INDEPENDENT CONSULTANT REPORT #2

OREGON HEALTH AUTHORITY

ACTIVITIES TO IMPLEMENT

THE OREGON PERFORMANCE PLAN

Submitted by Pamela S. Hyde, J.D.
Hyde & Associates –
Policy and Practice Consulting, LLC

October 2017

ACKNOWLEDGEMENTS

Many Oregon Health Authority (OHA)[1] staff and Oregon behavioral health system stakeholders helped me over the last several months to understand Oregon's contracting and regulatory system and understand the status of various activities to implement the Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (OPP). As with the first Independent Consultant Report, OHA staff met with me, provided me with materials and information, and briefed me on the State's plans for updating regulations and contracts to meet OPP as well as changing state and federal requirements. I continue to appreciate the openness with which OHA staff have worked with me to assure I had the information needed for this report, and to listen to my thoughts and suggestions as they continue with OPP implementation.

I will continue to call out for a special thanks key staff such as Cissie Bollinger and Michael Morris of OHA's Behavioral Health Policy unit within the Division of Health Policy and Analytics. Cissie and Mike have worked tirelessly and closely with me to get me the information I requested, explain unique aspects of Oregon's health system and transformation efforts, and assure I had access to the OHA staff and data I need to understand and report the status of OHA's activities and their impact on services for adults with serious and persistent mental illness (SPMI). As OHA leadership has changed, Cissie and Mike have remained the consistent voices pushing and leading OPP implementation and reporting, along with Royce Bowlin, Leslie Clement, Richard Wilcox, Geralyn Brennan, Rebecca Curtis, and Arthur Tolan. Many other staff and stakeholders too numerous to name have helped me, and helped the State do the work needed to move Oregon's behavioral health system along and to report on these activities and outcomes. A special word of thanks to Pat Allen, the newly appointed Director of OHA, who made time for me and for the USDOJ attorneys and expressed understanding and commitment to the OPP during the first annual meeting of OHA and USDOJ regarding the OPP.

Finally, a continuing note of thanks to John Dunbar and the other attorneys for the State of Oregon in this and in contracting matters, and the United States Department of Justice attorneys working on this project, especially Jessica Polansky in Washington, D.C. and Adrian Brown in Portland, OR. Their consultation and input have continued to help me understand Oregon's system, services, stakeholders, and constraints as well as the hopes and concerns about how the system is evolving and progressing. USDOJ leadership on this project is also undergoing change, therefore additional and different attorneys have become part of the USDOJ team for the future of this project, namely Judy Preston and Richard Farano. I have appreciated getting to know and work with them and to hear their perspectives on Oregon's system of services for persons with serious and persistent mental illness.

Respectfully and with gratitude,

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[1] See Appendix A for a list of acronyms used in this report.

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INTRODUCTION – BACKGROUND AND SCOPE OF REPORT #2

This is the second report of the Independent Consultant (IC) for the Oregon Performance Plan for Mental Health Services for Adults with Serious and Persistent Mental Illness (OPP). The overall context of the development of the OPP and the commitment of the State of Oregon represented in the provisions of the OPP were described in IC Report #1, dated March 2017.[2] This report is limited to specific provisions of the OPP having to do with contract and regulatory changes necessary to fully implement the OPP. IC Reports #3 through #5 will each address a subset of the ten (10) services and Performance Outcomes in Section D of the OPP as well as commitments about Quality and Performance Improvement in Section E of the OPP.

This IC Report #2 also includes a short section about the State's current data reporting about provisions of the OPP. However, since the timing of this report is prior to the availability of the first full year of data – Fiscal Year (FY) 2017 ending June 30, 2017, for which data will not be available until the State's data or narrative reports in early Calendar Year (CY) 2018 – this report will not include a full compliance assessment matrix similar to what was included in Appendix B of IC Report #1.

Scope of IC Report #2

This report focuses solely on those provisions of the OPP regarding commitments about contracts and regulations (or commitments requiring contract or regulatory changes) impacting services for adults with serious and persistent mental illness (SPMI), specifically those services and performance outcomes committed to in the OPP. In Subsection A.2. of the OPP, the State acknowledges Title II of the ADA "requires . . . 'a public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.' 28 C.F.R. § 35.130(b)(7)." Those reasonable modifications can often be made in contracts and regulations governing service delivery for, in this case, adults with SPMI. The OPP specifies some of the modifications to be made and implies others.

OHA has been or is working to modify language or requirements in a number of contracts and regulations. This report discusses these and other regulations or contracts that might be considered for amendments, including:

- Community Mental Health Program (CMHP) Contracts, including Service Elements (e.g., Mobile Crisis services, Rental Assistance, Jail Diversion)
- Coordinated Care Organization (CCO) Contracts
- KEPRO Contract
- Choice Contracts

[2] The first report and other materials related to the OPP can be found on OHA's website at http://www.oregon.gov/oha/HPA/CSI-BHP/Pages/Oregon-Performance-Plan.aspx

- OCEACT and OSECE Agreement with Josephine County
- Interagency Agreement with DPSST for CIT Training
- Interagency Agreement with EOHSC/GOBHI for CIT and SIM Training and Technical Assistance
- Memorandum of Understanding (MOU) with the Oregon Criminal Justice Commission
- Outpatient Services Regulations (including Crisis Line Regulations)
- Acute Care Psychiatric Services Regulations
- Hospital Services Regulations
- Community Mental Health Regulations
- CCO and Medicaid Managed Care Regulations
- Medicaid Behavioral Health Services Regulations
- Other regulations cited in the various contracts or regulations listed above
- Independent Consultant Contract

Generally, the provisions in the OPP that reference or have implications for modifications of contracts or regulations are noted in the table below.

OPP Provision	Topic	Critical OPP Language w/ Contract and/or Regulatory Implications
B.6.a. – o.	General Terms and Definitions	Various definitions for specific services and processes, including: a. Acute Care Psychiatric Facility or Acute Care Psychiatric Hospital b. Assertive Community Treatment c. CCO Region d. Competitive Integrated Employment e. Discharge Planning f. Evidence-Based g. Fidelity h. Homeless i. Jail Diversion Services j. Mobile Crisis Services k. Peer-Delivered Services l. Ready to Place/Ready to Transition m. Sequential Intercept Model n. Supported Employment Services o. Supported Housing
D.1.d.	ACT	"OHA may waive fidelity requirements regarding the number of individuals served by a team and the proportional reduction in staff for ACT teams in rural areas if the teams are unable to achieve fidelity. OHA shall report on any such waiver to USDOJ."
D.1.e. & f.	ACT	"By July 1, 2016, OHA will develop criteria for admission to ACT consistent with the definition in this Plan and based on national standards and provide them to USDOJ." "Thereafter, OHA will incorporate those admission criteria into administrative rules."
D.8.	Crisis Services	"OHA will track and report the number of individuals receiving a mobile crisis contact."
D.8.a. – c.	Crisis Services	"By the end of year one (June 30, 2017), OHA will develop a methodology to track dispositions after a mobile crisis contact." "Six months after the development of the methodology, OHA will begin

OPP Provision	Topic	Critical OPP Language w/ Contract and/or Regulatory Implications
		reporting the number of individuals whose disposition from mobile crisis is admission to Acute Care." "By the end of year two (June 30, 2018), Oregon will report the number of individuals whose dispositions after contact with mobile crisis result in stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to a acute care psychiatric facility."
D.9. – 11.	Crisis Services	"By the end of year one (June 30, 2017), for areas that are not rural or the frontier, mobile crisis teams shall respond 'from the initial call to face to face' within 1 hour." "For frontier areas . . . within 3 hours." "In rural areas . . . within 2 hours."
D.12.	Crisis Services	"In frontier and rural areas, a person who is trained in crisis management (such as a person from a crisis line or a peer) shall call within 1 hour."
D.13.	Crisis Services	"OHA will develop and enforce uniform standards for hotline services and County Crisis Lines."
D.20.f.	OSH	"OHA agrees that discharges from OSH of members of a Coordinated Care Organization ('CCO') should be consistent with Oregon Administrative Rules. OHA will work with CCOs to help them meet their obligations regarding the discharge of their members from OSH, consistent with the Oregon Administrative Rules." [D.21 states, "The preferred discharge is one where an individual is discharged from OSH within 72 hours of the determination that the individual is Ready to Place/Ready to Transition." (RTT)]
D.22.	OSH	"OHA will enter into performance-based contracts to help it pursue paragraphs D.20 and D.21. These contracts may be with Community Mental Health Programs ('CMHPS'), CCOs, or with other entities, as appropriate."
D.29.	Acute Psychiatric Care	"OHA shall require acute care psychiatric facilities to report to OHA all individuals who refused a warm handoff on a quarterly basis, and OHA shall report this information to USDOJ, beginning with data for the second quarter of year one (October 1, 2016 to December 31, 2016)."
D.30.	Acute Psychiatric Care	"OHA will continue to require that individuals receive a follow up visit with a community mental health provider within 7 days of discharge. . . ."
D.34.	Acute Psychiatric Care	". . . OHA will establish requirements for acute care psychiatric hospitals to assess the housing needs of individuals with SPMI. OHA shall require that, for all individuals with SPMI who are CCO members, the acute care psychiatric facilities shall consult with the individual's CCO in developing the assessment. . . ."

OPP Provision	Topic	Critical OPP Language w/ Contract and/or Regulatory Implications
D.40.a. – b.	Emergency Departments	a. ". . . OHA will monitor the number of individuals with SPMI with two or more readmissions to an emergency department for psychiatric reasons in a six month period, and will continue to work with CCOs and CMHPs to better address the needs of these individuals in less institutional settings . . ." b. ". . . OHA will seek contract amendments to CCO contracts in 2018 that will require that acute care psychiatric hospitals develop and implement plans to address the needs of these individuals and address their needs in less institutional settings."
D.46.	Supported Employment	D.45 states, "OHA will report the following: a. The number of individuals with SPMI who receive supported employment services who are employed in competitive integrated employment, as defined above. b. The number of individuals with SPMI who no longer receive supported employment services and are employed in competitive integrated employment without currently receiving supportive services from a supported employment specialist." D.46 states, "OHA will regularly monitor the foregoing data for the purpose of improving Supported Employment services."
D.49. – 50.	Secure Residential Treatment Facilities	D.49. "Civilly committed individuals in secure residential treatment facilities (SRTFs) whose clinical needs no longer necessitate placement in a secure facility shall be moved expeditiously to a community placement in the most integrated setting appropriate for that individual. a. These moves shall be consistent with the housing provisions in paragraph D.50. b. OHA will seek to reduce the length of stay of civilly committed individuals in secure residential facilities, . . . " D.50. "Civilly committed individuals who are discharged from [SRTFs] shall be moved to a community placement in the most integrated setting appropriate for that individual. . . . "
D.52.a.	Criminal Justice Diversion	D.52.a. "OHA will continue to report the number of individuals with SPMI receiving jail diversion services and the number of reported diversions. OHA will require, under new contracts with entities providing jail diversion services that contract providers report the number of diversions pre- and post-arrest. OHA will include this requirement in all RFPs for any new jail diversion programs."
D.52.b. & f.	Criminal Justice Diversion	D.52.b. "By July 2016, OHA will begin to work collaboratively with the Oregon Sheriffs' Association and the Association of Community Mental Health Programs to determine strategies to collect data on individuals with SPMI entering jails." D.52.f. "OHA shall continue to collect data regarding individuals with SPMI enrolled in mental health services who are arrested, the county where these individuals encountered law enforcement, existing jail diversion services, the impacts of these services, and obstacles to the success of these services. . ."

OPP Provision	Topic	Critical OPP Language w/ Contract and/or Regulatory Implications
D.52.c.	Criminal Justice Diversion	"By July 2016, OHA will contract with The GAINS Center to consult on the expansion of the use of the Sequential Intercept Model by local jurisdictions across the State, and will encourage local jurisdictions to adopt and implement interventions in accordance with this model. New funding for jail diversion services will require the county to adopt the Sequential Intercept Model."
D.52.f.	Criminal Justice Diversion	" . . . OHA-funded jail diversion grants shall prioritize pre-charge diversion activities."
E.1.	Quality and Performance Improvement (QPI)	" . . . The quality and performance improvement system will seek to ensure compliance with these outcome measures and will seek to ensure that the community-based services for individuals with SPMI describe in this Plan are offered in accordance with the requirements of the Plan."
E.4.a.	QPI	" . . . OHA shall collect and utilize consistent, reliable data regarding services for individuals with SPMI receiving publicly funded behavioral health services . . ."
E.4.b.	QPI	"OHA will issue regulations or enter into performance-based contracts with CMHPs and other providers, either directly or through its CCOs that specifically describe expectations with regard to the outcomes in Section D and the services and supports to be provided to individuals with SPMI consistent with the provisions of this Plan."
E.4.c.	QPI (SE & ACT)	"Supported Employment and Assertive Community Treatment Providers shall continue to be reviewed annually for fidelity to a specific set of standards that demonstrate that the program is following an evidence-based model. Providers may not bill Medicaid or use General Funds unless they are subject to this annual fidelity review. These reviews will include interviews with participants in the program and their families when appropriate. Regardless of a provider's overall fidelity score, if a fidelity review identifies particular areas of weakness, OHA or the Oregon Supported Employment Center for Excellence or the Oregon Center of Excellence for Assertive Community Treatment shall provide technical assistance or other support to the provider, in order to help the provider remedy that deficiency. OHA or the relevant Center of Excellence shall review the provider's implementation of any corrective measures, shall evaluate whether the provider's performance in those areas improves, and shall take further action as necessary to assist the provider in remedying the deficiency."
E.4.d.	QPI	"If a CMHP or CCO is acting in a way that OHA believes will frustrate substantial performance of this Plan, OHA will develop a corrective action plan, with timelines for implementation, oversight and monitoring by OHA."
F.1.	Compliance and Reporting	"OHA will contract with Pamela S. Hyde, who shall serve as the Independent Consultant to assess OHA's performance under this Plan."
F.6.	Compliance and Reporting	". . . To the extent that quarterly information from third parties, such as from jail diversion providers, is not currently available, OHA shall seek contract amendments in any contract entered into after July 1, 2016 that will require that data reporting be done on a quarterly basis."

In most cases, the OPP does not address when these contract or regulatory amendments have to be made. However, most of them are important to do soon because of the timing of contract or regulatory amendments and because many of the performance measures are dependent on those amendments being done sooner rather than later.

This report addresses the OPP provisions and the contracts and regulations listed above, and in some cases, other regulations or documents referenced in those listed contracts and regulations. This report will not address all the service elements or performance outcomes in each service area or subsection of the OPP. Those larger service element issues and performance outcomes will be addressed later in subsequent reports. Nor does this report assess actual compliance with elements of the OPP at this time.

A reminder about the drafting, review, and approval of IC Reports is in order. Subsection F.3. of the OPP provides that the IC "shall provide the report in draft to OHA and USDOJ, and OHA and USDOJ shall have 30 days to comment on the draft report." Hence, this report was drafted with information as of October 1, 2017, and was provided in draft to OHA and USDOJ in late October 2017. I considered comments from both of these entities in finalizing this report, with the intent of the IC report being to "aid in the resolution of this matter" as indicated in that subsection of the OPP.

STATUS OF OHA EFFORTS REGARDING CONTRACT AND REGULATORY CHANGES

Oregon's publicly funded behavioral health system and services, especially those focused on adults with SPMI, are undergoing transformation with significant efforts underway to align the system and services with OPP commitments. Along with larger state and federal changes in Medicaid and other funding, OHA's significant efforts to address the commitments in the OPP have resulted in many changes being undertaken. As of the date of this IC Report #2, OHA has done considerable work revising the CMHP contract and service element language, with other amendments in process. Likewise, the Choice contracts, the OSECE and OCEACT contracts, and the outpatient services and crisis lines regulations have all been changed significantly or are in the change process. Changes are underway to the CCO contracts for CY 2018, and are being considered for the CY 2019 contract extension. The process by which entities will be selected to participate as CCOs in the coming years (e.g., CY 2020 -- 2024) has not yet been announced. However, OHA has indicated OPP related changes will be made no later than in the CY 2019 CCO contract. Changes have also been made to jail diversion, rental assistance, mobile crisis, and other services contracts. The KEPRO contract just became effective in October 2016, and includes some language reflective of the OPP. Changes have been made and additional changes are also underway to the outpatient services regulations. It is not clear whether the regulations governing inpatient hospitals or emergency departments, or the regulations governing the Medicaid CCOs are undergoing OPP related changes at this point.

This IC Report #2 is generally organized by contract or by regulation. This report will attempt to describe those changes underway on these various documents at a point in time, recognizing the dynamic nature of the system may make some of the findings in this report out-of-date soon after its release. However, this IC Report #2 will also note contract language or regulations that I perceive may yet need to be addressed in order to fully implement the commitments in the OPP.

Finally, the system issues and recommendations coming out of the Behavioral Health Collaborative, described toward the end of IC Report #1, are in discussion for implementation via various work plans and directives, as well as in contracts. Some of these are critical to the success of the OPP, or will have a significant impact on that success. For example, the approach to developing single points of accountability regionally or locally may have tremendous impact on how CCOs, CMHPs, and various providers work together and perform. That impact can be healthy and helpful or time-consuming and bureaucratic, depending on how it is implemented. Likewise, workforce expectations for various practitioners can be helpful in improving quality or can serve to create more significant workforce pressures without additional gain. Since these and other recommendations are in process, it will be

important to make sure their implementation serves to improve rather than hinder the State's ability to implement and report on the performance outcomes and other commitments in the OPP for adults with SPMI.

Because OHA is in process with many of the issues addressed in this report, I will not assess compliance per se at this time, but rather indicate areas where contracts and regulations still need to be completed or adjusted (as of October 1, 2017) to meet the requirements or intent of the OPP. Areas identified below are examples of recommended changes rather than exhaustive of all changes or approaches either in process or that could be utilized to address the commitments and intent of the OPP. As there may be multiple approaches to addressing some of the issues in this report, recommendations in this report should not be considered compliance requirements at this point, but rather as approaches to consider in order to achieve compliance with the OPP as well as system improvements beyond OPP commitments and timelines.

GENERAL COMMENTS ABOUT OHA CONTRACTS AND REGULATIONS

Several overarching issues arose as I reviewed the current state of the various contracts and regulations affected by the OPP. Because each of the contracts are developed by different staff responsible for different programs or different funding sources (for example, housing, Choice, Medicaid, CMHPs, OSH, etc.) and because the services are touched across these program and funding lines, I encountered considerable inconsistencies and suggest ways to make changes in common ways across all contracts and regulations. Some of the key issues that need to be addressed across all documents impacting services for adults with SPMI are described briefly below.

- *Definitions* – OHA appears to have no consistent place or method for assuring terms important to the implementation of the OPP (or for overall management of the behavioral health system of care, for that matter) are defined consistently and with integrity to the OPP goals. OHA should consider having all contracts and regulations include all the definitions from the OPP or referenced in a single and consistent place for definitions, in order to insure service delivery, data collection, and reporting are done consistently across organizations and across time. It is also imperative that adults with serious and persistent mental illness (SPMI) be defined consistently as OHA utilizes that term for data collection, monitoring of performance outcomes, and expectation management. The definition of SPMI is not in the OPP, but is in earlier documents utilized by OHA, and is used in the same manner as data reporting on this population prior to and now during the OPP implementation.[3] Some efforts have been made to create consistency in identifying the SPMI population as a priority or as the primary population for certain services, especially those services described in the OPP. However, the term itself is used inconsistently in some regulations and alternative terms are utilized at times. This will be discussed in more detail later in this report.

- *Expectations about Services and Collective Responsibility for Outcomes for Adults with SPMI* – OPP Subsection E.4.b. commits OHA to include in regulations or CMHP or CCO contract language to "specifically describe expectations with regard to the outcomes in Section D and the services and supports to be provided to individuals with SPMI consistent with the provisions of this Plan [OPP]." Currently no consistent language exists across contracts in particular, and in some respects, within regulations, about expectations for services or outcomes for adults with SPMI consistent with the OPP. OHA has indicated it does not want to reference the OPP within contracts or regulations since the OPP will be changed or no longer in effect at some point during the lifespan of these contracts. OHA has indicated it wants to ensure changes brought about by the OPP are systemic and will stay in place beyond the timeline of the OPP. While not specifically referencing the OPP itself makes some sense, it therefore becomes even more imperative for OHA to describe consistently its expectations of its funded partners for the joint success of

[3] IC Report #1 discusses this definition at length on pages 10-12 of that report.

services and outcomes for adults with SPMI. This should be done in a way so accountability is understood, embraced, and can be enforced across various funded entities. At no time should an adult with SPMI be without a clear point of accountability for his/her overall care and outcomes (not just the care contracted for or funded to one of the various entities). Examples will be discussed more fully later in this report.[4] And at no time should a funded entity be able to say "that is not my responsibility," but rather to participate in State funding, an entity should be required to think and to say "how can I help facilitate the responsible party's ability to get that done" so the adult with SPMI is adequately served and his/her life is on track with his/her goals.

- *Relationship with Other Critical Entities* – Oregon's system of care for behavioral health services is somewhat fragmented – across community mental health (and addiction) programs, county public health programs, coordinated care organizations, service providers receiving funding directly as a result of an open Request for Proposals (RFPs), and the independent qualified agent required by Medicaid. The role of these various entities is not always clearly understood by other entities and by stakeholders in the system. I strongly recommend that OHA develop and disseminate a relatively simple, common, and consistent description of the role of these various entities, and include such a description in contract language or in appendices or regulations that can be part of common expectations and referenced consistently.

- *Subcontracting* – Almost all contracts have some sort of language regarding the ability of the contractor to subcontract the work to others, and the contractor will be responsible for the activities and outcomes of the contract, regardless of the use of a subcontractor. While these requirements may be different for contractors selected specifically to provide services, other contractors are expected to subcontract for service delivery (e.g., CCOs and in some cases, CMHPs). However, OHA should consider specific language about requirements that must be included in subcontracts in order to ensure a subcontractor cannot say they were unaware or are unable to comply with essential requirements. OHA may want to retain the right to review subcontracts before they are allowed, in some or all circumstances. This will be discussed further later in this report.[5]

- *Quality and Accountability Provisions* – Every contract and every regulation impacting adults with SPMI should have clear accountability provisions consistent with the outcomes committed to in the OPP and consistent across funded entities. That is, regulations should lay out the outcomes desired or expected for this population either within the language itself, or by reference to a website or other location or easily and publicly accessed document(s) identifying those desired or expected outcomes. Similarly, contracts should delineate these outcomes as well and to the extent possible, provide financial or other incentives to enhance the likelihood desired or expected outcomes will be achieved. In some cases, shared incentives or holding contractors collectively responsible for particular outcomes so that all succeed or fail together may be the best approach.

- *Data Collection Requirements* – Each contract impacting the success of OPP elements (and arguably contracts more generally) must note the data collection requirements that must be met in order for OHA to have and report the data required by the OPP. These data collection needs often require explicit instructions via manuals or other documents that should be kept updated and referenced in each contract. How OHA counts adults with SPMI in various services and how

[4] The most recent Choice Model Services contract language and the outpatient services regulation are two examples of significant revisions being more explicit about required or desired coordination efforts between partners within the system. The Choice and KEPRO contract language has incorporated specific OPP language and metrics as performance incentives. While additional changes may be needed, these approaches show OHA's efforts to implement the OPP through its contracts. These are discussed more fully later in this report.

[5] Note, I have requested subcontract language for a couple of items to see what and how requirements are passed along. I have not yet been provided with this subcontract language even though requested months ago. As would be expected, OHA apparently does not keep these subcontracts on file and must request them from the contractor when needed.

it expects its contractors to provide that information to OHA (whether via MMIS, MOTS, surveys, etc.) needs to be clear and consistently applied throughout the State.

- *Corrective Actions* – In Subsection E.4.d., the OPP explicitly commits OHA to develop a corrective action plan, with timelines for implementation, oversight and monitoring by OHA, if a CMHP or CCO is "acting in a way that OHA believes will frustrate substantial performance of this Plan . . ." This obligation should be incorporated consistently into CMHP, CCO, and any other contracts impacting services for adults with SPMI. Alternatively, OHA should include consistent language across contracts to easily transfer or direct transfer of a contract and funding to another entity who can adequately implement the function or provide the services for adults with SPMI. This process (corrective action or transferring of a contract) should be expedited and in the discretion of OHA[6] in order to assure services are provided and funding is appropriately spent to achieve the intended outcomes for adults with SPMI. The language should help entities who enter into these contracts know when the contracts are executed that: 1) OHA is serious about performance for adults with SPMI overall; 2) the contractor is a key part of that performance but is not the only entity capable of doing this part of the activities necessary to achieve performance; 3) because OHA is committed to these outcomes, it will be the judge of that performance by the contractor; and 4) OHA will take action to assure this contractor is able to perform at the level needed to achieve the performance desired and intended.

Examples of these general and specific issues about each of the contracts and regulations identified above are described in the next section of this report.

OHA CONTRACTS CRITICAL TO OPP SUCCESS

This section of the report addresses the following:

- CMHP Contracts, including Service Elements (e.g., Mobile Crisis Services, Jail Diversion, and Rental Assistance, Choice Model Services, etc.)
- CCO Contracts and related Request for Proposals (RFPs) and/or Request for Applications (RFAs) for FY 2019 – 2023 (and potentially CMS request for approval)
- KEPRO Contracts
- OCEACT and OSECE Contracts
- EOHSC/GOBHI Interagency Agreement for CIT and SIM Training and Technical Assistance
- Interagency Agreement with DPSST for CIT Support
- MOU with the Oregon Criminal Justice Commission
- Independent Consultant Contract

County/CMHP[7] Two-Year Contract 2017 – 2019 (FY 2018 and FY 2019)

This contract or interagency agreement (Agreement) with the County for Community Mental Health Programs (CMHPs) was completed in the spring of 2017 to cover services and responsibilities for years two and three of the OPP (FY 2018 and FY 2019), July 1, 2017 through June 30, 2019. It has changed in

[6] To the extent state statutes significantly constrain this process, OHA should consider requesting in the next legislative session changes consistent with the OPP goals and intent.

[7] The distinction between a County, a CMHP, and a LMHA (local mental health authority) are important in certain circumstances. This Interagency Agreement indicates it is with the political subdivision of the State of Oregon, or County. Some counties directly provide CMHP responsibilities and/or services; others contract for such responsibilities and/or services. Technically, OHA enters into agreements with an LMHA – a county or counties designated locally to perform this function. The Agreement is the mechanism by which the State provides a County Financial Assistance Award (CFAA) to the LMHA. The LMHA sometimes delegates the functions and services to a separate CMHP and sometimes the LMHA operates directly as the CMHP. As used in this report, CMHP means the program, regardless who runs or operates it in a particular jurisdiction or geographical area.

significant ways from the prior two-year CMHP Agreements which covered the two years prior to the OPP (FY 2016 and FY 2017) so covered year one of the OPP (FY 2017, July 1, 2016 through June 30, 2017). These changes in the current CMHP Agreement reflect OHA's efforts to meet its commitments in the OPP. As is usually the case, actions in the most recent State legislative session (ending in July 2017) require additional changes, so amendments are underway this fall. Because of commitments or requirements about the length of time Counties have to review and discuss these changes, those amendments are in process for the current two-year contract. It is critical that as many changes needed for the OPP be incorporated as these contracts are being amended. Anything that is not able to be accomplished now should be started now so that they can be included in the next amendments in 2018 and in the next two-year contract, the 2019 – 2021 biennial contract (for FY 2020 and FY 2021), planning for which will begin in mid-2018. As of this report, I have not seen the final proposed amendments for the current contract, although I understand OHA is taking this opportunity to make additional amendments to help implement OPP commitments. This section's comments reflect only the CMHP contract language in place as of October 1, 2017. I will consider any further amendments made as I look at services and other requirements in future reports.

The existing CMHP Agreement boilerplate language (Recitals through Exhibit J), contains several issues that should be addressed to help implement the OPP commitments.

CMHP Boilerplate Language – Definitions: CMHP Agreement boilerplate language does not include specific definitions similar to the OPP. While some of these definitions may exist in the service element language or in regulations to which CMHPs are subject (see further discussion below), it is hard on the face of the document(s) to determine whether CMHPs are on notice about and are required to utilize all of the definitions critical to OPP success, especially since the regulatory language is not always consistent (see further examples in this report). Some but not all of these critical definitions are in the State's outpatient regulation (OAR 309-019), but that regulation is not cited in boilerplate language. While other types of services or service needs are defined (e.g., gambling disorder and problem gambling), there is no mention of adults with SPMI in the boilerplate language. Some service definitions are included in the language of specific service elements. However, by the Agreement alone, stakeholders would find it difficult to know whether the State requires CMHPs and their subcontractors to consider adults with SPMI a priority or target population and whether CMHPs are subject to the OPP definitions (and other OPP requirements, for that matter).

An example of confusion discussed by various stakeholders, including CMHPs, is the definition of SPMI. In the CMHP Agreement boilerplate language, "mental health services" are defined as "treatment services for individuals diagnosed with serious mental health illness, or other mental or emotional disturbance, posing a danger to the health and safety of themselves or others." This term needs to be changed to incorporate the appropriate designation of SPMI and to remove the artificial differentiation between SMI (or in this case, the term "serious mental health illness" which is inaccurate for all kinds of reasons) and SPMI. Likewise, some of the service element language utilizes the term serious mental illness (SMI) without any mention of SPMI (e.g., MHS 20 – Non-Residential Mental Health Services for Children, Youth, and Adults). It is not clear from this language whether SMI and SPMI are synonymous or different and if the latter, what services for individuals with SPMI are to be provided. For example, service element MHS 20 requires care coordination services for individuals living in residential treatment programs. Yet KEPRO (described later in this report) is responsible for care coordination for certain individuals in some residential treatment programs, and hence, there is significant opportunity for confusion about roles. Likewise, even care coordination requirements are different in different OHA contracts. SPMI, care coordination, and other key terms need to be defined consistently throughout all documents so roles are clear and not duplicative, and so data reported for OPP purposes are consistent, whether reported by OHA, CMHPs, CCOs, KEPRO, or service providers. I understand OHA has made the commitment to use the term SPMI consistently and will be changing contracts accordingly.

CMHP Boilerplate Language – OPP Target Population(s) and Expectations: Oregon's Community Mental Health Programs are the primary source to ensure service delivery of non-Medicaid State or locally funded mental health services for adults with SPMI. They also play a critical role in helping to coordinate

all mental health services in a particular geographic area for this and other populations with mental health service needs, regardless of fund source. As such, it is critical this role be noted and specified in the State's Agreement with any CMHP and with any other entity receiving State provided or State administered funds. Similarly, the CMHP Agreement should specify what this role entails in terms of specific coordination requirements with other key State and local entities such as housing authorities, law enforcement and jail administrators, physical health authorities, authorities responsible for addiction services, local inpatient units, OSH, etc. The CMHP Agreement should specify what kinds of staff need to have what kind of coordinating roles for these responsibilities. That is, OHA should specify in the CMHP Agreement that the CMHP should designate an individual responsible for each of these coordination responsibilities. While these various responsibilities could be performed by one or more individuals (at the CMHP's discretion), it is imperative the individuals doing these duties have some expertise and sufficient time to play this coordination role for individuals served as well as for systems with which CMHPs must collaborate.

As indicated earlier in this report, all contract language impacting adults with SPMI needs to identify this population as a priority and delineate the role of various system players and this particular partner's role in helping OHA succeed in addressing the needs of this population. This language needs to identify the expectations for the various system players to work together and effectively to assure OHA is able to meet its commitments to adults with SPMI. If these matters are addressed in other documents, they need to be made an exhibit or referenced so that CMHPs, their providers/subcontractors, as well as other stakeholders can find this language easily.

CMHP Boilerplate Language – Subcontracting Provisions: While the boilerplate language makes it clear a CMHP can fulfill its obligations by providing or purchasing services through a subcontractor (referred to here as "Provider," although that term includes the CMHP if services are provided directly by the CMHP), the requirements of such providers are delineated in Exhibit H and are primarily administrative in nature except where Substance Use Disorder Services and Problem Gambling Services are required to be provided (Exhibit H.1.c.). A section of Exhibit H similar to this should be included to delineate the requirements for Providers of services for adults with SPMI. Similarly, while subcontracted provider agreements are required to include provisions "necessary to implement Service delivery in accordance with the applicable Service Descriptions, Specialized Service Requirements and Special Conditions" and are subject to OHA review upon request, OHA needs to consider specific language regarding services for adults with SPMI necessary for any provider/subcontract agreement. OHA may also want to consider – at least for the time period of the OPP and immediately following – requiring any language in a subcontractor/Provider agreement impacting this population and the services addressed in the OPP be reviewed and maybe even receive prior approval by OHA. Anecdotal reports from providers suggest that language in some subcontract/provider agreements may be inconsistent with the intent or desired outcomes of the OPP. However, I have not yet seen such subcontract language so cannot confirm these reports at this time.

CMHP Boilerplate Language -- Quality and Accountability Provisions: Exhibit D.8. addresses specific performance standards and quality measures, including the criteria to measure specific outcomes sought. While some of the performance outcomes committed to in the OPP are included in this section (e.g., housing status, employment status, criminal justice involvement, average daily population (ADP) in the state hospital (OSH), and average length of stay (ALOS) on the OSH Ready to Transition (RTT) list), some of these are not consistent with the data specifications used by OHA in its quarterly data and/or narrative reports about the OPP. OHA should seriously consider including all the performance measures in the OPP in this section, and specify the particular criteria for measuring these outcomes for adults with SPMI. In addition, to be performance-based, OHA should consider including financial incentives for meeting or exceeding OPP related metrics.

Likewise, while this subsection of Exhibit D indicates "[t]he criteria are applied on a countywide basis each calendar quarter . . .," neither this section nor other parts of the boilerplate language include a requirement that data be reported on a quarterly basis to assist in accurate OPP data reporting. Slow reporting can skew OPP data and make it difficult for OHA and for me as IC to determine whether the

State is meeting its commitments and whether any particular part of the State is having difficulty helping OPP meet its Statewide goals. Section F.6. of the OPP indicates that all data for the OPP are to be provided by OHA quarterly and that to the extent quarterly information is not currently available from "third parties," "OHA shall seek contract amendments in any contract entered into after July 1, 2016 that will require data reporting be done on a quarterly basis." While CMHPs are generally required to report quarterly or more frequently, this requirement is sometimes indicated explicitly and at other times by reference to a website and guidance document. It is important that the CMHP Agreement require such frequent reporting in a consistent manner, especially for the specific OPP services provided for adults with SPMI, ***and*** that OHA be able to withhold funding until such required reporting is accomplished.

Note: Exhibit E.8. and Exhibit H.2.f. also address reporting requirements, and the latter provides a link to the MOTS resource guide which does provide timelines for reporting into MOTS. Other federal and state requirements guide how frequently and within what timelines Medicaid billing data must be provided in MMIS. However, since the CMHP Agreement is about services funded by sources other than Medicaid, these other documents or guidelines are not referenced in the boilerplate language. Rather the MOTS manual is referenced in service element language with specific requirements about quarterly or more frequent reporting for certain purposes. When survey data are the source of data reporting for OPP performance measures, instructions likely require data to be submitted quarterly. However, without a specific requirement in each Agreement that any requested data be provided quarterly or sooner, and funds will be withheld until such data are provided, OHA may be subject to insufficient data reporting from its partners to meet its commitments in the OPP.

Some of the regulations do include requirements for quarterly reporting of data about individuals receiving particular services (e.g., reporting regarding individuals receiving ACT services, O.A.R. 309-019-0255). However, this requirement needs to be more broadly stated in the CMHP Agreement for all adults with SPMI, specifically for all services in the OPP.

Finally, the CMHP Agreement should indicate OHA's efforts and commitments regarding quality and performance improvement for adults with SPMI in Section E of the OPP. These commitments should be translated into language requiring CMHPs to assist with these efforts in ways that will help OHA meet its Statewide commitments for this population.

CMHP Boilerplate Language – Corrective Action Plan Processes: The CMHP Agreement includes Exhibit F.6., which addresses the potential of County default, and F.8., which describes the process OHA will use to terminate a CMHP Agreement. However, nowhere does this or other boilerplate language specify the ability of OHA to determine that a CMHP's actions need to change or be improved to help it meet its OPP commitments, nor does it indicate the ability of OHA to require development of "a corrective action plan, with timelines for implementation, oversight and monitoring by OHA." (OPP Subsection E.4.d.) Unless a regulation or other document exists that obligates CMHPs and specifies OHA's ability to develop and oversee such a corrective action plan, this CMHP Agreement needs to incorporate this authority and specify under what circumstances and how OHA will determine the CMHP "is acting in way that OHA believes will frustrate substantial performance of this Plan" (the OPP). Such language also needs to specify how funding will be impacted until the corrective action plan is adequately implemented. If this authority is specified elsewhere, that other authority source needs to be referenced in the CMHP Agreement. I understand OHA has committed to including corrective action plan language or reference in this and other contract language.

CMHP Service Element Language – Assertive Community Treatment (ACT) Services: Exhibit MHS 37 – ACT Services, does include a definition of ACT which is mostly consistent with the OPP, although the word "consumer" is used in the CMHP language whereas the word "individual" is used in MHS 37. Similarly, the definition of SPMI in MHS 37 is not entirely consistent with the SPMI definition utilized by OHA for purposes of the OPP. A consistent definition should be used, with qualifying language regarding which persons with SPMI are appropriate for ACT in regulations or elsewhere in MHS 37 – ACT. The regulations governing ACT are referenced in MHS 37 – ACT although the numbering of these regulations may have changed and needs to be updated for accurate reference (O.A.R. 309-019-0210 – 0240

compared to 309-019-0226 – 0255). Those regulations define SPMI and ACT slightly differently than the definitions in or used for the OPP, and reference "Providers" – ostensibly CMHPs or subcontracted CMHP providers.

Competitive Integrated Employment (CIE) is also defined in this service element language and is precisely the definition used in the OPP. The data reporting requirements in this service element does require the CMHP to provide quarterly reports on individuals served by ACT with specific data elements listed that are consistent with OPP requirements, along with a few other elements. However, important concepts such as "homeless" and "ready to transition" defined in the OPP, are not defined in this MHS 37 – ACT Services for purposes of data reporting. This list is also consistent with the regulation with a minor difference around Medicaid "Referrals and Outcomes" which probably should be cleaned up, but is not significant. The language in this service element also specifies that a month's funding may be withheld for any month with missing reporting requirements, but only until the CMHP submits the required reports. Hence, the CMHP can be late in providing data and still be paid at some point, potentially resulting in OHA data reporting being inaccurate, although generally this inaccuracy would be undercounting. Nothing in this language provides a fiscal incentive for meeting or exceeding any specific performance outcomes for ACT services or for adults receiving ACT services. While a corrective action plan approach could be used for this purpose, given the statutory constraints on this approach, it is likely not to be as strong or as a fiscal incentive to assist in achieving a performance-based approach.

The language in MHS 37 – ACT Services does require CMHPs to "implement a plan, in consultation with their respective CCO and OHA, to develop a qualified Provider network for individuals to access ACT services." The language also notes that ACT services must be provided by Providers meeting ACT fidelity standards in regulations referenced here. The CMHP is also required to work with their respective CCO(s) to increase the number of eligible individuals with SPMI served by ACT teams. Language similar to the OPP regarding referrals and waiting lists is also included. However, nothing is included regarding OPP commitments to provide other evidence-based services when an individual is denied, refuses, or is unable to access ACT services. Likewise, no consequence is stated for failure to take these actions.

While this service element has been changed to address some of the issues included in the OPP, further changes would help to strengthen requirements to assure CMHP provided or purchased ACT services are meeting the goals established in the OPP.

CMHP Service Element Language -- Crisis Services: All CFAAs with LMHAs (see Footnote 7) now include State funding for mobile crisis services. The language in Exhibit MHS 25 – Community Crisis Services for Adults and Children (Crisis Services) does include extensive definitions, including definitions of mobile crisis services consistent with the OPP. Outpatient regulations governing crisis services are referenced although regulation numbering may need to be updated. Service requirements and reporting requirements do appear to be generally consistent with the OPP, including the timeline for reporting quarterly. No financial incentive for meeting or exceeding performance outcomes is included. While this service element language references frontier, rural, and urban areas, the OPP references frontier, rural, and "areas that are not rural or the frontier." This subtle but critical distinction requires definition either here or within the regulations so that CMHPs know how to report and know what parts of their geographic area fall within these three designations. The discussion about this issue in the outpatient services regulation makes it clear that this language needs to be clarified there and should be clarified here as well. Similarly, no reference to crisis hotlines or standards for such lines is included here, although such standards are contained in the newly revised outpatient services regulation discussed later in this report.

CMHP Service Element Language – Rental Assistance: All State rental assistance funding is provided to LMHAs or their designee through the CFAA (see Footnote 7). Exhibit MHS 37 – Rental Assistance Services (RAS) addresses assistance with housing through funding for activities such as finding a rental unit, payments to landlords, financial budgeting, community navigation, and maintaining healthy relationships to help support maintenance of living in community settings. Persons identified as eligible for this service are individuals who are 18 years of age or older with serious mental illness (SMI) who are transitioning from OSH, from a licensed residential setting, or are homeless (as federally defined) or at

risk of being homeless, or without supported housing are at risk of reentering a hospital or licensed residential setting, Regulations are referenced here but the definition of SMI in regulations is not consistent with SPMI. Critical terms in the OPP are not included in MHS 37 – RAS. For example, SPMI, homeless, supported housing, are not defined or prioritized. Data are required quarterly, but no financial incentives for serving individuals with SPMI, using supported housing units versus other kinds of rental units, or helping individuals stay in stable housing situations are included. To the extent OHA is using data from this service element to report on OPP performance measures regarding supported housing, it is unclear how accurate those data are at this point. This service element does include language requiring coordination with CCOs and CMHPs to develop a plan to bill Medicaid for Medicaid eligible services. However, no further language about how to do this coordination, or having a staff specialist in housing is included.

Finally, a separate Exhibit MHS 39 – PATH provides funding and language for the federally funded PATH program which serves persons who are SMI and homeless. These funds are governed by federal requirements and language. Individuals served with PATH funds are not counted for OPP supported housing reporting purposes. OHA indicates PATH funding is not generally utilized for OPP related housing services. If it is used for these purposes, it would only pay for initial security deposits or one-time rental payments to prevent eviction of an adult with SPMI in or moving into supported housing as defined in the OPP.[8]

CMHP Service Element Language – Peer-Delivered Services (PDS): Exhibit MHS 37 – PDS describes PDS similarly to but not consistent with the OPP definition and is not completely consistent with the definition used in the recently revised outpatient regulation (O.A.R. 309-019-0105). These and other relevant regulations are not referenced in MHS 37 – PDS. The terms used within the MHS 37 – PDS description are terms used elsewhere in regulations and statute, including especially H.B. 2304, passed during the recent legislative session. Some of the requirements in that bill are consistent with the PDS language in the OPP and some go beyond the latter. Some terms such as “person centered care” are now defined in law (and in regulation) but are not referenced in MHS 37 – PDS, but are relevant to PDS services. This legislation requires OHA to adopt rules assuring CCO members are protected against underutilization and inappropriate denials of services, including the right to have access to peer-delivered services through peer support specialists and other enumerated peer workers. All these definitions and requirements need to be lined up in various OHA documents and regulations to assure CMHPs, CCOs, and other service providers all assure appropriate access to peer workers/advocates and peer-delivered services. MHS 37 – PDS does require quarterly reporting on a list of outcome measures consistent with and even beyond what is committed to in the OPP. However, some of these outcomes are a bit nebulous (e.g., “increase in a social support system) without further clarification or guidance, which presumably is provided in the “forms and procedures prescribed by OHA” but not referenced in this MHS 37 – PDS. Note: later in this report is a discussion of the KEPRO contract which defines similar terms inconsistently with the definitions in the service element language and the OPP. At this time, no State dollars other than Medicaid are being provided for PDS services. Consequently, this service element language will not be included in future amendments to the CMHP contracts until or unless such State funding is appropriated.

CMHP Service Element Language – Acute Psychiatric Care: OHA indicates persons served by this service element are not included in the data reports provided for OPP purposes. However, Exhibit MHS 24 – Acute and Intermediate Psychiatric Services (A&IPS) includes service descriptions for both acute

[8] O.A.R. 309-032-0311 et seq. cover mental health services for homeless persons funded through the PATH program which is not used or used infrequently to provide supported housing as described in the OPP. This regulation was last updated in June 2017. It defines serious mental illness with a reference to another regulation and does not define SPMI. The definition of homeless is also different and more extensive than the OPP definition of that term, which is specifically limited to persons with SPMI in the OPP. Generally, federal programs allow states to define populations such as SMI or SPMI in their own way. OHA has indicated it is attempting to utilize the SPMI terminology and definition to address that adult population who are utilizing high level services such as ACT, long term care at OSH, SRTF services, etc. OHA may want to consider how the PATH regulations need to be amended to help avoid system confusion about priorities, services, populations, and goals.

psychiatric inpatient services and for intermediate psychiatric inpatient services for persons on a waitlist for admittance to OSH. Regulations are referenced for outpatient and civil commitment services and processes (although numbering should be checked to assure consistency with the most recently updated regulations). The OPP defines acute care psychiatric facility or hospital (ACPF) as "a hospital that provides 24-hour-a-day psychiatric, multi-disciplinary, inpatient or residential stabilization, care and treatment, for adults ages 18 and older with severe psychiatric disabilities." A review of this language with the language describing MHS 24 services and responsibilities should be conducted to assure services are being provided and data are being collected consistently for purposes of the OPP commitments. MHS 24 – A&IPS prescribes the role of CMHPs in funding services for individuals in hospital or secure residential treatment facilities (SRTFs) who are receiving acute inpatient services and are not eligible for federally funded Medicaid services or have not yet been assigned to a CCO, or who are in need of intermediate psychiatric care services, specifically Long-Term Psychiatric Care (LTPC) – presumably in OSH. Such individuals could be adults with SPMI who are civilly committed, within the intent of the OPP, but could include others as well. While the regulations governing Oregon State Hospital Admissions and Discharges (O.A.R. 309-091-0000 – 0035) are referenced, they do not actually define LTPC services or the relationship among the various entities in this process. This regulation and this Exhibit, along with the CCO and KEPRO contracts, would be good places to describe and/or require specific roles and coordination/collaboration expectations among the various parties involved in these decision-making, care coordination, and funding responsibilities. Otherwise, it is left to the State to assure all of these parties are working together to assure appropriate care is provided and individuals are returned to the most appropriate community and evidence-based service environments as quickly as possible. Like other Exhibits described in this section, this language requires quick reporting (within 12 hours of admission or discharge from a provider facility). However, this information is required to be provided to the Oregon Patient and Resident Care System, a system different than the ones used by OHA for OPP reporting. No outcomes beyond these two measures are indicated in this Exhibit, and no financial incentives or other performance-based provisions are provided to reduce the use of LTPC, reduce the time spent on the OSH waitlist, or reduce the use of facility-based as opposed to community-based services for persons in need of acute or intermediate psychiatric care. Since CMHPs would likely be working with ACPFs under contract with CCOs and for which CCOs bear some responsibility for payment up to the time LTPC is determined to be needed, the earlier comments about OHA oversight of subcontracting language are relevant here as well.

A separate contract with an inpatient and residential treatment provider for acute and intermediate psychiatric input services was provided to me with the same MHS 24 code as the CMHP service element language. This language with the inpatient provider organization is similar in many respects to that of the agreement with the CMHPs but covers those who are Medicaid eligible but for whom authorization by the CCO for acute care has ended and who are waiting LTPC and are therefore no longer the responsibility of the CCO. The contract includes a little more language about how this process works for such individuals. This contract provides funding directly by OHA to the inpatient or residential facility in this circumstance. This contract raises the issue of the CCO responsibility which will be discussed at greater length later in this report. It is critical that OHA take this opportunity to work with CCOs, CMHPs, and CMS to determine how to assure an individual's care and treatment remains the responsibility of a single entity during these critical transitions. Otherwise, much administrative effort is spent and incentives are discontinued so that CCOs and/or CMHPs no longer bear the responsibility for the individual's care at critical junctures. This leaves OSH and/or entities such as KEPRO to make determinations about continued stay or appropriate care planning and leaves specialty contracts such as Choice contractors (most of whom are LMHAs/CMHPs but could also be a CCO)[9] to take responsibility. These handoffs are opportunities for system failures and certainly opportunities for confusion, and therefore need to be addressed in order to assure continued improvement in Oregon's system of care for adults with SPMI consistent with the state's OPP commitments.

[9] At the time of this report, three of the 19 Choice Model contracts are with CCOs and the remaining 16 are with LMHAs/CMHPs. However, these State funds are direct contracts and not part of the CCO Medicaid capitation payments or the CFAA funding agreement (see Footnote 7).

CMHP Service Element Language – Supported Employment Services: Exhibit MHS 38[10] – SES describes SES and competitive integrated employment (CIE) in a manner consistent with the definitions in the OPP. MHS 38 – SES also describes Individual Placement and Support (IPS) SES by reference to the national fidelity standards for this evidence-based practice and indicates this is what CMHPs are to provide, consistent with fidelity standards established in O.A.R. 410-172-0740 (which could not be found on the Secretary of State's regulation website) and also references fidelity standards on the OHA website. Providers are required to report quarterly using the OHA MOTS system. Performance measures for reporting are consistent with OPP commitments, although the terms "individual with SMI" and "individuals with SPMI" are used without differentiation by definition. The reporting requirements imply the latter are individuals who are part of an ACT program while the former are not. No financial incentives are included to encourage improvements on these measures.

CMHP Service Element Language – Secure Residential Treatment Facilities (SRTFs): Exhibit MHS – Residential Treatment Services describes residential treatment services as provided in facilities defined in regulation (O.A.R. 309-035-0105 and 0260, although the subsection references are inaccurate and need to be updated). This regulation also defines CMHP (with slightly different language than the relatively new outpatient regulation, 309-019-0100 et. seq.), but does not define SPMI or any of the other important concepts defined in the OPP such as ready to transition (RTT) or peer-delivered services (PDS). Services to be provided are listed as are performance requirements, although the latter includes additional services that may be provided (e.g., additional staffing; interpreter services; medical services and medications; rental assistance, room and board, and personal and incidental funds; and non-medically approved services). No actual performance is specified as required, nor are any of the OPP requirements or goals about adults with SPMI in SRTFs identified. Reporting is required in MOTS with reference to the resource guide which does specify some timelines.

A separate service element – Exhibit MHS 28A – SRTF – requires compliance with O.A.R. 039-035-0100 – 0190, a regulation covering "residential treatment facilities and residential treatment homes for adults with mental health disorders," including SRTFs. This regulation has an extensive list of definitions that should be compared to definitions in other regulations and contracts, and with the OPP. The regulations provide extensive guidance about the nature of the environment and setting that must be maintained (including individual furnishings), residents' rights, administration, record-keeping, staffing, fire safety, and other facility issues. The regulations also include a section on the admission process (0163) which needs review and perhaps revision to assure an SRTF will accept any individual appropriately referred who meets common Statewide criteria, with only an exception process when the SRTF has reason to deny admission. Also, the timelines in this regulation need review, given the increasingly tight turnaround required when an individual at OSH is determined to be ready to transition from OSH. Similarly, the section of these regulations governing termination of residency (0170), should be reviewed to include the role of CCOs and KEPRO in determining when the individual is ready to move to a less restrictive environment. Finally, the last section of this set of regulations (0190) provides an extensive description of the process for person-centered service planning. This description may need slight modifications to identify the roles of various actors in Oregon's current system (e.g., KEPRO or Choice providers). Nevertheless, it is an excellent description that should be updated and utilized or referenced for other documents that require or should require or reference person-centered planning.

CMHP Service Element Language – Criminal Justice Diversion: All State jail diversion funding is provided to LMHAs through the CFAA (see Footnote 7). Exhibit MHS 37 – Jail Diversion begins with a description of SPMI and is clear jail diversion is focused on adults with SPMI. However, SPMI is defined with reference to 11 diagnostic categories rather than the five listed in the definition of SPMI utilized for OPP data reporting (which is based on the prior SPMI definition and data reporting utilized consistently by OHA prior to the July 1, 2016 date of the OPP and since). While the diagnoses listed in this service element language may just be more detail, they reference the "USDOJ agreement" (which presumably means the 2012 agreement in which SPMI was defined) and therefore, to avoid confusion, should be grouped into the five categories utilized then and currently for OPP data reporting.

[10] Referred to previously as MHS 37 – SES.

As the State committed in the OPP, this service element language requires CMHPs to adopt the Sequential Intercept Model (SIM) approach to jail diversion utilizing various points of interception to prevent further penetration into the criminal justice system.[11] This language also includes the terms "pre-booking and post-booking" to incorporate the various OPP language concerning pre-arrest and pre-charge diversion. MHS 37 – Jail Diversion also includes quarterly reporting requirements through a survey-type reporting format rather than MOTS. This survey defines jail diversion services as "any service that is provided to divert individuals with mental illness charged with low-level, non-violent crimes from the criminal justice system or OSH." This definition for reporting purposes is not consistent with the service element language or the OPP. It could allow individuals with other than SPMI to be counted, and it by definition appears to indicate only those who have been charged with a crime should be counted. This definition should be revised to align with the service element and the OPP language. While the service element and the survey both request or require pre- and post-booking information, there is no specific language requiring prioritization of pre-booking diversion activities, nor are any financial or other incentives for such prioritization included, as required by OPP Subsection D.52.f. OHA may want to consider a review of this OPP section compared to this service element's reporting and other requirements to see if additional reporting by the CMHP will assist in identifying the desired information such as the county where individuals with SPMI encountered law enforcement, the existence of and impact of jail diversion services, and obstacles to their success.

Other CMHP Related Issues: No CMHP service element language regarding the financial role or responsibility of CMHPs for individuals in need of emergency department (ED) care was provided to or found by me. Because hospitals are generally required to see and assess those who present for emergency care and must provide sufficient services to stabilize the emergency situation,[12] ED visits in Oregon as in most states are likely funded by Medicaid, Medicare, or commercial insurance, or are considered part of hospitals' uncompensated care. However, to the extent CMHPs have responsibilities for mobile crisis services, helping to assure adults with SPMI do not have to go to EDs, their role is a critical. Likewise, adults with SPMI who go to EDs for services, whether voluntarily or through law enforcement transport, and who are the responsibility of the CMHP should be followed and assisted with service needs beyond the ED as part of the CMHP's overall responsibility. A description of the CMHP's role in such encounters is addressed to some extent in regulation at O.A.R. 309-032-0311 and 309-032-0860 (however, CMHPs are defined differently in these two regulations). However, these regulations do not provide a specific description of CMHP responsibilities for care coordination or other assistance for adults with SPMI who are in EDs, nor do they identify expected performance or outcomes for EDs, CMHPs, or CCOs.

Finally, as indicated earlier in this section, the CMHP boilerplate language does include two outcome measures regarding ADP and ALOS in the Oregon State Hospital (OSH). However, that language does not distinguish civilly committed adults with SPMI from other persons in OSH for which the County/CMHP is responsible. This language also does not provide any direction or requirements of the Counties or CMHPs with regard to interactions with OSH regarding admissions or service/discharge planning (including for ACT), coordination or collaboration with CCOs about these interactions, or interface with other critical players such as acute care psychiatric facilities/hospitals, emergency departments, KEPRO, etc. To the extent a County/CMHP is a Choice provider, that contract (discussed later in this report) is relevant to these issues. To the extent these issues are covered in regulations, those would also be relevant. However, this is a clear example of the need for a consistent set of language about roles, responsibilities, and expectations across the system in all contracts, regulations, guidance, and other documents impacting Oregon's approach to any persons in need of behavioral health services, especially for adults with SPMI. Without this common language, all responsibility for the overall system of care

[11] Policy Research Associates, Inc, which operates the SAMHSA GAINS Center, recently introduced the "Intercept 0" idea, to help train and encourage service providers to anticipate and prevent individuals with behavioral health needs from interacting or becoming engaged with the criminal justice system at all. See, https://www.prainc.com/introducing-intercept-0/.

[12] See, Emergency Medical Treatment and Labor Act, https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/.

resides with OHA which has little direct responsibility for service delivery except for OSH. All entities under contract with OHA need to have the same requirements and expectations imposed for the overall success of the system of services for adults with SPMI.

CCO Five-Year Contracts (CYs 2013 – 2018, CY 2019 Extension, and CYs 2020 – 2024)

Status and Process for the Next CCO Contracts: The Oregon CCO contracts are for five calendar years (CYs) and are amended each year to address any new State or federal requirements, any rate changes, and any changes in OHA's needs, without major changes to the underlying contract language. Because these contracts utilize Medicaid funds, they must be approved by the Centers for Medicare and Medicaid Services (CMS) before they can be executed. The contracts in place now are in the process of being amended for CY 2018, the final year of this five-year process. OHA has indicated it intends to extend this contract one additional year (for CY 2019) and incorporate OPP requirements in that contract extension. The next five-year contract (for CY 2020 – 2024) would then have to be developed in 2018 in order to be developed, reviewed, approved, and executed before January 1, 2019.

In IC Report #1, a tentative timeline was provided by OHA for the CCO contract development for 2019 – 2023. That tentative timeline indicated November 2017 would be the time for USDOJ and IC review of the contract template for the next five-year contract. Since then, OHA has indicated the CCO contracts for the next five-year period may need to be procured in some fashion, either through a Request for Applications (RFA) or Request for Proposals. The former would provide current CCOs the opportunity to apply to continue as a CCO with clear indications about what OHA is looking for in the future to which CCOs would need to respond. The latter would allow current CCOs or new organizations to bid to become a CCO with proposals scored and the best proposals selected (hence, existing CCOs would not be guaranteed the right to continue in that role). Given this pending decision about the type of procurement process for the CY 2020 – 2024 contract, any RFA or RFP document itself will be absolutely critical for OPP purposes. Any such RFA or RFP is also likely to include draft contract language to which CCOs and/or organizations proposing to become a CCO would have to agree to be bound. While the RFA or RFP and the draft contract could be amended, if any such changes were significant, it could slow down the process or require the process to begin anew. As a consequence, it is critically important for USDOJ and me as IC to be provided an opportunity to review and comment on any such documents in confidence, before they are released to the public. I would not be able to make any determination of compliance with the OPP until I have reviewed those documents, and in fact until I have seen the final contract language OHA is proposing to utilize for the next five-year CCO contracts. Similarly, given the decision to extend the CCO contracts for one-year (CY 2019) and include OPP related language, the timing and process for this extension is equally critical for OHA to share with USDOJ and the IC. We have been promised a timeline for both processes but have not yet seen either. OHA must make changes to address OPP issues in the CY 2019 contract extension language. Otherwise, the entire three years of the OPP timeline will have passed without any changes to the CCO contract specific to OPP commitments, and that would be a compliance issue. In any case, OHA must build in sufficient time for USDOJ and IC review before contract amendments or a procurement process begins.

In the meantime, I have been provided with contract amendments for the CCO contract for CY 2018. As of the time of this report, these amendments were already in process pending review and approval by CMS when the language was provided to me. While I will comment about the current contract and these proposed amendments in a general way, these comments may or may not reflect the reality of what OHA is proposing for the CY 2019 or for the next five-year contract. Without this proposed new contract and CY 2019 contract extension language as well as the procurement document(s) to review, neither USDOJ nor I as IC can give meaningful input for the CY 2019 or the CY 2020 – 2024 period. Presumably OHA is considering the OPP commitments as these documents are being developed. What follows are general comments about the CY 2018 contract as I am aware of this language as of October 1, 2017. Hopefully, these comments will provide some assistance to OHA as it develops the procurement process and the language for the CY 2019 extension contract and the next five-year contract. However, given the status of the process, the comments will not be as extensive as the comments earlier in this report about the CMHP Agreement language.

General Comments and Role of the CCOs: In general, this CY 2018 contract language (and the KEPRO contract language) is significantly different from other OHA services contracts because of the Medicaid funding source and the federal government's role in that program. The contract language also references different regulations and has different emphasis (e.g., an interest in increasing value-based purchasing). It seems obvious from the language that different OHA staff, with different histories and understandings of their responsibilities, and different philosophies and cultures about the relationship between the State and the contracted entities, have written these different documents very differently. To the extent OHA is committed to creating a single and effective system of care – a single Oregon Health Plan – especially for adults with SPMI, now is the time for the contracting approach for Medicaid and non-Medicaid funded services to be consolidated and made consistent regardless of the entity with whom the State is contracting or to whom it is providing funds. As indicated earlier, this means similar definitions, similar expectations and collective responsibility, similar role definitions, similar subcontracting and corrective action requirements, and similar quality and accountability and data reporting requirements. Most of these issues are not adequately addressed in the current CCO contract language.

It should be the successful community living and the health/behavioral health of individuals served, not the type of contract, program, fund source, or relationship among entities, that drives the contract development process and language. OHA leadership needs to take on this culture shift, which may require significant discussions among various staff and contracted entities. This is not a matter of picking one approach over the other. Rather, the best elements of both approaches would help the system as a whole get clearer about the various entities' roles, and the manner in which individuals with SPMI should be served and helped to succeed by effectively utilizing public resources. Similarly, requiring CCOs, CMHPs, KEPRO, and other entities to which the State provides resources to work collectively to create common pathways to success for individuals in need in a given locality might help to reduce duplication and confusion of effort. Such a requirement could also help OHA work toward a method of incentivizing outcomes sought for this (and for other) critical populations. This would also be consistent with the recommendations of the Behavioral Health Collaborative noted in IC Report #1.

CCO Contract Definitions: Terms are currently defined in the CCO contract primarily by reference to regulations that are specific to Medicaid (O.A.R. 410-141-000 and 410-120-0000). A few terms are defined within the CCO contract itself, some of which are specific to a particular population (e.g., wraparound and system of care, terms generally used as a description of service and approach for youth with specific types of behavioral health needs and multi-system involvement). Regulations generally utilized for issues affecting adults with SPMI do not appear to be specifically referenced. Terms such as long term psychiatric care (LTPC), ACT, supported employment, and other terms important for the success of the OPP are used in various places in the contract without inclusion or reference to definitions that would help assure consistency with CMHP and other providers of care. The definitions list in the Medicaid regulations might be a good place to put all critical definitions for adults with SPMI to provide one common place for reference for all relevant documents.

Specific OPP Services and Processes: While several services and processes central to the OPP are referenced and required in the CCO contract language, collaboration and other specific requirements included in the OPP are not often clear in the CCO contract. For example, ACT services are required to be provided without reference to fidelity measures or fidelity reviews. While the CMHPs are required to work with the CCOs if additional ACT services are needed, the CCO contract language does not mention collaboration with CMHPs in developing additional ACT teams. The process for applying for LTPC in OSH is described with only general language about working with "the appropriate OHA Team in managing admissions, discharges and transitions from LTPC . . . to ensure that Members are served in and transition into the most appropriate, independent, and integrated community-based setting possible." (Section 4.i.(2)(d), page 51 of 241). Similarly, a section on crisis, urgent, and emergency services for mental health needs describes CCO responsibilities to have written policies and procedures and monitoring systems that provide such services for mental health emergencies. However, neither the regulations incorporating the OPP commitments nor other OPP requirements and goals about such services are referenced or delineated.

Similarly, the section of the contract regarding acute inpatient hospital psychiatric care says simply that the CCO shall provide such services for members who do not meet criteria for LTPC and shall submit data through the OPRCS, a data system not utilized for OPP data reporting. LTPC services are of course considered non-covered services for the CCO. Neither this section nor others I could find describe the OPP processes regarding warm handoffs or other goals reducing or limiting the utilization of acute care where it can be safely avoided. Likewise, I could find no language about criminal justice diversion, peer-delivered services, quality and performance improvement consistent with Section E of the OPP, or incentives for outcomes sought in the OPP. Language regarding residential treatment is also largely non-existent for adults, since many of those Medicaid covered services are not covered in the managed care portion of Oregon's Medicaid program. (See further discussion of this issue below.) Housing and the role of the CCO to assist members obtain and retain supported housing in community living settings is also not clear from this language. CCOs should have responsibility by contract terms for their members regardless of the setting in which they live or receive services, even if that responsibility is not to fund those settings and services, but rather to stay in touch and coordinate transitions for times the Member will return to the community and CCO financial responsibility for their services resumes.

Language about care coordination responsibilities is included in the CCO contract and also in O.A.R. 410-141-3160 which was updated in the Spring of 2017, more recently than the CCO contracts in 2016. This regulation is quite explicit about care coordination services. This new regulation is specific about CCOs' responsibilities for hospital and specialty services for "adults with serious behavioral health conditions." This regulation should be amended to include specific reference to individuals with SPMI as well, along with other OPP services for this population). This regulation also requires CCOs to assure "transitional services and supports for [such adults] facing admission to or discharge from acute psychiatric care, residential treatment settings and the state hospital." This language should be sufficient to require CCOs to play a more central role in the care of their members who are in OSH or SRTFs, even if that care is not their financial responsibility during that time. Likewise, this regulation requires CCOs to "ensure that members with high needs, multiple chronic conditions, or behavioral health issues are involved in accessing and managing appropriate preventive, health, behavioral health, remedial and supportive care and services." This language and the KEPRO contract care coordination language should be compared and perhaps could be utilized more extensively by OHA to assure the physical health as well as the behavioral health needs of adults with SPMI are met. This language may also be utilized to assure CCOs are addressing supported housing needs and services to prevent criminal justice involvement, although language more specific to those issues is needed. Care coordination responsibilities, whether by KEPRO, CCOs, or CMHPs should be described similarly to assure that the entity responsible for this activity must do so consistently from one setting to another. This care coordination language in regulations might be a good place to describe all care coordination requirements for reference in all relevant documents.

Language explicitly giving OHA the authority to review and approve contracts/subcontracts for services, especially for adults with SPMI, should be considered. Financial and/or other incentives need to be included to encourage outcomes sought in the OPP for this population. For example, contracts and subcontracts should assure admission criteria, fidelity requirements, and tracking denials processes are followed, and OHA is alerted when individuals referred are on a waitlist for more than 30 days. Similarly, the authority to take corrective action when individuals referred are improperly rejected should be clearly stated. Mobile crisis response times should be included or a specific reference to the regulation where these are delineated should be included with clear incentives and/or corrective actions taken when these response times are not met. CCO responsibilities for assisting OSH with discharge planning (as committed to in OPP Subsection D.20.f.) and meeting timelines in the OPP should be explicit, with (as committed in OPP Subsection D.22.) performance metrics and performance incentives included. Similarly, the requirement to document linkages to appropriate behavioral and primary health care in the community along with the requirement to offer a warm handoff to a case manager, peer bridger, or other community provider prior to discharge from an acute care psychiatric facility (ACPF) needs to be explicit in contracts and required in subcontracts, along with documentation of such and collection of data regarding whether the warm handoff was successful as described in OPP Subsection D.29. Likewise, the requirements that ACPFs (or hospitals) assess the housing needs of individuals with SPMI, make that

housing part of the discharge plan, and notify the community provider regarding the plan for housing should all be explicit, either in a referenced rule or in contract language, along with requirements for documentation and data collection about these issues as described in OPP Subsection D.34. Any subcontract between a CCO and an ACPF should transfer these requirements and references to the ACPF/hospital.

The CCO contract does include in Exhibit G a short section on reporting about cooperative agreements with publicly funded programs, but it simply requires reporting about MOUs in place and reporting about involvement with local mental health authorities or CMHPs, specifically whether these public programs are represented on the CCO's board, advisory council, or quality assurance committee, or if the CCO has a subcontract with these public programs. The contract also includes in Exhibit B a section on subcontracting, and does require the subcontract to provide for termination or imposition of other sanctions if the subcontractor's performance is inadequate. Exhibit D includes language regarding OHA's role in overseeing or reviewing subcontract arrangements. These two parts of the CCO contract might be important to consider for other contracts impacting OPP commitments.

The CCO contract mentions quality in a number of ways, but I could find no language specifically requiring a quality improvement plan or any performance metrics or financial incentives to assure the performance outcomes sought by the OPP commitments will be achieved. OHA should consider requiring a quality improvement plan and reporting on the successes and barriers encountered. This plan could be for services in general, but specifically to include OPP services and measures or specifically for services and measures in the OPP for adults with SPMI. The KEPRO contract and the OSECE/OCEACT contracts have language about such a plan and reporting that might be considered. The CCOs are paid utilizing a managed care payment for covered lives for certain types of services and uses a risk corridor approach to incentivize performance and limit CCO and State risk. Given the OPP commitment to revise this and the CMHP contracts to be performance-based, especially with regard to Subsections D.20. and D.21. regarding discharges from OSH, the CCO contract should be revised to include performance-based payments or consequences to incentivize the achievement of these goals. Finally, acknowledging the CCO's role in the State's quality and performance improvement efforts outlined in OPP Section E would be helpful as OHA continues to work on its behavioral health delivery system.

The point of these and other examples is that the various contracts do not yet line up together and do not totally comport with the goals of the OPP. Before the next version of this contract is released for CY 2019 or for the procurement process for CY 2020 – 2024, the OPP along with the three main contracts with entities providing or funding services need to be reviewed and made consistent for all things associated with adults with SPMI, especially those issues in the OPP.

<u>CCO Roles Compared to KEPRO and CMHPs</u>: At this juncture in OHA's development of a single integrated health care system including behavioral health for all Oregonians in need of publicly funded services, three key policy issues need to be seriously considered:

- *Medicaid funded services* – It is time to bring all residential and any other outstanding behavioral health services from the fee-for-service Medicaid system and incorporate them into the regular managed care part of the Oregon Health Plan. This would make CCOs responsible for their members who are adults with SPMI regardless of the service setting in which services are being provided. This would also reduce confusion and hold a single entity responsible for the successful treatment and community living of adults with SPMI, with one set of contractual language and one set of regulatory guidance.

- *Individuals who are not Medicaid eligible* – Oregon should take this opportunity to consider how to make all services for persons with behavioral health needs, regardless of the fund source of those services, commonly managed and overseen. CMHPs provide critical coordination of all service systems and all funding for many non-Medicaid services critical for the population of adults with SPMI (housing, jail diversion, crisis services, etc.). State law (O.R.S. 414.153) requires a written agreement between CCOs and the LMHA served by the CCO, outlining the

responsibilities of the LMHA in cooperation with the CCO. OHA currently leaves most of these relationships to the local area, out of respect and deference to each local area's unique desires and capacities. However, this makes for difficult navigation of systems and services statewide. Some consideration of the CCO's responsibility to contract with CMHPs that provide services or to utilize CMHPs' special capacity for system management should be considered. Alternatively, giving CMHPs the first option or the requirement to serve as the CCO (that is, manage the Medicaid dollars) for the populations they serve might be considered. Another alternative is to find a way (as proposed in the BH Collaborative recommendations) to hold the CCOs and CMHPs jointly accountable for delineated performance outcomes. The OPP measures would be a good area in which to test approaches to joint accountability.

- *Services provided by the State (especially OSH)* – The idea that an individual who is admitted to OSH is no longer a "member" of the CCO during the time the individual is in the hospital is not a good way to assure coordination of care over the life or treatment trajectory of adults with longer term needs. Roles and decision-making responsibilities are confused, and financial incentives are misplaced when the CCO is not responsible for paying for OSH services. OHA should seriously consider and begin now to create a way for CCOs to maintain responsibility for a member, even while they are in State-operated services. One way to do this is to shift all or a portion of State funding from OSH to CCOs and let them do the care coordination and be responsible and have financial incentives to keep adults with SPMI out of OSH to the extent possible or help them get out of OSH as soon as possible. This would not be an easy transition, for all kinds of reasons, but including this concept in CCOs contracts for the next five years and noting the process for coming to this end goal, would need to start with the next five-year contracting process if not in the CY 2019 contract extension language. An alternative to this approach that might be somewhat easier would be to change the concept of CCO "membership" to include times when the individual is in a service setting for which the CCO is not financially responsible but for which the CCO is still responsible for care coordination and transition planning and success. Financial incentives or other consequences would need to be included to make this work; for example, a small portion of the monthly per member payment continuing to the CCO while the adult with SPMI is in OSH to continue responsibility but incentivize discharge planning and community follow-up. Another example might be the CCO losing a portion of the monthly payment in the month before and/or months after a set time which should be the time a member is no longer in OSH or similar non-covered setting. The point is, CCOs being required to help coordinate care for members in OSH or SRTFs, but without financial incentives is not consistent with a managed care approach to overall care. At the very least, specific language regarding expectations and requirements of CCOs for admission processes, participation on interdisciplinary treatment teams, and discharge planning should be included more explicitly in future CCO contracts.

KEPRO Contract:

This contract was effective October 1, 2016 and covers the time period July 1, 2016 through June 30, 2019 (FYs 2017, 2018 and 2019), precisely the same time period as the OPP. However, because it was drafted prior to the completion and implementation of the OPP, it has some of the same limitations and some of the same strengths as the CCO contracts in that it was developed and written from a different programmatic perspective, e.g., Medicaid program culture and requirements rather than non-Medicaid funding source culture and requirements, and inconsistency of language with the OPP. However, OPP commitments are evident in some of this language. OHA should seriously consider making a few amendments to this contract to incorporate additional OPP requirements regarding adults with SPMI, especially as it relates to individuals in SRTFs. Consideration should be given to recommendations earlier in this report about moving residential services for this population from fee for service (FFS) Medicaid to managed care and CCO responsibilities, along with consideration of putting CCOs at some or total risk for the care of members admitted to OSH. This would reduce KEPRO's role, but would simplify the system and provide closer to a single point of accountability for such members' care. Without such amendments, it could be difficult for OHA to meet some of the commitments made in the OPP for this particular population.

While the KEPRO contract has many strengths just as does the CCO and the CMHP contracts, OHA and Oregon's system would benefit from an analysis of and efforts to line up language about all critical and similar functions in the various contracts touching Oregon Health Plan (OHP) members. Starting with those functions impacting adults with SPMI would be less overwhelming than tackling the entire OHP population and services, but would be a significant first step in helping move toward the OHP stated goal of a single system of care, and would reduce confusion, help meet OPP commitments, and perhaps increase efficiency of limited state and federal funds utilized for this and other OHP populations. Amendments to the KEPRO contract now rather than waiting until the end of the contract period is important to this process of lining up requirements and expectations across all system players. KEPRO is required to provide care coordination for FFS "clients." Presumably, this is the same role CCOs provide for managed care clients or CCO members. Yet the care coordination language is significantly different. Care coordination is also required of CMHPs for certain purposes as noted earlier in this report, yet the language in that Agreement is significantly less specific. This language in all of these contracts should be compared to determine how to utilize the best language consistently for all three purposes/entities and where to specify relevant differences.

The KEPRO contract also has explicit language in Exhibit A Subsection 5.b. regarding Disease Management (DM) and Intensive Case Management (ICM) – concepts often seen in managed care arrangements – and requires "stratification of these services by assigning FFS clients to unique, mutually-exclusive morbidity categories, based on patterns of disease and expected healthcare resource requirements." This stratification must be affirmed monthly. These stratifications and the explicit contract requirements of KEPRO for each stratification – especially for high acuity, high risk clients – could have significant impact on some or all adults with SPMI. An analysis would be in order to assure the requirements of KEPRO for each stratification level will not inhibit meeting the needs of adults with SPMI, and especially the services described in the OPP. KEPRO's contract requires it to "make reasonable best efforts" to achieve expected DM and ICM outcomes, including some outcomes similar to the OPP. These include reducing non-emergent utilization of emergency departments, maintaining or improving health functioning of long-term services and support recipients, and maintaining or improving health functioning of long-term psychiatric care recipients. Similarly, strong language about conflict free case management, community transition plans, and person-centered planning is included in the KEPRO contract. While the terms are not the same as in the OPP, similar intent can be inferred although I strongly recommend the language be standardized in all contracts. This language may be an example for use in CCO and in other OHA contracts and regulations impacting this population.

Exhibit F Section 2 includes specific performance metrics and incentive payments for reducing lengths of stay in SRTFs and reducing the number of days until discharge after an individual is placed on the RTT list at OSH. These performance metrics are consistent with the OPP goals and could be an example for other OHA contracts impacting this population. However, since other populations within OSH and SRTFs could be part of the data count for KEPRO's performance incentives and since the monthly amount is capped at a specified number of clients for which it can bill for performance incentive payments, it is possible some adverse incentives could exist in this arrangement. However, without additional analysis, on its face, this contract is evidence of OHA attempting to meet some of its commitments in the OPP utilizing performance-based contract approaches. OHA may want to utilize similar approaches in the CMHP and CCO contract amendments to help incentivize each part of the system and to set common expectations about outcomes sought.

A nurse triage and healthcare advice line are required for all KEPRO clients, including those receiving DM and ICM services. The language and requirements for these lines is relatively specific with standards delineated at Exhibit A Section 6. These triage and advice lines are not considered to be subject to the new uniform standards for hotline services and County Crisis Lines committed to in OPP Subsection D.13. (See description later in this report.) However, OHA may want to look at both set of standards to determine where consistency in requirements will increase the coordination, quality, and outcomes of all crisis or helplines within Oregon's health and behavioral health systems.

Definitions in the KEPRO contract are missing key OPP terms such as SPMI, warm handoff, supported housing, ready to transition, and mobile crisis services. However, the recently amended outpatient behavioral health treatment services regulations (see description later in this report) are referenced in appropriate places. The contract language utilizes the term "chronic mental illness" (CMI) as defined by Oregon Revised Statutes (ORS) 426.495 in Subsection 7.b.(5). This definition is very similar to the OPP definition of SPMI. Hence, OHA may want to consider utilizing the term SPMI and indicating it is the same as CMI in Oregon statutes or indicate the term CMI utilized in the KEPRO contract is the same as SPMI utilized in other OHA contracts and documents. Alternatively, OHA could work with the legislature to revise terms for consistency so confusion can be reduced about priority populations and who is to be served in various circumstances.

Consistent with OPP commitments, KEPRO reporting requirements seem consistently to require data at least every 90 days if not sooner.

Choice Model Services Contracts

This contract language for Choice Model Services provided by CMHPs (MHS 37 – Choice Model Services) was revised effective October 1, 2017[13] and has been significantly amended to account specifically for OPP definitions, specified population, desired outcomes, and expectations. With minor exceptions, these changes reflect the approach OHA can and will eventually need to take to bring contracts to maximum effectiveness for adults with SPMI. A few minor differences should be reviewed to assure the language is as it needs to be (e.g., SPMI includes Bipolar Disorder as a separate diagnostic category; the RTT definition is different from the OPP and references the State Hospital Admissions and Discharges regulation which does not define RTT and needs to be updated). However, critical concepts such as discharge planning, supported housing, ACT, and peer-delivered services are defined largely as they are in the OPP. While "warm handoff" is not defined in this contract, "face-to-face" is defined to allow in person meetings or meetings via telehealth where voice can be heard and the person can be seen. This definition may be helpful in other documents impacting the warm handoff process. Choice contractors are CCOs or LMHAs (see Footnote 9) to which OHA has provided State funding specifically to collaborate and be the point of contact for critical transitions of persons with SPMI between OSH and other facility-based service settings and community providers. Choice providers are also held to being conscious of and communicating identified capacity needs to CCOs, CMHPs, and OHA. Choice contractors provide the critical Exceptional Needs Care Coordination (ENCC) function through a CCO, County, or CMHP staff person. As indicated earlier, the various roles of the CCO care coordination activities, provider case managers, hospital discharge planners, KEPRO staff, Choice providers, and others needs to be documented and shared widely.

It should be noted that Choice providers have responsibility for these same ENCC functions for persons who are not the subject of the OPP, that is, for persons who are admitted to OSH by guardian authorization. Performance metrics and incentives include specific discharge timeline goals and measures consistent with the OPP, and the contract language includes data reporting requirements in the performance payment. Only individuals who are adults with SPMI are included in the incentive metric and only such individuals are counted for the OPP data reporting.

Jail Diversion Contracts

In Subsection D.51., the OPP commits OHA to reporting on jail diversion services and specifically to requiring, "under new contracts with entities providing jail diversion services, that contract providers report the number of diversions pre- and post-arrest [now collectively referred to as pre-booking]. OHA will include this requirement in all RFPs for any new jail diversion programs." As of the time of this report, I have not been provided any new jail diversion RFP language beyond the one issued prior to the OPP

[13] I have not been provided so have not seen contract language for the three non-CHMP Choice Model contractors (see Footnote 9). Presumably, it is the same as the language described here except perhaps with different boilerplate contract language due to the different entity being engaged.

effective date for services in FYs 2016 and 2017, which did not include this requirement. However, OHA has indicated any new jail diversion RFP will include such language. Since these State funds are provided to counties through the CFAA (see Footnote 7), the earlier discussion of this CMHP service element language applies. I have not seen so cannot comment on subcontract language to providers for this service.

Mobile Crisis and Rental Assistance Contracts

Since State funds for these services are provided to counties/CMHPs through the CFAA (see Footnote 7), the earlier discussion of CMHP service element language applies. I have not seen so cannot comment on subcontract language to providers for these services or on any contracts for these services that are with entities other than counties/CMHPs.

Josephine County Intergovernmental Agreement for Centers of/for Excellence (OSECE and OCEACT)

OHA has a contract with Josephine County to be the Center of Excellence for ACT (OCEACT) and the Supported Employment Center for Excellence (OSECE).[14] This contract was amended in July 2017 and now extends to June 30, 2019, concurrent with the timeline of the OPP. The contract language has been changed to align OCEACT's and OSECE's functions to be consistent with the goals of the OPP, including additional data collection and quarterly reporting, performance outcome monitoring consistent with and beyond OPP commitments, technical assistance to address program plans of correction, and use of fidelity requirements consistent with newly promulgated regulations as committed to in the OPP. No performance incentive payments are included in this contract as the contractor is paid a flat quarterly amount upon submission of quarterly invoices and required quarterly reports. However, the contractor is charged with creating a set of measures to track the efficacy [sic] of the technical assistance plans and identify barriers to ACT program implementation and improvements. The contractor is also charged with using these measures to identify system or regional level issues, service gaps, and accessibility of services and create system level recommendations.

What is not clear from this contract language is OCEACT's role if any in waiving fidelity requirements in rural areas or in assuring individuals referred but denied or who refuse ACT services are provided with alternative evidence-based services. OCEACT's role in identifying when waitlist numbers indicate ACT teams need to be increased is also not stated. However, other players may have roles in these functions as indicated in other parts of this report.

Finally, several key OPP related terms are used but not defined in this contract (e.g., homeless, individual placement and support model of supported employment, etc.). Similarly, the contract requires the contractor to assess fidelity of ACT programs based on the Dartmouth ACT fidelity scale found in the SAMHSA toolkit with Oregon modifications, and to assess fidelity of SE programs based on the Dartmouth IPS Practitioner Manual and Fidelity Implementation Guides. These are neither defined nor are references made to the outpatient regulations in which these fidelity requirements have been recently added. I recommend these be tied more closely together with references so no concern can emerge about inconsistency between fidelity requirements being used by the centers and required by the regulations.

DPSST Interagency Agreement for CIT Training and EOHSC/GOBHI Interagency Agreement for CIT and SIM Training and Technical Assistance

Subsection D.52. of the OPP commits OHA to contract with The GAINS Center to consult on the expansion of the use of the Sequential Intercept Model (SIM) by local jurisdictions across the State. That contract was executed and The GAINS Center was onsite in early 2016 with a report produced as a result

[14] This contract provides Josephine County funds to provide similar technical assistance and training issues for supported education, but that service is not part of the OPP.

of that effort. In late June 2017, OHA entered into an Interagency Agreement with the Oregon Department of Public Safety Standards and Training (DPSST) to provide training and technical assistance for law enforcement regarding the Crisis Intervention Team (CIT) approach to community policing and crisis resolution involving persons with mental illness. This CIT effort is designed to help jail diversion efforts statewide. DPSST provided this training multiple times in September and October with a statewide CIT conference in early October.[15] OHA also entered into an Intergovernmental Agreement with Eastern Oregon Human Services Consortium (EOHSC)[16] to provide training and technical assistance to counties, law enforcement, and other community entities regarding CIT and to "offer SIM mapping facilitation to communities statewide to identify gaps and opportunities for CIT and Jail Diversion program development." The most recent amendment to this contract was in March of 2017, which also extended the Agreement through June 30, 2019 (the end of FY 2019, in line with OPP timelines). In conversation with Greater Oregon Behavioral Health, Inc. (GOBHI)[17] leadership and briefly with The GAINS Center staff, I learned about additional SIM training provided by GOBHI in September 2017. This train-the-trainers event included over 20 Oregon participants representing over 15 Oregon counties and statewide trainers. GOBHI also co-sponsored with DPSST and the Washington Criminal Justice Training Commission (WCJTC) a series of training events during 2017 throughout the State for criminal justice and mental health professionals as well as service recipients and advocates. These events were focused on CIT (the "Memphis Model") to assist local law enforcement and local jurisdictions interact more positively with persons with mental illness who encounter law enforcement officers. GOBHI and DPSST have formed a CITCOE or Center of Excellence to further expand CIT concepts in conjunction with the SIM approach to service delivery and jail diversion. While the GOBHI SIM training was funded through the GAINS Center rather than directly by the State, this effort and the Interagency Agreements clearly are helping to implement the State's commitment in the OPP to encourage local jurisdictions to adopt and implement interventions in accordance with this SIM approach.

MOU with the Oregon Criminal Justice Commission for Data Sharing

OHA entered into an agreement with the State's Criminal Justice Commission (Statistical Analysis Division) in the summer of 2017 to exchange data about individuals receiving Medicaid funded mental health services who have been arrested and/or charged with a crime locally. This MOU was explicitly drafted to further the goals of OPP Subsection D.51 – 53. I have been briefed on this data-sharing arrangement and how it may help to address OPP issues,[18] however, I understand the details are still a work in process. Therefore, I cannot yet comment on the sufficiency of this language or the progress of this MOU at this time.

Independent Consultant (IC) Contract

Section F of the OPP commits OHA to contracting with me as Independent Consultant to assess performance and whether OHA is meeting the provision of the OPP. That contract was entered into effective July 1, 2016. The contract also provides for IC consultation to assist in implementing provisions of the OPP. OHA has been open to and accepting of informal consultation and suggestions as I have met with them throughout the first 15 months of this engagement. OHA also committed to facilitate the IC's access to documents, staff, and other information necessary to assess OHA's implementation of the Plan, and make a designated contact person available to respond to requests by the IC. As indicated in the Acknowledgments section of this report, I have experienced that OHA has largely fulfilled this commitment to date and continues to try to do so to the best of its ability. Where this report or IC Report #1 indicate I have requested but not yet seen certain contracts or other documents, the OHA project Director and I have been or are in discussion about getting access to that information.

[15] See http://www.oregon.gov/dpsst/CPE/Documents/summer%202017%20CIT%20newsletter.pdf for DPSST's latest CIT Newsletter, including upcoming training events.
[16] EOHSC is the parent company under which GOBHI operates. See Footnote 17 below.
[17] GOBHI serves as both a CMHP and a CCO for several counties in central and eastern Oregon. See, www.gobhi.org.
[18] The status of this MOU was also discussed at the recent annual meeting between OHA and USDOJ.

REGULATIONS

OHA has engaged in considerable effort to revise regulations relevant to OPP services and commitments, and continues to make additional changes. This section describes some of the strengths and weaknesses of a few critical regulations OHA has amended, and comments briefly on regulations not yet changed. Generally, OHA is working to make its regulations consistent with OPP commitments and goals to the extent possible and practicable, and will need to continue that process across program and funding sources (e.g., regulations impacting Medicaid behavioral health services), utilizing the best language already in regulations or proposed in upcoming amendments for reference or repetition in other critical regulations. Some of these amended and yet to be amended regulations are discussed below with recommendations or suggestions about approaches for consideration.

Outpatient Behavioral Health Treatment Services Regulations

O.A.R. 309-019-0100 et. seq. provides the behavioral health field in Oregon with service delivery standards for outpatient behavioral health treatment services. This set of regulations has been amended twice since the OPP became effective, most recently in June 2017. OHA is continuing to work on this regulation and expects to release for public comment another version of the regulation in early 2018. These regulations include some definitions utilized in the OPP (e.g., acute care psychiatric hospital, mobile crisis services, peer-delivered services, although this definition is slightly different from the one in the OPP). However, other important definitions are not included. Some definitions critical to OPP implementation such as “mobile crisis response time” and “warm handoff” are included in these regulations, the latter by reference to another set of regulations governing acute care services (O.A.R. 309-032). Interestingly, SPMI is not defined in this regulation.

To OHA’s credit, O.A.R. 309-019-0151 does now cover mobile crisis services and incorporates the OPP standards into regulation. However, in Subsection (3)(a), response times are written for counties rather than “areas” as indicated in OPP Subsection D.9 – 12. It is not clear how counties that have rural, frontier, and other areas (urban and suburban) in their boundaries are supposed to track and report these response times. Similarly, this subsection of the regulation refers to counties classified as “urban” rather than to “areas that are not rural or the frontier.” OHA has indicated it will revise this part of the regulation to either define urban as including suburban or define urban as any area that is not rural or the frontier. These references and issues exist in O.A.R. 309-019-0152 as well. O.A.R. 309-019-0151 Subsection (4) requires CMHPs to establish by July 1, 2018 (for FY 2019) internal policies to monitor the number of instances that mobile crisis response times exceed the maximum response times established. This subsection also indicates OHA will review these records and a sample of mobile crisis events at the time of the site certification review to evaluate adherence to the maximum response times. However, this Subsection does not say what proportion of calls must meet response time requirements in order for certification to continue without sanction or interruption. While it is not reasonable to require 100 percent of all calls to meet required response times, it will be important that CMHPs as well as the public know whether 90, 95, 98 or some other percentage of calls are expected to meet the standards while working to meet 100 percent as a quality improvement goal.

This regulation also does not require CMHPs to track or report “the number of individuals whose dispositions after contact with mobile crisis result in stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute care psychiatric facility.” OHA has committed in the OPP to develop a methodology for tracking such dispositions by June 30, 2017 with reporting to begin six months after the development of the methodology. OHA’s performance on this commitment will be addressed in a later IC report. However, as OHA amends the outpatient regulation in early 2018, it should strongly consider putting this requirement if not the actual methodology in the revised regulation.

O.A.R. 309-019-0190 provides standards for services and supports for individual in the criminal justice system due to substance use issues. Given the OPP’s emphasis on criminal justice diversion for adults

with SPMI, OHA may want to amend this regulation to include a section to address services for and tracking of arrests of such individuals to assist with performance of Subsection D.51. of the OPP.

O.A.R. 309-019-0225 – 0295 cover ACT and supported employment (SE) services and do now incorporate commitments from the OPP, including fidelity standards, admission criteria,[19] provider qualifications, program operational standards, and waiver of fidelity requirements (by OHA). Note, the definition of community-based in this set of regulations includes a statement indicating ACT services may not be provided to individuals residing in a residential treatment facility or residential treatment home licensed by OHA except in certain indicated circumstances. This statement should probably be in a separate subsection and should be revised to be clear that ACT services may never be provided to adults with SPMI residing in secure residential treatment facilities (SRTFs). This clarification will help facilitate the discharge planning process for adults with SPMI at OSH being recommended for release to an SRTF.

Several key OPP terms are defined in these regulations, namely "fidelity," "hospital discharge planning," "individual placement and support (IPS) supported employment services," and competitive integrated employment" – all terms important to the contract with Josephine County for OSECE and OCEACT functions (see discussion earlier in this report), and all consistent with or nearly consistent with the OPP. These regulations also describe requirements of the ACT admission process with timelines that may impede OHA's ability to meet the OPP OSH discharge timelines. This process also allows the provider to make the final decision regarding whether it will admit a person referred to its ACT program. This may be contrary to the OPP commitment in Subsection D.2. stating "individuals who meet the admission criteria for ACT will be admitted to ACT." OHA may want to consider amending this regulation to allow a provider to request an individual not be admitted to its program, but leave to OHA or some other independent reviewer the final decision. Anyone denied to an ACT program who meets criteria will need to be admitted to another ACT program. The responsibility of the CCO, Choice provider, or other entity for finding that alternative program needs to be clear, especially for adults with SPMI being referred to ACT for release from OSH. At the least, OHA will want to clarify recordkeeping requirements about why individuals are denied admission and OHA's role in assessing whether these denials are appropriate. Given the commitment in Subsection D.3. of the OPP that OHA will track such denials and take corrective action if providers are improperly rejecting individuals for ACT services, OHA may want to consider including that corrective action possibility in its outpatient regulations.

O.A.R. 309-019-0248 refers to "alternative rehabilitative services" as described in the Oregon Medicaid State Plan that must be made available to an individual who is denied admission due to capacity. OHA may want to make it clear whether these services are the same as an evidence-based alternative" referenced in OPP Subsection D.23.a. and which of these count as the "alternative evidence-based intensive services" referenced in OPP Subsection D.23.b. to be offered to individuals discharged from OHS who refuse ACT services.

The portions of these regulations covering supported employment services appear to include the requirements necessary to help OSECE and OHA meet the State's commitments in the OPP.

Crisis Services Regulations

O.A.R. 309-019-0300 et seq. cover crisis line services. This set of regulations is new and begins to fulfill the State's commitment in OPP Subsection D.13. to develop uniform standards for hotline services and county crisis lines. Staffing, training, reporting/documentation, and provider standards are included. The enforcement process is not specifically described in these regulations, but presumably these standards will be utilized as OHA reviews programs to ascertain whether they are meeting certification

[19] Note, the ACT admission criteria describe SPMI in a slightly different manner than the definition used for the OPP and also indicate individuals other than adults with SPMI may be admitted to ACT. Consequently, I make no comment at this point whether these admission criteria are best suited to OPP implementation goals. Similarly, I make no judgment at this point whether the fidelity standards with Oregon modifications being utilized by OCEACT at this time are sufficient. This issue will be addressed in a later IC report.

requirements. OHA did talk with national crisis line experts as they developed the content for these regulations.

Acute Care Regulations

O.A.R. 309-032-0850 – 0870 cover regional acute care psychiatric services for adults. These regulations have been amended effective June 2017 to include a definition of "warm handoff" and a description of the warm handoff process consistent with the OPP. As in some other regulations, the term SPMI is defined to include a separate diagnostic category of Bipolar Disorder, which is not included separately in the original SPMI definition. The regulation does reference the website where ICD 9 & 10 codes for SPMI (as opposed to DSM V) can be found. However, this list of code variations is complicated and can be confusing so is not currently on the OHA website. These acute care regulations specifically require a warm handoff to be offered to individuals with SPMI and the discharge plan to include whether that warm handoff occurred and the entities involved, and whether the person declined a warm handoff, all consistent with OPP commitments. These regulations also specify discharge planning for persons with SPMI and do include a requirement to assess housing needs, among other continuing care needs and collaborate with the individual's CCO for the latter. The detail found in OPP Subsection D.34. is not reflected in the regulations. This detail includes OHA's commitment to require ACPFs to collaborate with CCOs and CMHPs to seek to ensure individuals with SPMI are discharged to housing that meets the individual's immediate need for integrated housing "based on the individual's treatment goals, clinical needs, and the individual's informed choice." OHA may want to consider making this requirement more explicit in these regulations as well as in the CCO and CMHP contracts and in the subcontract requirements for CCOs with ACPFs.[20]

Nothing is noted in these regulations about the direct payment by OHA to ACPFs for inpatient services for individuals who are on the waitlist for OSH admission. This issue was discussed earlier, and I reiterate my recommendation that OHA consider changing this practice to place the incentives in the right place to move those in need of OSH services more quickly out of ACPFs and into OSH.

Oregon does have other regulations covering hospital functions. These are generally in O.A.R. 333-505, 333-520, and 333-525. None of these regulations have been changed to address OPP issues. O.A.R. 333-520-0070 covers emergency departments and emergency services.[21] However, none of the commitments in OPP Subsections D.37. – 44. are referenced. OHA may want to review this regulation to determine which of those commitments would be better met by inclusion in these or related regulations.

State Hospital Admissions and Discharges Regulations

O.A.R. 309-091-000 et seq. covers admissions and discharges from OSH. This set of regulations was last updated in 2012, prior to the OPP. The term utilized in this regulation is SMI rather than SPMI and the definition does not comport with the definition being utilized to report on the OPP performance measures. The admission criteria in the regulation does not include the requirement in OHA's 2015 -2018 Behavioral Health Strategic Plan, Initiative 5, Goal 5.1 which requires that in most cases, only those who have

[20] H.B. 2023 passed in the 2015 legislative session requires hospitals to adopt and enforce policies for the discharge of a patient who is hospitalized for mental health treatment. This law covers individuals of all ages, not just adults. Requirements in these policies include suicide risk assessment, coordinating the patient's care and transition from an acute care to an outpatient setting that may include community-based providers peer support, lay caregivers, and others. Some of the changes to the acute care psychiatric services regulations appear to have included these requirements.

[21] H.B. 3090 passed in the 2017 legislative session amended O.R.S. 441.015 to 441.063 to require hospitals with an emergency department to adopt and implement policies for the release from the ED of a patient presenting with a behavioral health (BH) crisis, including suicide prevention measures. Hospitals are required to provide such policies to OHA, and OHA is mandated to report to the Legislature by January 1, 2018 on the policies, progress on and barriers to implementation, and recommendations for legislative changes to improve behavioral health outcomes for individuals released from EDs following treatment for a BH crisis. OHA indicates the requirements on hospitals of this law have not yet been translated into regulation.

received treatment on an inpatient psychiatric unit for seven days can be considered for admission to OSH. In practice, treatment for this purpose is defined as receiving antipsychotic medication, voluntarily or forced. If this criterion is going to continue to be used in practice, the regulations need to be revised to reflect this requirement along with a description of the circumstances that will result in consideration of admission without the patient having previously received seven days of antipsychotic medication. It is not clear to me at this point what role if any the use of this criterion affects the waitlist for admission to OSH. However, OHA will want to understand this and determine the best way to capture that requirement in regulation to affect the goal of community-based inpatient treatment first before referral for longer term inpatient care at OSH.

Similarly, this set of regulations includes discharge criteria and procedures for those who are civilly committed and those who are placed at OSH "voluntarily" by a guardian. These criteria are very high level and do not reflect the roles and processes currently utilized by OSH and OHA. The discharge criteria and process for those admitted due to forensic involvement are different in these regulations. To the extent the OPP specifically covers only those who are SPMI and are civilly committed, OHA will want to consider updating these regulations to more fully and accurately describe the criteria, process, and roles of the various players currently involved (e.g., CCO, CMHP, Choice provider, KEPRO, hospital personnel, etc.). Such revisions would be an opportunity to establish timelines for each party's activities and decision-making to reflect and assist the OPP goals of rapid discharge to appropriate community settings and services following a determination that a civilly committed adult with SPMI in OSH is ready to transition.

In September 2017, OHA staff issued a memo to Acute Care, Civil Commitment Monitors, and Choice Contractors describing changes to the Long Term Care Referral Form and Process to include both the Choice contractor and the CCO of responsibility and this information will be tracked in the OSH electronic health record. The memo indicates this revised process will allow OHA to monitor whether the Choice provider has met with the patient prior to referral to OSH but no later than 72 hours from the date of approval for long-term psychiatric care. The memo indicates this process will also allow OSH to ensure the Choice provider is invited to the initial Interdisciplinary team meeting as well as all subsequent IDTs. This memo shows OHA's effort to implement the changing requirements in the Choice provider contract language and implement these changes throughout the system.

Residential Treatment Facilities for Adults with Mental Health Disorders Regulations

O.A.R. 309-035-0100 et seq. were updated in June 2017 and cover licensing, administrative management, record keeping, staffing, setting requirements, and a number of other detailed requirements for residential treatment facilities (including SRTFs) and residential treatment homes for adults with "mental health disorders." O.A.R. 309-035-0163 covers admission criteria and process leaving the policy and decision about such admissions to the provider. Admission to and discharge from SRTFs is not delineated separately, and KEPRO's role is not described. Since most admissions to SRTFs originate from the state hospital or similar state-controlled environment and since these facilities are so highly regulated in terms of what they must do and provide to be licensed, I highly recommend OHA consider a fundamental change for admission to such SRTFs, with OHA referring to a licensed SRTF facility any individual who meets admission criteria and who agrees to go to a particular SRTF. The SRTF would have to accept the individual for admission unless, through an exception process under the control and discretion of OHA, the SRTF makes a case for not admitting the individual. OHA should keep track centrally of all available SRTF beds available for civilly committed adults with SPMI and utilize this list to get individuals on the RTT list who meet criteria for SRTF admission into such a setting more quickly than currently occurs due to provider review and screening processes.

I also recommend a specific section of these regulations be developed to address admission, discharge, and service requirements for civilly committed adults with SPMI since such individuals are not subject to forensic psychiatric services review board oversight and decision-making and may be released from SRTFs to RTFs or RTHs or directly to a supported or supportive housing setting with significant community services in place to prevent the need for higher level care again after discharge. Since the

OPP commitments represent a goal to shorten the length of stay in SRTFs for such individuals, the requirements for the facility to help make that happen will be important to delineate in regulation.

Person-centered service plans are described in some detail in these regulations at O.A.R 309-035-0190 and may be useful language to consider compared to such language in other regulations or when revising other regulations or documents.

Medicaid Related Regulations – General and Specific to BH

Oregon has additional regulations governing the Medicaid program, specifically O.A.R. 410-120 and 410-141. These regulations have not been amended to address OPP commitments. Terms used but not defined include "adults with serious behavioral health conditions" while adults with SPMI is not a term that is used or defined. These regulations do require CCOs to have agreements with CMHPs regarding the management of adults who "were members upon entering the state hospital and are transitioning from the Oregon State Hospital; and care coordination of residential services and supports for adults . . ." Given the earlier discussion regarding the role of CCOs, CMHPs, KEPRO, and Choice providers, OHA should take a serious look at these regulations as they are revising other documents to assure the definitions, expectations, standards, and requirements all line up with the commitments in the OPP.

Likewise, O.A.R. 410-172-0600 et seq. provides guidance for Medicaid payment for behavioral health services. OHA will want to look at this set of regulations as well as those mentioned in the previous paragraph as it is revising the CCO, KEPRO, and other relevant contracts and regulations. Since Medicaid is by far the largest payer of behavioral health services for adults with SPMI, the definitions and references to OPP commitments in these regulations will be important. This set of regulations has specific sections covering substance use disorder treatment services and residential treatment services for children (the latter largely defining processes and limitations). Telemedicine for behavioral health is also covered, which may be relevant for the warm handoff requirements mentioned earlier. However, there is no specific section on services for adults with SPMI or services specifically the subject of the OPP.

STATUS OF OHA DATA AND NARRATIVE REPORTS

The most recently available narrative report from OHA at the time this report was drafted was released at the end of July and covered the time period ending December 31, 2016 or the first six months of the OPP timeline. The next OHA report will provide data through the end of March 2017, not yet the full first year of the OPP timeline.[22] The next report is due in late January 2018 and will cover the 12 months through the end of June 2017 (FY 2017) or the first full year of the OPP timeframe. As such, this January OHA report will be helpful in determining direction and compliance with some of the commitments in the OPP. Because of these factors, I have not included a compliance matrix in this IC Report #2. However, my next report (IC Report # 3) to be released in the Spring of 2018 will begin to assess compliance with some of the OPP performance metrics for Year One (FY 2017).

Reviewing the data provided to date (that is, through December 2016), it appears OHA is on track in some areas such as mobile crisis services, ACT services, supported housing services, peer-delivered services, supported employment services, jail diversion services provided, and length of stay in SRTFs.[23] On the other hand, the data show some concerns regarding OSH discharge timelines and rates of visits to EDs. Similarly, in some areas OHA is tracking data but does not have a specific target to meet, and these data show concerns about the direction or trend. These include readmissions to EDs and acute care facilities, length of stay in ACPFs, and whether jail diversions are working to prevent individuals with

[22] This OHA report was released at the beginning of November 2017.

[23] While these data do show positive trends, I should note that these are OHA provided data that have not been verified by me. I will be reviewing some of the data for some of the performance measures through a team review of community providers and services sometime during 2018.

SPMI from being booked into jails rather than provided alternative community-based behavioral health treatment. OHA is cognizant of these data trends and considering how to impact the areas of concern.

In four areas, USDOJ raised issues with the definition and method of data collection. These generally have to do with lengths of stay calculations for individuals in but not yet discharged from OSH, SRTFs, and ACPFs and the denominator for the calculation of ACPF admissions. USDOJ has requested and OHA is considering how to respond to USDOJ concerns. The first of three annual meetings between OHA and USDOJ is occurring in early November and these issues will be discussed at that meeting.[24]

CONCLUSION

Overall, OHA has made significant effort and good progress toward meeting its commitments in the OPP regarding contract and regulatory changes. OHA continues to do more and is working on additional changes and amendments. While even more could certainly be done to align service definitions, requirements, expectations, performance outcomes, collaborations, and incentives for adults with SPMI, this process of alignment is a daunting task and will no doubt take additional time to negotiate State and federal requirements for such changes. Given the dynamic state of these changes, this IC Report does not attempt to assess compliance, but rather identifies areas in which the State has made considerable progress, areas where existing language is good or could be reviewed prior to additional changes in other documents, and areas in which the State could make a bigger impact by addressing some outstanding issues. This IC Report #2 identifies examples of areas for improvement and possible approaches. It does not attempt to identify all such improvements that could be made.

Given the enormity of this larger task of alignment, OHA's efforts to date show its commitment to addressing the OPP provisions and indicate a willingness to tackle big issues in consultation with stakeholders and with USDOJ's and this Independent Consultant's input.

[24] This meeting was held in early November and these issues were discussed.

APPENDIX A – ACRONYMS USED IN THIS OR OTHER IC REPORTS

- ACPF – Acute Care Psychiatric Facilities
- ACT – Assertive Community Treatment
- ADA – Americans with Disabilities Act
- ADP – Average Daily Population
- A&IPS – Acute and Intermediate Psychiatric Services
- ALOS – Average Length of Stay (or mean)
- AMHI – Adult Mental Health Initiative
- APAC – All Payer All Claims
- AOCMHP – Association or Oregon Community Mental Health Programs
- BH – Behavioral Health
- CCO – Coordinated Care Organizations
- CFAA – County Financial Assistance Award
- CFR – Code of Federal Regulations
- CIE – Competitive Integrated Employment
- CIT – Crisis Intervention Team
- CITCOE – Crisis Intervention Team Center of Excellence
- CMHP – Community Mental Health Program
- CMI – Chronic Mental Illness
- CMS – Centers for Medicare and Medicaid Services
- CY – Calendar Year (from January 1 through December 31)
- DPSST – Department of Public Safety Standards and Training
- DSM – Diagnostic and Statistical Manual
- ED – Emergency Department
- EDIE – Emergency Department Information Exchange
- EHR – Electronic Health Record
- e.g. – For Example
- ENCC – Exceptional Needs Care Coordinator
- EOHSC – Eastern Oregon Human Services Consortium
- FEP – First Episode Psychosis
- FFP – Federal Financial Participation
- FFS – Fee for Service
- FMR – Fair Market Rent
- FPL – Federal Poverty Level
- FY – Fiscal Year (July 1 through June 30)
- GAF – Global Assessment of Functioning
- GOBHI – Greater Oregon Behavioral Health, Inc.
- HIPAA – Health Insurance Portability and Accountability Act
- HPB – Health Policy Board
- HUD – Housing and Urban Development
- IC – Independent Consultant
- ICD – International Classification of Diseases
- ICM – Intensive Case Management
- i.e. – that is
- IMD – Institution for Mental Diseases
- IPS – Individual Placement and Support
- LEDS – Law Enforcement Data System
- LMHA – Local Mental Health Authority
- LTPC – Long Term Psychiatric Care
- LOS – Length of Stay
- M – Million
- MHAO – Mental Health America of Oregon
- MHBG – Mental Health Block Grant
- MHS – Mental Health Services
- MOTS – Measures and Outcomes Tracking System
- MOU – Memorandum of Understanding
- NCQA – National Committee for Quality Assurance
- NOFA – Notice of Funds Availability
- OACP – Oregon Association of Chiefs of Police
- OAHHS – Oregon Association of Hospital and Health Systems
- OAR – Oregon Administrative Rule
- OCA – Office of Consumer Affairs
- OCAC – Oregon Consumer Advisory Council
- OCEACT – Oregon Center of Excellence for Assertive Community Treatment
- OCJC – Oregon Criminal Justice Commission
- OEI – Office of Equity and Inclusion
- OHA – Oregon Health Authority
- OHCS – Oregon Human and Community Services
- OHP – Oregon Health Plan
- OPP – Oregon Performance Plan for Adults with Serious and Persistent Mental Illness
- OPRCS – Oregon Patient/Resident Care System
- ORS – Oregon Revised Statutes
- OSECE – Oregon Supported Employment Center for Excellence
- OSH – Oregon State Hospital
- OSJCC – Oregon Sheriff's Jail Command Council
- OSSA – Oregon State Sheriffs Association
- OSU – Oregon State University
- PATH – Projects for Assistance in Transition from Homelessness
- PDS – Peer Delivered Services
- QHOC – Quality Health Outcomes Committee
- QPI – Quality and Performance Improvement
- RAC – Rules Advisory Committee
- RFA – Request for Applications
- RFP – Request for Proposals
- RTT – Ready to Transition (also Ready to Place)
- SAMHSA – Substance Abuse and Mental Health Services Administration
- SE – Supported Employment
- § – Section
- SIM – Sequential Intercept Model
- SMI – Serious Mental Illness
- SOS – Secretary of State
- SPMI – Serious and Persistent Mental Illness
- SRTF – Secure Residential Treatment Facility
- SSI – Supplemental Security Income
- TA – Technical Assistance
- TAC – Technical Assistance Collaborative, Inc.
- USC – United States Code
- USDOJ – United States Department of Justice
- w/ – with
- w/in – within