for the Medicaid population for 2021.

Region	No MH Claims	One Conditions	Two Conditions	Three Conditions	Four Conditions
North Coast Basin	77.5%	17.6%	4.7%	0.2%	0.0%
Lower Willamette Basin	75.3%	20.1%	4.4%	0.2%	0.0%
Central Coast/ Upper Willamette Basin	70.2%	23.8%	5.8%	0.3%	0.0%
Southwest Oregon Basin	77.2%	18.4%	4.2%	0.2%	0.0%
Deschutes Basin	74.5%	20.8%	4.6%	0.2%	0.0%
High Desert Basin	77.9%	17.3%	4.5%	0.2%	0.0%
John Day Umatilla Basin	84.5%	12.4%	3.0%	0.1%	0.0%
Snake River Basin	79.3%	16.1%	4.4%	0.2%	0.0%
Total	**75.2%**	**20.1%**	**4.6%**	**0.2%**	**0.0%**

Around 4.8% of the Medicaid population are identified with having co-occurring MH conditions, with Central Coast/ Upper Willamette Basin region having the highest prevalence rate at 6.1%.

The exhibit below focuses on members with co-occurring MH conditions and presents the prevalence by the 11 targeted cohorts by region, separated by Non-Dual eligible and Dual-eligible members.

Region	Cohort	MH+ SUD+ PG+ I/DD	MH+ SUD+ PG	MH+ SUD+ I/DD	MH+ PG+ I/DD	SUD+ PG+ I/DD	MH+ SUD	MH+ PG	MH+ IDD	SUD+ PG	SUD+ IDD	PG+ IDD	Total
North Coast Basin	Dual	0	4	6	2	0	124	0	60	0	1	0	197
	Non-Dual	0	38	6	3	0	1228	3	98	1	1	0	1378
Lower Willamette Basin	Dual	0	61	105	50	1	1985	6	1618	1	25	3	3855
	Non-Dual	10	558	178	87	2	18053	62	2815	11	51	6	21833
Central Coast/ Upper Willamette Basin	Dual	0	29	47	18	0	934	2	592	0	9	1	1632
	Non-Dual	0	232	109	41	1	7496	25	1326	4	32	1	9267
Southwest Oregon Basin	Dual	0	19	26	10	0	620	2	313	0	4	1	995
	Non-Dual	0	178	29	18	0	5757	17	594	4	7	1	6605
Deschutes Basin	Dual	0	8	12	3	0	257	1	108	0	1	0	390
	Non-Dual	0	92	27	9	0	2988	10	279	1	9	1	3416
High Desert Basin	Dual	0	3	5	2	0	81	0	62	0	1	0	154
	Non-Dual	0	31	24	4	0	1004	3	142	0	1	0	1209
	Dual	0	2	3	1	0	61	0	31	0	0	0	98

Region	Cohort	MH+ SUD+ PG+ I/DD	MH+ SUD+ PG	MH+ SUD+ I/DD	MH+ PG+ I/DD	SUD+ PG+ I/DD	MH+ SUD	MH+ PG	MH+ IDD	SUD+ PG	SUD+ IDD	PG+ IDD	Total
John Day Umatilla Basin	Non-Dual	0	23	3	2	0	736	2	56	1	0	0	823
Snake River Basin	Dual	0	4	2	2	0	117	0	50	0	4	0	179
	Non-Dual	0	31	5	2	0	998	2	72	1	1	0	1112
Total	**Dual**	**0**	**130**	**206**	**88**	**1**	**4179**	**11**	**2834**	**1**	**45**	**5**	**7500**
	Non-Dual	**10**	**1183**	**381**	**166**	**3**	**38260**	**124**	**5382**	**23**	**102**	**9**	**45643**
Duals %		**0.0%**	**9.9%**	**35.1%**	**34.6%**	**25.0%**	**9.8%**	**8.1%**	**34.5%**	**4.2%**	**30.6%**	**35.7%**	**14.1%**

Overall, about 86% of the identified members were Non-Dual eligible. Targeted cohorts that include members with I/DD are more often dual-eligible than the others, indicating that I/DD services are more likely subsidized by payers other than Medicaid.

The table below combines the Dual-eligible and Non-Dual eligible prevalence and summarizes the estimated number of members identified using the available data.

Region	MH + SUD +PG + IDD	MH + SUD +PG	MH + SUD + IDD	MH + PG + IDD	SUD + PG + IDD	MH + SUD	MH + PG	MH + IDD	SUD + PG	SUD + IDD	PG + IDD	Total
North Coast Basin	0	42	12	5	0	1352	3	158	1	2	0	1575
Lower Willamette Basin	10	619	283	137	3	20038	68	4433	12	76	9	25688
Central Coast/ Upper Willamette Basin	0	261	156	59	1	8430	27	1918	4	41	2	10899
Southwest Oregon Basin	0	197	55	28	0	6377	19	907	4	11	2	7600
Deschutes Basin	0	100	39	12	0	3245	11	387	1	10	1	3806
High Desert Basin	0	34	29	6	0	1085	3	204	0	2	0	1363
John Day Umatilla Basin	0	25	6	3	0	797	2	87	1	0	0	921
Snake River Basin	0	35	7	4	0	1115	2	122	1	5	0	1291
Total	**10**	**1313**	**587**	**254**	**4**	**42439**	**135**	**8216**	**24**	**147**	**14**	**53143**

In total, 53,143 members were found to have two or more co-occurring conditions.

The exhibit below further summarizes the distribution of the identified members into the targeted cohorts by region.

Region	MH+ SUD + PG+ I/DD	MH+ SUD +PG	MH+ SUD +I/DD	MH+ PG+ I/DD	SUD +PG + I/DD	MH+ SUD	MH+ PG	MH+ IDD	SUD + PG	SUD + IDD	PG + IDD	Total
North Coast Basin	0.0%	2.7%	0.8%	0.3%	0.0%	85.8%	0.2%	10.0%	0.1%	0.1%	0.0%	100.0%
Lower Willamette Basin	0.0%	2.4%	1.1%	0.5%	0.0%	78.0%	0.3%	17.3%	0.0%	0.3%	0.0%	100.0%
Central Coast/ Upper Willamette Basin	0.0%	2.4%	1.4%	0.5%	0.0%	77.3%	0.2%	17.6%	0.0%	0.4%	0.0%	100.0%

Region	MH+ SUD + PG+ I/DD	MH+ SUD +PG	MH+ SUD +I/D D	MH+ PG+ I/DD	SUD +PG + I/DD	MH+ SUD	MH+ PG	MH+ IDD	SUD + PG	SUD + IDD	PG + IDD	Total
Southwest Oregon Basin	0.0%	2.6%	0.7%	0.4%	0.0%	83.9%	0.3%	11.9%	0.1%	0.1%	0.0%	100.0%
Deschutes Basin	0.0%	2.6%	1.0%	0.3%	0.0%	85.3%	0.3%	10.2%	0.0%	0.3%	0.0%	100.0%
High Desert Basin	0.0%	2.5%	2.1%	0.4%	0.0%	79.6%	0.2%	15.0%	0.0%	0.1%	0.0%	100.0%
John Day Umatilla Basin	0.0%	2.7%	0.7%	0.3%	0.0%	86.5%	0.2%	9.4%	0.1%	0.0%	0.0%	100.0%
Snake River Basin	0.0%	2.7%	0.5%	0.3%	0.0%	86.4%	0.2%	9.5%	0.1%	0.4%	0.0%	100.0%
Total	**0.0%**	**2.5%**	**1.1%**	**0.5%**	**0.0%**	**79.9%**	**0.3%**	**15.5%**	**0.0%**	**0.3%**	**0.0%**	**100.0%**

Among the 11 cohorts, co-occurring of MH and SUD was by far the most common for each of the regions. Overall, 79.9% of the identified members fall into this sub-population.

The sub-population distribution findings align with the learnings from the SME interviews, where PG and I/DD were discussed as separate and siloed programs. For PG, while statewide data was obtained for the purpose of the analysis, the utilization was found to be much lower than the prevalence for mental health and substance use disorder treatments. The stigma around PG, where members may not want to be associated with needing treatment, is likely a key driver of the variances in prevalence. For I/DD, the data from ODDS indicates that the average monthly cost per case for members in the developmental and disabilities system is $6,280. While these costs are not MH related, potential increase in cost on these expenditures through integration is highly likely due to reducing gaps in care, and therefore should be considered.

Trends, Gaps, and Promising Practices

State Landscape

Research into the Oregon service system further affirmed a bifurcation between MH, SUD, PG, and I/DD services. While Oregon has a strong array of MH, SUD, and PG[11] services available to people with MH, SUD, PG, and I/DD, the ability of individuals with these different conditions to obtain these services, and in ways which best meet their needs, varies widely. This research suggests that barriers to integration have less to do with the services available, and more with the channels through which they are available — meaning that services for these four conditions are not currently aligned under a singular funding stream or government agency. For instance, individuals with I/DD have their I/DD service needs met through waivers. Should they also need supports for MH, the access point is often different for them, since these services are not included to any significant degree on waivers. This may mean that they enter unfamiliar territory

[11] Services to be integrated through ICD efforts. Because I/DD services are typically not specific to COD, these are not included in this reference.

in a new branch of service, and that interactions between their existing services and providers and any new providers require a greater degree of coordination to avoid duplication of services.

MH and SUD services appear to have the highest level of integration due to being offered under the same Medicaid program (OHP), and to provider models such as dual-credentialing and team-based approaches that allow individuals to receive treatment and services for both conditions at once. Importantly, however, individuals cannot receive treatment at the same time for multiple conditions, due to broader federal regulations that disallow providers to bill concurrently for different modalities. For example, an individual with SUD and MH may see a provider who is dually-credentialed and able to provide support for both conditions. However, any service the provider renders and bills for can only be coded using one bill code, forcing the provider to choose whether the supports provided should be billed as SUD or MH. One prominent exception to this can be seen in the ACT service, which flips the service paradigm somewhat by allowing providers of many different backgrounds to bill to one service code that encompasses a broader type of treatment.

In addition to the structural issues identified by Mercer's research and in SME interviews, significant issues are outlined in the SB5529 report relating to discriminatory practices, insufficient provider capacity, insufficient knowledge of the PG and I/DD populations and consequent reluctance of providers to serve these populations, and insufficient accommodation provided to people with I/DD also deeply impact the ability of people with PG and I/DD to receive COD services.

National Landscape

As noted, Mercer also conducted research into integrated co-occurring disorder services including PG and I/DD across other states. This scan produced best-practice literature on COD services specific to MH and SUD,[12,13] some information on recommendations and examples of integration of populations,[14,15] and some relating to the integration of I/DD.[16,17] Mercer found few resources related to the integration of PG, however did not place as much emphasis on this, given Oregon's reputation as a national leader in PG, and our understanding that this area would likely return few resources.

COD policy recommendations included developing a systematic approach to identifying and monitoring the prevalence of co-occurring disorders, streamlining the licensure process for providers seeking dual-licensure, making improvements to payment policies that limit access to

[12] Substance Abuse and Mental Health Services Administration. (Updated 2020) Treatment Improvement Protocol TIP 42. Retrieved from https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-02-01-004_Final_508.pdf

[13] Substance Abuse and Mental Health Services Administration. (2009) Integrated Treatment for Co-Occurring Disorders: Building your program. DHHS Pub. No. SMA-08-4366, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-building-your-program-10112019.pdf

[14] Minkoff, K., Covell, N.H. (2021) Recommendations for Integrated Systems and Services for People with Co-occurring Mental Health and Substance Use Conditions. Psychiatric Services. 73(6), 686-689. doi: https://doi.org/10.1176/appi.ps.202000839

[15] Commonwealth of Massachusetts Health Policy Commission. (2019) Co-occurring disorders care in Massachusetts: A report on the statewide availability of health care providers serving patients with co-occurring substance use disorder and mental illness. Retrieved from https://www.mass.gov/doc/co-occurring-disorders-care-in-massachusetts-a-report-on-the-statewide-availability-of-health/download

[16] Mid-America ATTC, UMKC Institute for Human Development, and Opioid Response Network. (n.d.) IDD/SUD Roundtable Toolkit: Working with People with Intellectual and Development Disabilities who Struggle with Substance Use Disorders. Retrieved from https://peerrecoverynow.org/ResourceMaterials/IDDSUD%20Roundtable%20Toolkit.pdf

[17] Bhatt, N.V., Gentile, J.P. (2021) Co-occurring intellectual disability and substance use disorders. AIMS Public Health. 8(3), 479-484. doi: 10.3934/publichealth.2021037

MH and SUD services.[18] Practice recommendations include the utilization of motivational interviewing and specific interview techniques for individuals with ID/SUD.[19]

As part of this national environmental scan, Mercer also looked for examples of COD practices or payment models from states specific to states who have included PG or I/DD in COD integration efforts. The most publicly available information on COD inclusive of I/DD was found in Ohio. Through joint funding from the Ohio Department of Mental Health and Addiction Services and the Department of Developmental Disabilities, an entity called the Mental Illness/Intellectual Disabilities Coordinating Center of Excellence (MI/ID CCOE) was developed. This center focuses on creating access to assessments and expert recommendations, providing training and education for providers and future providers to address MH and DD needs, supporting MH and DD in coordinating, and working together, and building knowledge and resources for communities serving this population. The MI/ID CCOE operates a telepsychiatry project for ID, which connects children and adults with DD in rural areas to psychiatric services. They also offer psychiatric consultation for teams working with individuals with complex needs, and have a focus on mental wellness, trauma-informed care, and increasing family resilience.

Although we were unable to find information on the rates paid for any of these services, we did determine that a portion of funding for DD services in Ohio comes through tax levies. This funding is then managed and distributed by County Boards. By using a mix of levy, state, and federal dollars, Ohio can run innovative programs. In relation to I/DD and COD, County Boards are required to provide a contact person to assist with coordinating the tele psychiatry services specifically and are expected to create a collaborative relationship between themselves and county MH Boards to support individuals with DD's full-service needs. We also learned that collaborative efforts are in place between the Ohio Office of Disability (Opportunities for Ohioans with Disabilities/OOD) and the Ohio Department of Mental Health and Addiction Services (OMHAS). Specifically, OOD partners with OMHAS in promoting positive employment outcomes for individuals with severe and persistent MI and/or co-occurring SUD. Additional information about what this looks like in practice was not available.

Existing research completed by Mercer on the integration of MH and I/DD services, programs, pilots, and services specific to this population found activity in six additional states, including Maryland, New Hampshire, New Jersey, Pennsylvania, Tennessee, and Washington state. These activities ranged from services focused on acute care and residential treatment programs, to the use of dual diagnosis (MH/IDD) treatment teams, assessment and stabilization teams, and START (Systemic, Therapeutic, Assessment, Resources, Treatment) programming and pilots. These activities were paid for via Medicaid Waiver and ICD/IID funding authorities. While these models are helpful to understand activities other states are undertaking in this area, they are not exactly on par with the kind of multi-population, cross-system integration that Oregon is looking to achieve. They are included here, however, to demonstrate some potential activities that may be of interest to Oregon as a means of moving toward integration of people with I/DD.

[18] Commonwealth of Massachusetts Health Policy Commission. (2019) Co-occurring disorders care in Massachusetts: A report on the statewide availability of health care providers serving patients with co-occurring substance use disorder and mental illness. Retrieved from https://www.mass.gov/doc/co-occurring-disorders-care-in-massachusetts-a-report-on-the-statewide-availability-of-health/download

[19] Bhatt, N.V., Gentile, J.P. (2021) Co-occurring intellectual disability and substance use disorders. AIMS Public Health. 8(3), 479-484. doi: 10.3934/publichealth.2021037

Section 7
Conclusion

Mercer found that Oregon has begun taking many positive steps toward the integration of COD to include MH, SUD, I/DD, and PG, but still has several challenges to overcome to achieve it. A particular strength for Oregon is the commitment to strengthen its efforts to make PG increasingly more accessible and to include extension of these services to persons with I/DD. In addition, several SME interview respondents indicated much intentional effort across the departments and divisions of OHA to continue work toward integration of services, member access to care and systems integration. Cross department training efforts contain content stressing the importance of whole-person care, including behavioral health, problem gambling, I/DD, and physical health. However, the review of programming and policies in Oregon and SME interviews acknowledges that while there are many good services in place as well as many good practices emerging at the county and provider levels, not all individuals are connecting to the services they need or are receiving services in the manner that works best for them.

Structurally, there are different agencies managing services, different funding streams, different governing rules, regulations, and different service orientations and modalities, as well as differing levels of understanding of what is available and who can receive services. Regional differences in service provision also contribute to this issue. Individuals in rural areas may be served by dually/multi-credentialed staff while individuals in urban areas may see more care-team like models and services which are organized through a single entity but provided by multiple staff, or co-location of services, but not dually credentialed staff. Data analysis conducted by Mercer underscores these findings. Across the state, more rural areas, such as the northern coast, and the northeastern and far eastern areas showed significantly less spending and utilization of MH services than other areas in the state.

It is also notable that access to services may differ based on provider availability and enforcement of policies that prevent discrimination across provider systems, Individuals may require different accommodations in order to access services, and such accommodations are not always available.

People served should, if they choose, be able to discuss any aspect of their health care with any service provider that supports them or be indirectly supported by a multi-disciplinary team which can integrate all their care needs into a well-coordinated plan of care. Similarly, Oregon should continue its work toward a fully integrated administrative structure which integrates payment models, program authorities, policies, and regulations. Such integration efforts should be structured to reflect the cultural and social diversity that represents Oregon’s citizens.

A thorough understanding of the reimbursement system is a solid foundation on which to build additional programmatic reform. While additional funding may help to stabilize a workforce and provider system that is currently stretching to serve people living with COD, financial assistance and dual credentialing alone may not deliver the return that Oregon is hoping to achieve. Additional efforts in the following areas are strongly encouraged:

- Initiation of stakeholder roundtables for each COD population group (MH, SUD, I/DD, and PG) in effort to glean the perspective of persons served beyond the SME interviews conducted as part of this paper.
- A comprehensive review of policies and administrative rules identified in the SME interviews which present barriers to COD progress in Oregon.
- Analysis of all services in each of the MH, SUD, I/DD and PG programs with the goal of identifying specific services which could support further integration efforts (e.g., case management, care coordination, and services where service coordination is embedded).

Section 8
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Appendix A

SME Interview Questions

1. How do people with co-occurring disorders enter the system and receive their initial needs assessment?

2. What happens when a new co-occurring condition surfaces during treatment that might be considered out of scope for the provider working with the person?

3. How do case managers and care coordinators currently support people with co-occurring needs who may be served across different disciplines?

4. Describe areas within the Oregon service system where integrated treatment is currently being done well.

5. Describe what a fully integrated system would look like that could effectively and efficiently support a person living with mental health, substance abuse, intellectual and developmental disability, and problem gambling?

6. What do you think it would take to transform the current system into one that was better or fully integrated? What changes to you think could be most easily accomplished? What would be most challenging?

7. What costs do you anticipate that providers of MH, SUD, IDD and PG services would incur that are not currently covered by service reimbursements?

8. Are there current workforce development issues that should be considered as part of Oregon's service integration efforts?

9. What issues should we consider as part of the reimbursement study for people with more than one type of insurance coverage?

10. What other considerations would help develop a roadmap for an integrated service system?

Appendix B

SME Interview Cohort

Name	County/Agency	Title	Focus Area
Amber Clegg	Deschutes County	Access Manager	Outpatient MH and SUD treatment
Anna Lansky	ODDS	Deputy Director	ODDS System Administrator
April Nelson	ADAPT	Lead Counselor/Supervisor	Outpatient SUD
Brandi Johnson	ADAPT	Program Director SUD Outpatient	Outpatient SUD
Dannielle Brown	Pacific Source	CCO BH Director	CCO Administration
Denna Vandersloot	NWATTC/U of W	Director	Educator, Trainer, Program Evaluation
Emilie Dauch	Bestcare Treatment	QA Manager	SUD, PG, and MH Outpatient and Residential Provider
Greta Coe	OHA	Program Manager	PG System Administrator
Jerry O'Sullivan	ADAPT	Chief of Regional Business Operations	Business Affairs
Jessica Macklin	NW Treatment	Manager	Outpatient SUD
Karen Cady-Pyle	OHA	Certification & Licensing Specialist	OHA Policy and Practice
Kathy Prenevost	Additions Team Supervisor	Washington County Behavioral Health (Center for Addictions, Triage, and Treatment)	SUD and MH
Paul Roberston	ADAPT	Program Director for Adult Residential Treatment	MH, SUD, Inpatient Residential Treatment
Rachel McWilliams	Deschutes County	QA Manager	Outpatient MH and SUD Treatment
River McKenzie	Emergence	Program Supervisor	PG, SUD and MH Outpatient Program
Samuel Denney	ADAPT	Program Director for Opioid Treatment	SUD Inpatient and Outpatient
Tami Stump	Polk County Behavioral Health	Health Service Finance Officer	BH and SUD Billing and Claims

Name	County/Agency	Title	Focus Area
Tara Modungo	ADAPT	BH Director for Curry County	MH and SUD
Thad Labhart	Community Counseling Solutions	Clinical Director	MH, SUD, and Primary Care

Appendix C

Crosswalk of the Diagnosis Coding and COS Mapping Logic

Co-occurring disorder member identification by diagnosis code:

Condition Group			
SUD	MH	MH + SUD	I/DD
F1010	F060	F1014	F700
F1020	F062	F10159	F701
F1110	F0631	F10180	F708
F1120	F0632	F10231	F709
F1123	F0633	F10232	F710
F1210	F0634	F10239	F711
F1220	F064	F1024	F718
F12288	F2081	F10259	F719
F1310	F209	F10280	F720
F1320	F21	F1094	F721
F13232	F22	F10959	F728
F13239	F23	F1114	F729
F1410	F250	F11188	F730
F1420	F251	F1123	F731
F1423	F310	F1124	F738
F1510	F3111	F11288	F739
F15121	F3112	F11921	F780
F15129	F3113	F11988	F781
F1520	F312	F12159	F788
F15229	F3131	F12180	F789
F1523	F3132	F12259	F790
F15929	F314	F12280	F791
F1810	F315	F13121	F798
F1820	F3173	F1314	F799
F630	F3174	F13159	
	F3175	F13180	
	F3176	F13181	
	F3181	F13182	
	F319	F13221	
	F320	F13231	
	F321	F1324	
	F322	F13259	
	F323	F1327	
	F324	F13280	
	F325	F13281	
	F329	F13282	

Condition Group			
SUD	MH	MH + SUD	I/DD
	F330	F13288	
	F331	F13921	
	F332	F1394	
	F333	F13980	
	F3341	F13981	
	F3342	F13982	
	F339	F13988	
	F340	F1414	
	F40000	F14159	
	F4010	F14180	
	F410	F14181	
	F411	F14182	
	F42	F14188	
	F4310	F1424	
	F4320	F14259	
	F4321	F14280	
	F4322	F14281	
	F4323	F14282	
	F4325	F14288	
	F4481	F1494	
	F4522	F14981	
	F481	F15122	
	F5001	F1514	
	F5002	F15159	
	F502	F15180	
	F508	F15181	
	F600	F15182	
	F601	F15188	
	F602	F15221	
	F603	F1524	
	F604	F15259	
	F605	F15280	
	F606	F15281	
	F607	F15282	
	F900	F15288	
	F901	F15921	
	F902	F1594	
	R4183	F15959	
		F15980	
		F15982	
		F15988	
		F1814	
		F18159	
		F18180	

Condition Group			
SUD	MH	MH + SUD	I/DD
		F1824	
		F18259	
		F18280	

Category of Service (COS) mapping logic:

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Ip-Ther-Abort-Ip-Hosp	Inpatient	FFS/EXCLUDE	FFS/EXCLUDE
Ip-Acute-Detox	inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Med-Surg-Med-Only	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Med-Surg-Surg-Only	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Or-Spec-Drg-NeoNates	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Newborn-Complicated	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Newborn-Well	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Post-Hosp-Ext-Care	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Or-Spec-Drg-Rehab	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Rehab	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Steril-Hosp-F	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Steril-Maternity	Inpatient	40% IP A&B Hospital, DRG Hospital, or OTH Hospital; 60% Maternity - IP	Physical Health - Hospital DRG or A&B
Ip-Missing-DRG	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Unbucketed	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Ip-Hyster-Hosp	Inpatient	IP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B DRG or A&B
Ip-Mat-C-Section	Inpatient	Maternity – Inpatient	Sub-Capitated Maternity
Ip-Mat-Non-Delivery	Inpatient	Maternity – Inpatient	Sub-Capitated Maternity
Ip-Mat-Normal	Inpatient	Maternity – Inpatient	Sub-Capitated Maternity
Op-Maternity	Outpatient	Maternity – Outpatient	Sub-Capitated Maternity

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Prof-Phys-Maternity	Professional	Maternity – Physician	Sub-Capitated Maternity
Prof-Phys-Maternity-PCP	Professional	Maternity – Physician	Sub-Capitated Maternity
Ip-Mh-Acute-Ip-A	Inpatient	Mental Health Services Inpatient	Mental Health - Inpatient
Ip-Mh-Acute-Ip-B	Inpatient	Mental Health Services Inpatient	Mental Health - Inpatient
Prof-MH-ABA-Services	Professional	Applied Behavior Analysis (ABA)	Applied Behavior Analysis (ABA)
Prof-MH-ACT	Professional	ACT/SE	ACT/SE
Prof-MH-Support-Employment	Professional	ACT/SE	ACT/SE
Prof-MH-CANS	Professional	CANS	CANS
Op-Mh-Other	Outpatient	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Alt-To-Ip	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Assessment-Evaluat	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Case-Management	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Case-Mgt	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Consultation	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Crisis-Services	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Eval-Mgmt-PCP	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Interp-Services	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Med-Mgt	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-MST	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Op-Therapy	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-PDTS	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Phys-Op	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Prof-MH-PRTS-Child	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Respite	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Skills-Training	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-SubAcute	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-SUD-Unbucketed	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Support-Day	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Therapy	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Therapy-Inpatient	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-MH-Unbucketed	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-Phys-Other-E-M-MH	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-Phys-PrimCare-E-M-MH	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Prof-Phys-Somatic-MH	Professional	Mental Health Services Non-Inpatient	Mental Health - Non-Inpatient
Op-Prevent-Non-Covered	Outpatient	EXCLUDE	EXCLUDE
Op-Admin-Exams	Outpatient	FFS/EXCLUDE	FFS/EXCLUDE
Op-Ther-Abort-Op-Hosp	Outpatient	FFS/EXCLUDE	FFS/EXCLUDE
Op-Anes-Other	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Basic	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Clinics	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Diag-Oth	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Er	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Er-Somatic-Mh	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Fp-Hosp-A	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Op-Fp-Hosp-B	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Fp-Hosp-C	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
OP-Home-Health	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Hyster-Hosp	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Lab	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Lab-Inject-Oth	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Op-Room-Other	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Oth-Med-Hospice	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Oth-Med-Mat-Mgt	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Phys-Admin-Drugs	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Post-Hosp-Ext-Care	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Pres-Drugs-Basic	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Pres-Drugs-Mh	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Prevent-Covered	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Professional-Fees	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Radiology-MRI	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Radiology-PET	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-SNF	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Somatic-Mh	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Steril-Hosp-F	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Supplies-Devices	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Surgery	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Op-Ther-Rehab	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Xray	Outpatient	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Op-Cd-A	Outpatient	Substance Abuse	Physical Health - Physician
Op-Cd-B	Outpatient	Substance Abuse	Physical Health - Physician
Rx-Pres-Drugs-Carveout	Pharmacy	FFS/EXCLUDE	FFS/EXCLUDE
Rx-Med-Assis-Treat-MAT	Pharmacy	Prescription Drugs	Physical Health - Other
Rx-Oth-Med-Dme	Pharmacy	Prescription Drugs	Physical Health - Other
Rx-Pres-Drugs-Basic	Pharmacy	Prescription Drugs	Physical Health - Other
Rx-Pres-Drugs-Fp	Pharmacy	Prescription Drugs	Physical Health - Other
Rx-Pres-Drugs-Immunization	Pharmacy	Prescription Drugs	Physical Health - Other
Rx-Pres-Drugs-Otc	Pharmacy	Prescription Drugs	Physical Health - Other
Prof-Cd-Non-OHP-Outpat	Professional	EXCLUDE	EXCLUDE
Prof-Not-Covered	Professional	EXCLUDE	EXCLUDE
Prof-Prevent-Non-Covered	Professional	EXCLUDE	EXCLUDE
Prof-Behav-Rehab-Service	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-Excluded-Admin-Exams	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-AFC	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-Intense-Rehab-Serv	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-PAITS	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-RTF-A	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-RTF-B	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-SCIP-SAIP-Sts	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-SCIP-SAIP-Sts-19	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-SRTF	Professional	FFS/EXCLUDE	FFS/EXCLUDE

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Prof-MH-Support-Housing	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-School-Based Svces	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-Tcm-Leveraged	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-Ther-Abort-Phys-A	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-Ther-Abort-Phys-B	Professional	FFS/EXCLUDE	FFS/EXCLUDE
Prof-MH-Wraparound-Service	Professional	MH Children's Wraparound	MH Children's Wraparound
Prof-Op-Basic-ASC	Professional	OP A&B Hospital, DRG Hospital, or OTH Hospital	Physical Health - Hospital DRG or A&B
Prof-Oth-Med-Dme	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Oth-Med-Supplies	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Phy-Other-Services	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Speech-Hearing	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Trans-Ambul	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Vision-Exams-Therapy	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Anesthesia	Professional	Physician Services	Physical Health - Physician
Prof-Emerg-Life	Professional	DME and Miscellaneous	Physical Health - Other
Prof-Eval-Mgmt-PCP	Professional	Physician Services	Physical Health - Physician
Prof-Fp-Phys-B	Professional	Physician Services	Physical Health - Physician
Prof-Fp-Phys-C	Professional	Physician Services	Physical Health - Physician
Prof-Hyster-Phys	Professional	Physician Services	Physical Health - Physician
Prof-Inpatient-Visits	Professional	Physician Services	Physical Health - Physician
Prof-Lab-Lab	Professional	Physician Services	Physical Health - Physician
Prof-Neonate-Newborn-Care	Professional	Physician Services	Physical Health - Physician

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Prof-Op-ASC	Professional	Physician Services	Physical Health - Physician
Prof-Op-Dental-Anes	Professional	Physician Services	Physical Health - Physician
Prof-Op-Dental-Fluoride	Professional	Physician Services	Physical Health - Physician
Prof-Oth-Drugs-Supplies	Professional	Physician Services	Physical Health - Physician
Prof-Oth-Med-Mat-Mgt	Professional	Physician Services	Physical Health - Physician
Prof-Phys-Other-E-M	Professional	Physician Services	Physical Health - Physician
Prof-Phys-PrimCare-E-M	Professional	Physician Services	Physical Health - Physician
Prof-Prevent-Covered	Professional	Physician Services	Physical Health - Physician
Prof-Prevent-Immunization	Professional	Physician Services	Physical Health - Physician
Prof-PreventWellBaby-Exams	Professional	Physician Services	Physical Health - Physician
Prof-Radiology	Professional	Physician Services	Physical Health - Physician
Prof-Steril-Phys	Professional	Physician Services	Physical Health - Physician
Prof-Surgery	Professional	Physician Services	Physical Health - Physician
Prof-Unbucketed	Professional	Physician Services	Physical Health - Physician
Prof-Urgent-Care-Visits	Professional	Physician Services	Physical Health - Physician
Prof-Cd-Assess-Screening	Professional	Substance Abuse	Substance Abuse
Prof-Cd-Methadone-AMH	Professional	Substance Abuse	Substance Abuse
Prof-Cd-Methadone-Treat	Professional	Substance Abuse	Substance Abuse
Prof-Community-Detox	Professional	Substance Abuse	Substance Abuse
Prof-SBIRT-A	Professional	Substance Abuse	Substance Abuse
Prof-SBIRT-B	Professional	Substance Abuse	Substance Abuse
Prof-SUD-Unbucketed	Professional	Substance Abuse	Substance Abuse

OHG Description	Claim Type	Expenditures – Categories of Service	Sub-Capitation – Categories of Service
Prof-CD-Res-Adult	Professional	A&D Residential	A&D Residential
Prof-CD-Res-Child	Professional	A&D Residential	A&D Residential
Op-Trans-Ambul	Professional (& some Outpatient)	DME and Miscellaneous	Physical Health - Other
Prof-NEMT	Professional	NEMT	NEMT
Dental-Anes	Dental	Dental	Dental
Dental-Diag	Dental	Dental	Dental
Dental-Endo	Dental	Dental	Dental
Dental-I-P-Fixed	Dental	Dental	Dental
Dental-Oral-Surgery	Dental	Dental	Dental
Dental-Ortho	Dental	Dental	Dental
Dental-Perio	Dental	Dental	Dental
Dental-Prevent	Dental	Dental	Dental
Dental-Pros-Remov	Dental	Dental	Dental
Dental-Restore	Dental	Dental	Dental
Dental-Unbucketed	Dental	Dental	Dental

Appendix D

OHA ICD Initiative Subject Matter Expert Interviews Summary

Background

Between October 19-28, 2022, Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, conducted a total of 15 interviews with 20 Subject Matter Experts (SMEs) from across Oregon. SMEs represented a range of experiences at many levels in the Oregon service system. SMEs included administrators in Behavioral/Mental Health (MH), Substance Use Disorder (SUD), or both (referred to as Co-Occurring Disorders or COD), Intellectual or Developmental Disability (I/DD), and Problem Gambling (PG), providers of I/DD, PG, and MH/SUD/COD services (including outpatient and residential), Coordinated Care Organization (CCO) administrators, and others in education, training, program evaluation, primary care integration, policy, and practice.

SMEs interviewed as part of this work included:

Amber Clegg	Jessica Macklin
Anna Lansky	Karen Cady-Pyle
April Nelson	Kathy Prenevost
Brandi Johnson	Paul Robertson
Danielle Brown	Rachel McWilliams
Denna Vandersloot	River Mckenzie
Emilie Dauch	Samuel Denney
Greta Coe	Tami Stump
Heather Jeffris	Tara Modungo
Jerry O'Sullivan	Thad Labhart

SMEs were interviewed using the same ten question interview instrument created by Mercer and vetted by the Oregon Health Authority (OHA) project staff. Interviews were conducted by three Mercer staff members (Jeff Payne, Brittany van der Salm, and Rose Farrell). Interview questions aimed to gather perceptions of the current state of COD integration across individuals with MH or SUD support needs, I/DD, and individuals requiring assistance with PG as well as ideas for how further integration may be achieved.

This document presents a summary, arranged by key themes, of what was learned through conducting these interviews. Although SMEs presented a range of perspectives on the integration of COD, many focused on similar themes, opportunities, and challenges. Each key theme contains a narrative summary of what was heard and understood by interviewers, and incorporates direct quotes whenever possible.[20]

Introduction

SMEs described two ways of viewing the relationship between the MH and SUD service systems for all individuals accessing the services:

- First, that in practice, there are many good examples of organizations or even counties working to pair these services together to ensure that individuals are served appropriately.
- Second, that policies, regulations, and billing requirements currently pose challenges that make integration difficult to achieve.

The current challenges with integration of COD services came through clearly with some SMEs responding to the question of “Describe areas within the Oregon service system, where integrated treatment is currently being done well” with a simple “I cannot,” or “Integrated care is not currently completely integrated,” noting that the challenges exist at the level of policy and regulation.

All SMEs, however, offered ways the system is moving in this direction, and suggested cause for hope for greater integration in the future. SMEs highlighted the progress made through the integration efforts of OHA in the last year. One in particular stated that the work of the past year or so, with OHA, has been successful, adding that they look forward to further implementing integrated treatment with the assistance of the available grant funding. They described the integrated work as going “beautifully.”

One SME described the current state as having achieved “*coordinated* co-occurring services,” not truly “co-occurring services,” because of the inability to truly blend services together. This sentiment was strongly echoed by other SMEs. Separations between these systems were described as beginning at the point of assessment and remaining through the billing stage. Mercer has therefore selected the following themes to summarize SME feedback:

4. Assessment
5. Workforce Development and Certification

[20] Please note, however, that quotations are not linked with SMEs to provide a degree of anonymity.

6. Multi-disciplinary Teams
7. Intellectual and Developmental Disabilities
8. Problem Gambling
9. Financing
10. Diverse Voices

Assessment

SMEs reported conducting assessments after initial client intake, with some referencing a specific instrument such as the American Society of Addiction Medicine (ASAM) Criteria Assessment, PHQ 9, GAD-7, or MoCA, while others use home-grown or derived tools that may draw from various instruments. On the whole, most SMEs who mentioned a specific instrument noted using the ASAM. This instrument is described in literature as "a comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions."[21] Of note, the ASAM is not used to diagnose MH conditions, PG, or I/DD.

SMEs consistently reported that the most pressing need for an individual is assessed first. For example, an individual in the midst of a MH crisis would be evaluated for that first, while other diagnoses, such as I/DD, would be assessed or considered later. Furthermore, SMEs described MH and SUD as often being intertwined, resulting in multiple assessments. One SME described the availability of assessment as positive and frequent, but the access to services as more challenging. In contrast, however, another SME described it as "clunky and problematic" to do two assessments.

Many SMEs reported that an assessment performed by COD providers focuses on MH and SUD, and does not directly assess for I/DD (although many noted that select assessment items touch on I/DD), and that instruments may not focus on, and thereby underdiagnose, PG. Opinions differed as to the efficacy of assessments currently in use in uncovering service needs across individuals with MH, SUD, PG, and/or I/DD. Most providers of SUD and MH services tended to view existing instruments as sufficient for identifying all of these potential need areas. However, some suggested that they may not sufficiently screen for I/DD or PG. Some SMEs reported that separate assessments for "each disorder" are used (i.e., MH, SUD, PG, and/or I/DD) and that regulations are in place that restrict an integrated assessment and service plan.

One SME raised concerns about the potential cost of implementing an instrument, namely the ASAM, on a statewide level. They noted a per-user per-year fee to access the assessment. They added that there may be costs associated with integrating this assessment into electronic health records, or otherwise a cost to data entry to make reporting possible.

[21] https://www.asam.org/asam-criteria/about-the-asam-criteria

Workforce Development and Certification

Many SMEs focused on the fragmentation that results from the system of staff credentialing. Oregon Administrative Rules (OARs)[22] govern credentialing requirements for providers of outpatient behavioral health services, including SUD. While there is strong overlap in provider qualifications for MH providers and providers of SUD services,[23] SMEs reported that a significant amount of SUD services are delivered by providers with a CADC (Certified Alcohol and Drug Counselor) I certification. CADC certification is available at three levels described in Oregon's Medicaid State Plan.[24] The first, CADC I, does not require a Bachelor's or Master's level of education, which are key requirements to be credentialed as a Qualified Mental Health Associate (QMHA), Qualified Mental Health Professional (QMHP), or Mental Health Intern (who must be in process of obtaining a Master's degree)—common qualifications for the provision of MH services in Oregon. In addition to a different practical focus area, this difference in educational requirements can legally preclude CADC I from providing MH services. CADC II and CADC III are required to have a Bachelor's or Master's (respectively) in counseling or a closely related field, and so potentially may more readily provide MH services. CADCs at these levels meet educational qualifications to be dually credentialed as a QMHA, QMHP, or MHI, they may not have the required amount of relevant work under supervision that is required to obtain this credential.

In instances where a MH concern arises that requires treatment or other intervention, if a CADC is not dually credentialed and able to provide this support, the individual in service would need to be referred to another provider credentialed to provide MH treatment.

Examples of the primary challenges noted regarding credentialing included the following:

- Lack of dually-credentialed providers who can provide both MH and SUD services
- Insufficient provider pool to move toward mandatory dual-credentialing for ICOD
- Limited financial incentive to providers who are dually credentialed
- Difficulties for dually credentialed providers created by the need to code treatments as either MH or SUD distinctly

SMEs reported the national staffing shortage in human services as a fundamental problem on the road toward integrating COD services. SMEs described being understaffed in all areas, from support staff up through staff with prescriber qualifications. High staff turnover and decreasing numbers of new service staff entering the human services field in general were commonly reported across SMEs. A number of SMEs discussed staff retention, noting that providers are offering bonuses and perks to recruit, but that more thought has to go into creating a culture that makes staff feel valued and allows them to grow their careers. Multiple SMEs mentioned student educational debt as a reason it is difficult to stay in this field, as they could get paid more in positions like a "barista" and be able to pay their student loans, which is difficult to do under the current wage for MH and SUD providers.

This combination of staffing shortages and high turnover has resulted in staff at all levels across services, including MH and SUD, taking on higher caseloads. This impacts the

[22] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285593

[23] https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=285593

[24] https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf

provider pool available to become dually credentialed. While there may be existing staff interested in attaining additional credentialing, such as dual CADC/QMHP, these staff would have to reduce caseloads or potentially step out of the field temporarily to pursue required educational levels. It was also reported, however, that billing rates are not higher for dually-credentialed providers. For those who would have to obtain Bachelor's or Master's levels of education toward becoming certified as a QMHP, the lack of differential pay creates a significant financial burden without a worthwhile financial incentive. Financial assistance with the cost of obtaining certification and services with higher reimbursement rates for dually-credentialed providers were listed as potential means to increase the numbers of dually-credentialed providers.

SMEs also discussed a common situation in which credentialed providers leave positions at agencies to work in private practice, due to higher rates of compensation, resulting in unfilled positions at agencies. This feeling was echoed by another SME who expressed that providers do not have a financial reason to become dually-credentialed. One SME anticipated further costs of integration later down the line, when providers need further training to become dually-credentialed, leaving a position unfilled while they are receiving training, contributing to the staff shortage.

An SME summed up their feelings on the difficulties with credentialing in the area of COD by stating "I fear that this ICOD program is well-intended and clinically sound, but is going to burn people out because we don't have the staff to maintain it." Another added that there is "no incentive for people who have a heart for this work to do it because they're essentially taking a pay cut to do it," noting specifically that case managers get $5 more per unit of services than CADCs.

Many SMEs fundamentally agreed with the clinical basis for further integrating these services, and believe that individuals would be better served were such integration achieved. However, they relayed concerns and fears about the adequacy of the current and future provider pools to maintain their current workloads and to achieve the additional credentialing required to make this happen. Some suggested that changes to who is legally able to provide services (i.e., opening up service provision to different types of credentials) may be one way to move toward offering more integrated services.

Multi-Disciplinary Teams

Many administrators and providers currently providing MH and SUD services noted that programs that have this dual focus as a part of their service model are having good success with integration. This held true for administrators and providers in both urban and rural areas. Some providers or administrators described systems or programs that integrate MH, SUD, PG, I/DD services, and physical health under a single roof or single provider. This creates a singular touch point for individuals to receive wraparound services regardless of the diagnosis with which they enter the system.

SMEs described agencies that offer a variety of treatment services, such as PG, MH, and SUD, allowing individuals to maintain services in the singular location, rather than being referred out to a different agency. When individuals are referred to different agencies and receive supports from multiple, distinct programs, the need for care coordination arises. This was one of the reasons SMEs described integration as easier to achieve within one agency. SMEs also reported that in these instances, many individuals struggle to keep multiple appointments with a variety of providers, making services less effective. Multiple SMEs

described that it is easier for individuals to access services when they are under the same roof. One SME described difficulties in agencies communicating and working together to provide services when not co-located.

In some instances, there also appears to be good collaboration happening between government branches (OHA, Oregon Department of Human Services) and providers. One county administrator stated that they have a dedicated staff member whose focus is system collaboration across and outside of their county.

A particular distinction that was made by one SME is that there are not "co-occurring services" in and of themselves, but rather "coordinated co-occurring services." The latter, this SME stated, explains the current system where individuals can become connected to a variety of different services to meet co-occurring support needs they may have, which is done through coordination between entities or performed by a case manager/care coordinator, or in some cases a clinician. The ideal system would be a singular service through which an individual's needs could be met at one time by the same provider. To provide this, another SME noted, there would have to be clinicians with training and certification to meet all member needs—something that does not currently exist on a policy level.

One SME particularly highlighted the potential of multi-disciplinary teams for achieving integration. They described how this model allows for providers to work at the top of their field, alongside other providers doing the same. They elaborated further that multi-disciplinary teams allow for better training opportunities and could help prevent staff burnout. This SME described how multi-disciplinary teams could help break down the "siloed" systems of care, and potentially support further integration of I/DD treatment into other areas. Another benefit of multi-disciplinary teams, they mentioned, was the potential for this model to reduce higher caseload, helping ease the impacts of the workforce crisis.

Several SMEs mentioned the ACT (Assertive Community Treatment) service model as the closest to representing a multi-disciplinary team providing integrated service. This model can bring together psychiatric medication providers, MH treatment providers, nurses, SUD treatment providers, peer specialists, and employment specialists to provide care to individuals with extraordinary MH support needs that cannot be otherwise met by lower intensity services. SMEs noted that one of the biggest benefits of the ACT service is that providers with different focuses and qualifications are able to bill to the same service code. This billing structure allows the team to work seamlessly in concert to provide team-based wraparound service to an individual.

Intellectual and Developmental Disabilities

When asked about the integration of people with I/DD into existing SUD, MH, and PG services, SMEs on the whole described a "siloed" system. Administrators and providers from MH and SUD backgrounds stated that they did not see very many clients with a diagnosed I/DD, or in some cases seemed to conflate I/DD with learning disabilities or reading comprehension. An SME from the I/DD field reported that the MH/SUD system in Oregon "discriminates" against people with I/DD by not providing services when requested.

They suggested that this discrimination is the result of a variety of factors, including a combination of a shortage of MH professionals, lack of exposure among MH professionals to people with I/DD (resulting in a discomfort or hesitation with working with this population),

and a lack of enforcement around discrimination and accommodations. On this latter point, this SME felt that, at present, providers are easily able to decline to serve individuals with I/DD by citing that they lack experience or credentials to serve this population well and that there is no consequence to them for doing so. The SME stated that "people will call over 100 providers to get service," both for ongoing and crisis MH service needs.

While few SMEs had strong experience with I/DD, given that the majority of interview subjects represented the MH and SUD service fields, some did report serving people with I/DD as part of their practice. Several SMEs from a provider organization reported that if they suspect someone they are serving may have an I/DD, they work to determine if that individual is able to make decisions on their own and benefit from the services being provided. How these determinations are made was not described. They also reported that, as appropriate, they may make referrals to I/DD services and/or may make efforts to determine if the needs or behaviors fall outside of their service scope. One service provider SME stated that while they do not get many individuals with I/DD in her practice, they do get some individuals who have fetal alcohol syndrome. These clients are afforded extra time and support. One additional SME reported, "All of our providers are capable of working with members with I/DD." On the other hand, a different SME described their providers as not knowing what training is required to treat individuals with I/DD and that they refer out to another program or agency when the individual's I/DD prevents them from receiving treatment.

One SME described "not knowing where to start" in terms of integrating I/DD into other areas of treatment. The "siloed" system, they described, leads to undiagnosed or unidentified I/DD. This SME also reflected a preference for dually-credentialed providers, rather than multi-disciplinary teams. This was echoed by other SMEs as a desire for a "one-stop-shop" type of system where an individual only has to see one provider, make one appointment, and miss work one time rather than multiple times seeing multiple providers.

Another SME representing the MH and SUD field noted that therapy curriculums and treatment plans have historically been built to cover behavioral health needs alone. They further noted that I/DD is "not addressed in the current system of care for SUD" and that therapy curriculums and treatment plans are not well suited to individuals with intellectual disabilities, and that they were not sure what it would take to integrate this population into existing MH and SUD treatment efforts.

This same SME, however, did highlight programming at Albertina Kerr in the Portland metro area, and in some counties (namely Benton) where there are integrated services for people with I/DD and MH support needs. They noted that this integration is achieved through co-location and targeted programming.[25] A different SME also touted co-location as a positive step toward meeting the support needs of individuals with I/DD and MH support needs, noting that their county had previously had an I/DD specialist co-located on site at the county agency who was able to attend staff meetings to answer general questions from other providers.

Payer sources for individuals with I/DD also appear to create some confusion or conflict as well. One SME stated that individuals with I/DD are covered by Medicare, and therefore are not eligible to receive MH and SUD services from the majority of providers who do not have

[25] It bears note, however, that this SME stated that the creation of programs outside of the standard service continuum for MH/SUD/COD itself perpetuates a siloed system.

Licensed Clinical Social Worker (LCSW) licensure, which is required to bill Medicare. When pressed on this, they stated that individuals who get Supplemental Security Income (SSI) and are on Medicaid are "kicked over" to Medicare after two years due to their SSI eligibility. This belief gave this individual the impression that people with I/DD cannot be served through traditional MH and SUD service channels.

Regarding what it would take to integrate individuals with I/DD into the broader service system, one SME noted that numerous additional trainings or credentials were not needed. Rather, generic training on what I/DD is and on the most prevalent presentations (such as Autism), as well as on what accommodations would be sufficient to assist MH, SUD, and COD providers in working with this population. They added "there is a fine line of developing awareness but not a need to assume people are totally different than a 'typical' mental health client." Accommodations specifically noted were for activities of daily living and/or personal care during an appointment, for a telehealth option, and to relocate services to different locations in keeping with a trauma-informed perspective, as some individuals with I/DD may not feel comfortable receiving services in an office environment.

OHA's ICD initiative has been and will continue to provide training to MH/SUD/PG professionals across the state regarding I/DD to improve practice knowledge for providers and access to services for enrollees.

Problem Gambling

On the whole, PG was also discussed as a separate and "siloed" program. This was not unexpected, given that at present PG services are funded through an entirely separate stream than MH, SUD, or I/DD, and therefore are separate at a fundamental level. Reports of the utilization of PG resources and referrals differed widely. Some SMEs reported easy collaboration with county-based PG representatives, while others suggested that PG services are likely underutilized. One SME reported that individuals coming to their agency for MH services could also be seen for PG. Another SME positively described the integration efforts of the last year and explained that dually-credentialed providers have been able to further support people with PG, MH, and/or SUD. The same SME described the advantages of having their case managers/care coordinators trained in PG, in addition to SUD and MH, to help integrate the care of individuals receiving services. Otherwise, SMEs generally reported that if PG was suspected or diagnoses, a referral to another provider would be made. SMEs did not discuss how PG was assessed.

Other issues raised specific to PG included the stigma of PG, with some providers noting that it can be difficult to engage clients in treating this behavior in addition to another such as SUD at the same time, as the compounding of stigma in these areas can be significant. Another SME described that individuals with PG tend to be the most private. One SME added that some individuals do not want PG listed or associated with their Medicaid documentation and worry about the future of treatment for individuals who need PG treatment but would be reluctant to obtain these services through Medicaid. The same SME wondered about how privacy regulations will come into play through integrated care, in a situation in which a person's record needed to be shared, but the individual's desire to not have PG disclosed could get in the way of that.

In terms of screening for PG, one SME described the system as "not doing a wonderful job." Differences in policies and regulations related to PG may also inhibit the engagement of both the individual and coordination of care into this area. As with other areas, the billing system

allowing only one condition at a time to be associated with a treatment was mentioned as a potential barrier to the integration of PG.

Financing

Many respondents described Oregon Health Plan (OHP) being far and away their single biggest payer source. Some deal with public/private combination insurance, although the administrative burden that this presents is too great for some smaller providers to manage. Most described a positive experience with OHP and the services that it provides for people experiencing COD. A number, in fact, lamented that private insurance does not offer the same type of spectrum of supports for COD that OHP does. They reported difficulties with getting the same level of treatment for clients, or in some cases even avoiding clients with private insurance for this reason.

The primary note that SMEs had regarding individuals on Medicare was that in relation to COD services, only LCSWs can bill to this payer, making it very difficult, if not impossible, for some providers to serve individuals with Medicare. One added that for individuals dually insured by Medicaid/Medicare, having Medicaid as a secondary payer appears to disallow them from billing to Medicare for some services. Another described that Medicare is “pretty awful” for MH.

At least one SME reported that CCOs differ in what they consider billable. This creates administrative burden for providers who have to track differences in allowable billing between counties (for providers with a multi-county presence). Administrative burden was also described in the potential future training for integration of care, including training costs.

One SME who specializes in billing reported difficulties with matching billing codes across different payers. They noted that MH and SUD services are coded differently from each other through OHP bill codes, and differently still from private insurance or Medicare. Attempting to translate codes across different payers was reported as being nearly impossible.

Another common theme demonstrated across interviews was the inability to bill Medicaid for more than one condition at a time, meaning providers can only bill for MH or SUD, but not both. SMEs expressed that improving this system would lead to much more integrated care. One described the model of billing used by Certified Community Behavioral Health Clinics (CCBHCs), projective per-person payment, as a leading example to capture the co-occurring services a person is receiving. The SME further explained that not all providers would be able to implement this model, particularly smaller providers who would need a specialized pathway to implement it. Another SME described that it is not that the providers do not want to integrate care, rather that it is not financially feasible to do so because of the billing system. Furthermore, a SME said that in a “dream world,” I/DD and MH or MH and SUD could be billed together under one bill code. Another described true integration coming with the cost of “double or triple” the amount of work in regards to billing Medicaid.

OHA’s ICD initiative is developing new payment plans for both fee for service and for capitated payments to CCOs to help reduce administrative burden for providers regarding reimbursement.

Diverse Voices

Several SMEs noted the need to include diverse voices in all stages of ICOD efforts. Inclusion of individuals with lived experience, individuals from diverse cultural backgrounds, and who represent different parts of the broad Oregon service system was framed as being integral to creating a program that will appropriately serve the most people, and in creating reimbursement rates that are reflective of differing needs. On this front, particular attention was suggested to how individuals from different cultural or educational backgrounds are desired in service positions to reflect the different cultural backgrounds of service recipients, but that rates or grant schemes may not account for higher levels of training or education that may be required to enable these individuals to attain provider credentialing.

Some SMEs also described the powerful role that peer supports can provide in service delivery, as they could have lived experience similar to the individual receiving services, making the individual more willing to engage with the service. This model was reported as being increasingly implemented in the MH and SUD field.

Finally, one SME stated that the OARs, having been “developed by the dominant culture” do not fit all provider or service recipient presentations.

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