June 15, 2018

Patrick Allen
Director, Oregon Health Authority

VIA EMAIL

Dear Director Allen,

NAMI Oregon has a long history of advocating for quality, accessible behavioral health services that are provided in a consistent and predictable manner to all Oregonians across the state. Many times over the years NAMI Oregon has convened various stakeholders to discuss and identify issues in our system that need improvement. NAMI recently convened a group that includes advocates, Coordinated Care Organizations, providers, County Commissioners and hospital systems to discuss needed changes to the current system.

Based on the group's conversations to date, we would like to see a system that isn't carved out and that provides an individual a certain path to a higher standard of care based on an assessment or event that qualifies her or him for that care. Once that person qualifies, we want to ensure that they have quality care coordination that gives them access to an appropriate array of services in a timely manner. To that end, we would like to take the opportunity while the Oregon Health Authority is focusing on CCO contracts and the Behavioral Health System to make the following recommendations to the agency.

CCO Contracts

We suggest that you review the RFP and contract language that Arizona uses in their managed care contracts. We have included portions from the contract that highlight specific language that we found beneficial for individuals with significant, ongoing behavioral health needs and for individuals who have exceptional need in a moment in time, such as someone in crisis who requires inpatient psychiatric care.

The full RFP and actual contracts can be found at:
https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html

Arizona started with a simple vision: to prevent individuals with serious mental illness from dying 25 years early, as they do now. To fix that catastrophic outcome, Arizona designed a conceptually simple system. Rather than carve out the behavioral health benefit and coordinate an individual's multiple needs via multiple entities, the language

that Arizona employs clearly delineates the responsibility of a single contractor — to be responsible for their member's total health.

Arizona does so with explicit expectations in its contracts without being too prescriptive. They truly achieved a higher standard of care that is uniform and predictable for individuals and families trying to navigate health care services. We were highly encouraged by the clear and descriptive language of care coordination and case management.

When you examine the Arizona materials available online, you will note that the state carved out the population with serious mental illness rather than carving out benefits. We are unsure of the wisdom of this approach in Oregon. However, as we suggest in our letter's opening, some assessment and/or major event such as hospitalization could provide a predictable pathway to the higher standards of care delineated so clearly and effectively in the Arizona contracts.

Delegation of Care

We recommend that you look closely at the delegation and sub-delegation of care and risk for mental health services and determine if they are appropriate. If so, we suggest that there be language in the contracts that specifically outlines what is expected when there is delegation and that requires clear and transparent assignment of responsibilities.

We question the wisdom of carve outs that separate behavioral health benefits from other benefits offered by the Oregon Health Plan through the individual CCOs. Even with the examination we suggest, a bifurcated benefit creates obstacles to care and prevents true integration and care coordination from occurring.

Parity and Use of Prior Authorization

As a matter of parity, if a CCO does not prior authorize (PA) routine medical care, the CCO shouldn't be allowed to PA community mental health care. We recommend that language is included in the contracts clearly stating this and that the Oregon Health Authority more aggressively assess and enforce parity on an ongoing basis.

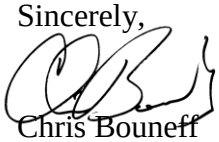
Residential Treatment Services

We recommend that the agency move swiftly in transferring the responsibility for residential treatment services from the state to CCOs. There is no incentive for CCOs to provide appropriate lower levels of care to patients when the CCOs are not financially responsible for the most expensive set of higher-end services. With that in mind, we also recommend that you look closely at putting the CCOs at risk for Oregon State Hospital stays and consider a pilot program that would allow for that.

Thank you for the consideration of these recommendations. We invite you and your staff to attend one of our group meetings if you would like to discuss any of these in depth.

You can also call me or Lara Smith, NAMI's Government Relations Liaison, (504-804-9750) with any questions or for clarification.

Sincerely,



Chris Bouneff
Executive Director

c.c.:
Governor Brown
President Courtney
Speaker Kotek
Chief Justice Balmer

Contract Language from Arizona

This is language from managed care contracts implemented in Arizona. Arizona carved out the SPMI population into its own managed care contract that included physical and behavioral health. The approach is integrated as compared to Oregon's system, where behavioral health benefits are carved out regardless of level of need in many regions.

The standards below are pulled directly from the RFP. The language also is repeated in the contracts themselves.

NAMI Oregon is interested in this language because it gets at the heart of Oregon's "diffusion of responsibility." Because everyone is responsible in Oregon, in truth no one is responsible.

The full RFP and contracts can be found online at:
https://www.azahcccs.gov/AHCCCS/Initiatives/CareCoordination/behavioralhealth.html

4.4 Behavioral Health Service Delivery Approach
The Contractor shall:

- Provide each member with a behavioral health assessment in accordance with the ADHS/DBHS Policy on Assessment and Service Planning.
- Develop and revise the member's individual service plan in conformance with the ADHS/DBHS Policy on Assessment and Service Planning.
- Make referrals to service providers.
- Coordinate care as described in Section 5.1, Care Coordination.
- Develop and implement transition, discharge and aftercare plans for each person prior to discontinuation of covered services.
- Require subcontractors and providers to actively engage and involve family members in service planning and service delivery.

4.5 Behavioral Health Service Delivery for Adult Members
The Contractor shall:

- Ensure services are delivered to adults in conformance with Exhibit 6, Nine Guiding Principles for Recovery-Oriented Adult Behavioral Health Services and Systems.
- Implement the American Society of Addiction Medicine Patient Placement Criteria (ASAM).
- Implement the following service delivery programs for SMI members consistent with U.S. Department of Health and Human Services (DHHS), Substance Abuse and Mental Health Services Administration's (SAMHSA) established program models:
    - Assertive Community Treatment (ACT),
    - Supported Employment,
    - Permanent Supportive Housing, and
    - Consumer Operated Programs.
- Monitor fidelity to the service delivery programs described in Section annually using the ADHS/DBHS adopted measurement instrument, for example, the SAMHSA

4.8.6 Effective use of a comprehensive Care Management Program as described in 8.13 Care Management Program Goals, and Care Management Program General Requirements, Sections 8.13 and 8.14;

- 4.8.7 Coordination of care as described in Section 5.1, Care Coordination;

8.6 Discharge Planning

For all populations eligible for covered services under this Contract, the Contractor shall:

- Develop and implement policies and procedures for proactive discharge planning when members have been admitted into inpatient facilities even when the Contractor is not the primary payor.

8.11 Care Coordination

For all populations eligible for covered services under this Contract, the Contractor shall:

- Comply with all requirements in Sections 5, Care Coordination and Collaboration.
- Establish a process to ensure coordination of member care needs across the continuum based on early identification of health risk factors or special care needs.
- Ensure the provision of appropriate services in acute, home, chronic, and alternative care settings that meet the members‘ needs in the most cost effective manner available.
- Establish a process for timely and confidential communication of clinical information among providers.
- Address, document, refer, and/or follow up on each member‘s health status, changes in health status, health care needs, and health care services provided.
- Include the health risk assessment tool in the new member welcome packet.

8.13 Care Management Program-Goals

Care Management is essential to successfully improving healthcare outcomes for a specifically defined segment of Title XIX eligible SMI members receiving physical health care services under this Contract. Care Management is designed to cover a wide spectrum of episodic and chronic health care conditions for members in the top tier of high risk/high cost members with an emphasis on proactive health promotion, health education, disease management, and self-management resulting in improved physical and behavioral health outcomes. Care Management is an administrative function and not a billable service. It is performed by the Contractor‘s Care Managers. While Care Managers can provide consultation to a member‘s Treatment Team, they should not perform the day-to-day duties of case management or service delivery.

The primary goals of the Contractor‘s Care Management program are as follows:

- Identify the top tier of high risk/high cost members with serious mental illness in a fully integrated health care program (estimated at twenty per cent 20%);
- Effectively transition members from one level of care to another;
- Streamline, monitor and adjust members‘ care plans based on progress and outcomes;
- Reduce hospital admissions and unnecessary emergency department and crisis service use; and
- Provide members with the proper tools to self-manage care in order to safely live work and integrate into the community.

8.14 Care Management Program-General Requirements

For SMI members receiving physical health care services under this Contract, the Contractor shall:

- Establish and maintain a Care Management Program (CMP). See Exhibit 1, Definitions for an explanation of ―Care Management Program‖.
- Have the following capability for the top tier of high risk/ high cost SMI members:
    - On an ongoing basis, utilize tools and strategies to stratify all SMI members into a case registry, which at a minimum, shall include:
    - Diagnostic classification methods that assign primary and secondary chronic co-morbid conditions;
        - those members at a high risk for over utilization of behavioral health and physical health services, adverse events, and high costs;
    - Incorporation of health risk assessment into predictive modeling in order to tier members into categories of need to design appropriate levels of clinical intervention, especially for those members with the most potential for improved health-related outcome and more cost effective treatment;
    - Criteria for identifying the top tier of high cost, high risk members for enrollment into the Care Management Program; and
    - Criteria for disenrolling members from the Care Management Program.
- Assign and monitor Care Management caseloads based upon national standards and consistent with a member's acuity and complexity of need for Care Management.
- Allocate Care Management resources to members consistent with acuity, and evidence-based outcome expectations.
- Provide technical assistance to Care Managers including case review, continuous education, training and supervision.
- Communicate Care Management activities with all of Contractor's organizational units with emphasis on regular channels of communication with Contractor's Medical Management, Quality Management and Provider Network departments.
- Have Care Managers who, at a minimum, shall be required to complete a comprehensive case analysis review of each member enrolled in Contractor's Care Management Program on a quarterly basis. The case analysis review shall include, at a minimum:
    - A medical record chart review;
    - Consultation with the member's treatment team;
    - Review of administrative data such as claims/encounters; and
    - Demographic and customer service data.
- Care Managers shall establish and maintain a Care Management Plan for each member enrolled in Contractor's Care Management Program. The Care Management Plan, at a minimum, shall:
    - Describe the clinical interventions recommended to the treatment team;
    - Identify coordination gaps, strategies to improve care coordination with the member's service providers;
    - Require strategies to monitor referrals and follow-up for specialty care and routine health care services including medication monitoring; and
    - Align with the member's Individual Recovery Plan, but is neither a part of nor a substitute for that Plan

9.1 Appointments

For all populations covered under this Contract, the Contractor shall:

- Develop and implement policies and procedures to monitor the availability and timeliness of appointments for members and disseminate information regarding appointment standards to members, subcontractors and providers in conformance with the ADHS/DBHS Policy on Appointment Standards and Timeliness of Services.
- Except as otherwise specified in Section 9.2 and in conformance with the ADHS/DBHS Policy on Appointment Standards and Timeliness of Services, provide appointments to members as follows:
    - Emergency appointments within twenty-four (24) hours of referral, including, at a minimum, the requirement to respond to hospital referrals for Title XIX/XXI members and Non-Title XIX members with SMI;
    - Routine appointment for initial assessment within seven (7) days of referral; and
    - Routine appointments for ongoing services within twenty-three (23) days of initial assessment.
- Actively monitor and ensure that a member's waiting time for a scheduled appointment is no more than forty-five (45) minutes, except when the provider is unavailable due to an emergency.
- For referrals from a PCP or Health Plan Behavioral Health Coordinator for a member to receive a psychiatric evaluation or medication management, appointments with a behavioral health medical professional, will be provided according to the needs of the member, and within the appointment standards described above, with appropriate interventions to prevent a member from experiencing a lapse in medically necessary psychotropic medications.
- Monitor subcontractor compliance with appointment standards and require corrective action when the standards are not met (42 CFR 438.206(c)(1)(iv), (v) and (vi)).
- Require all disputes to be resolved promptly and intervene and resolve disputes regarding the need for emergency or routine appointments between the subcontractor and the referral source that cannot be resolved informally.
- Provide transportation to all Medicaid eligible members for covered services including SMI members receiving physical health care services so that the member arrives no sooner than one (1) hour before the appointment, and does not have to wait for more than one (1) hour after the conclusion of the appointment for return transportation.
- Require that transportation services be pre-arranged for members with recurring and on-going behavioral and physical health care needs, including, but not limited to, dialysis, radiation, chemotherapy, etc.
- Implement appointment standards of practice as they are identified by ADHS.
- Develop a corrective action plan (CAP) when appointment standards are not met. If appropriate, the corrective action plan should be developed in conjunction with the provider manual [42 CFR 438.206(c)(1)(iv), (v) and (vi)].
- Respond to all requests for services and schedule emergency and routine appointments consistent with the appointment standards in this Contract.

- 9.2.2 **Monitor appointment availability utilizing the methodology found in the AHCCCS Contractor Operations Manual Appointment Availability Monitoring and Reporting Policy**. For purposes of this Section, "urgent" is defined as an acute, but not necessarily life-threatening disorder, which, if not attended to, could endanger the member‘s health.

- 9.2.4 Utilize the results from appointment standards monitoring to assure adequate appointment availability in order to reduce unnecessary emergency department or crisis services utilization.
- 9.2.5 Consider utilizing non-emergency facilities to address member non-emergency care issues occurring after regular office hours or on weekends.
- 9.2.6 Develop and distribute written policies and procedures for network providers regarding appointment time standards and requirements.
- 9.2.7 Establish processes to monitor and reduce the appointment —no showǁ rate by provider and service type