We Belong Together

Oregon's Roadmap Toward Creating Unified Reimbursement Rates for Co-Occurring Disorder Treatments

HCBS CONFERENCE
Home & Community-Based Services

2023 Home and Community-Based Services Conference

Our discussion today

- Overview of Oregon's Development of Integrated Co-occurring Disorder (ICD) Services
- Overview of ICD Reimbursement Study Phase I
- Overview of ICD Phase II
- Interactive Q&A

Your Panelists

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Activity #1

Please imagine that you are attending the conference in person with us

It’s the end of the conference, and you are tired

A snack and a drink are just what you need to make it through

Great news!

We have a nice array of snacks, and you pick one you like and eat it

Your hunger is satisfied for now

Overview of Oregon's Development of Integrated Co-occurring Disorder Services

History and Background

Problem Gambling in Oregon

Oregon voters passed expansion of State-operated gambling in 1991

Problem Gambling Treatment Fund created by Oregon statute in 1992

Problem Gambling Treatment and Prevention Systems developed through support from this fund

An innovator

Oregon became an early and consistent innovator in problem gambling treatment and prevention

Continues to be one of the top funded State-supported problem gambling (PG) systems per capita

The Oregon Problem Gambling Treatment System

Outpatient treatment at **over 45** locations

At least one location in **each of our 36** counties

One standalone problem gambling residential provider

Most treatment provider organizations are also **substance use disorder** treatment providers

Some are also **mental health** treatment providers

Gambling disorder prevalence in Oregon is estimated at **2.6%**

Approximately **86,000** Oregonians

Treatment is **free** to the consumer and concerned others

Fewer than 1,000 Oregonians engage in State-supported treatment yearly

Lack of awareness, stigma, shame, and bifurcation of treatment systems and payment models are contributing factors to this low engagement

(OHA data)

Co-Occurring Disorders and Problem Gambling

Over two-thirds

of people dealing with gambling disorder **also deal with** co-occurring mental health and/or substance use disorders

Over 15%

of people dealing with **substance use** disorders deal with co-occurring gambling disorder

With variability across disorders,

10% to over 30%

of people dealing with **mental health** disorders also deal with co-occurring gambling disorder

Co-Occurring Disorders and Intellectual/Developmental Disabilities

Approximately 5%

of adults dealing with I/DD are dealing with co-occurring substance use disorders

Approximately 7%-20%

of adults dealing with I/DD are dealing with co-occurring mental health disorders

Co-occurring gambling disorder

Prevalence data is hard to come by

We do know that people with intellectual disabilities, cognitive impairments, and acquired brain injuries are particularly vulnerable to problems with gambling

Social Determinants of Health and Co-Occurring Disorders

OHA Strategic Goal | **Eliminate health inequities by 2030**

Central to this goal is the idea of shaping strategy, systems, and policy guidance around SDoH/HRSN factors

OHA seeks to address gaps that are disengaging for those dealing with co-occurring disorders …

and SDoH factors appear to be present at these gaps

The Call for Integration

Oregon's **four** separate, but somewhat overlapping, treatment and support systems

- Mental health treatment
- Substance use disorder treatment
- Problem gambling treatment
- I/DD support systems

For people dealing with **two to four** co-occurring disorders

- Redundant services
- Logistical and service coordination problems
- Clinical blind spots leading to disengagement and poor outcomes (scope of practice, challenges considering SDoH)
- Multiple and disconnected reimbursement/payment systems

Integrating Treatment Services for Co-Occurring Disorders

Creating a **specialty** clinical endorsement

Developing clinical training that addresses **integration** of services

Supporting development of multiple **credentials** for clinical staff

Providing technical assistance to support integrated **processes** in program development

Funding programs through start-up **grants**

Enhancing **payments** for services

Supporting care coordination organizations (CCO) payers through directed payment mechanism, technical assistance, and adding problem gambling as a Medicaid covered service within ICD programs as well as independently within behavioral health clinics

Overview of ICD Reimbursement Study Phase I

Activity #2

Now, imagine that the snack we gave you helped with your craving, but it has left you thirstier than when we started!

You wonder if we might also have beverages you could have.

Several of you muster the gumption to ask us if we have any beverages. We do!

While on a break, those few people each ask a different presenter for a drink.

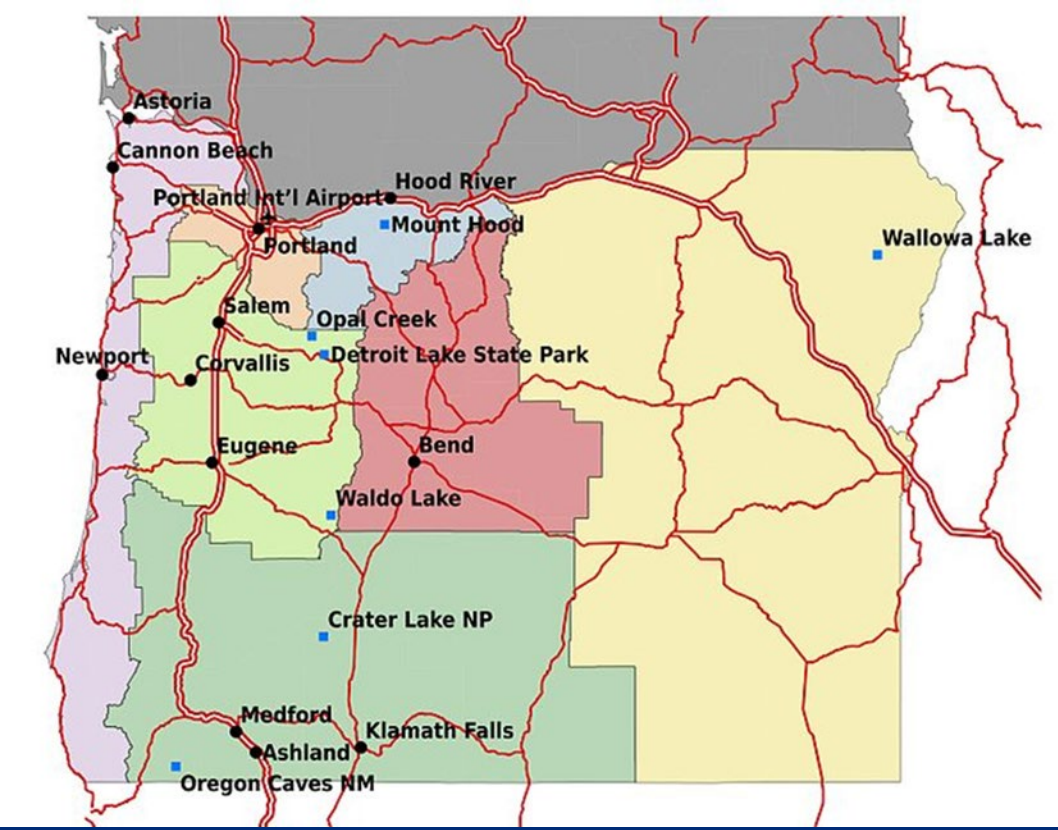
What happens next?

OR HB 2086 (2021)

OHA shall conduct a study of reimbursement rates for co-occurring disorder treatments, including treatment of a co-occurring intellectual and developmental disability and problem gambling disorder

In response to this order, OHA and Mercer developed an initial workplan that focused on understanding the present landscape of ICD service adoption and implementation statewide

Phase I



Data collection and landscape analysis:

- Identify current ICD services
- Review claims and encounter data
- Literature review on integration of MH, SUD, PG, and I/DD services

Interviews and engagement with subject matter experts (SMEs), including providers of ICD services, OHA, and its partner divisions and departments (behavioral health, I/DD)

Aggregate input and present final report

Phase I

Key findings – strengths

Oregon has a strong array of services for MH, SUD, PG, and I/DD

Oregon is a national leader in PG services

SME interviews showed where integration is going well

- Strong commitment to ICD from OHA
- Examples of organizations and counties working together to pair services
- Instances in which an individual can receive services under one roof
- MH and SUD frequently assessed together

Phase I

Key findings – challenges

Provider interviews illustrated where there are challenges in the provision of ICD services

Although there are areas where integration is going well, the ability of individuals to get their needs met can vary widely

Challenges

- Siloed nature of services
- Difficulties in billing – dually credentialed providers, utilizing one bill code
- Issues with access, including provider shortages
- Insufficient provision of services and accommodations for people with I/DD
- Less frequent assessment of I/DD and PG compared to MH and SUD
- Differences in experience of services based on where an individual is located

Financial Analysis – Prevalence Rate Comparison

Oregon versus national

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

The Oregon prevalence rates are developed using identified members who were billed for care, while the national metrics are based on assessment rates, not individuals in service. Oregon has lower prevalence rates than national almost across the board.

The lower prevalence rate for Oregon is not indicative of people not having those conditions, but that not all people having these conditions are being identified in the current setup. Study shows that there are members with mental health conditions that are not receiving the care they need.

Financial Analysis — Penetration Rate of Service Engagement by Region

Region	No MH Claims	One Condition	Two Conditions	Three Conditions	Four Conditions	MH Cost PMPM
North Coast Basin	77.5%	17.6%	4.7%	0.2%	0.0%	147.75
Lower Willamette Basin	75.3%	20.1%	4.4%	0.2%	0.0%	301.68
Central Coast/Upper Willamette Basin	70.2%	23.8%	5.8%	0.3%	0.0%	282.65
Southwest Oregon Basin	77.2%	18.4%	4.2%	0.2%	0.0%	169.26
Deschutes Basin	74.5%	20.8%	4.6%	0.2%	0.0%	350.98
High Desert Basin	77.9%	17.3%	4.5%	0.2%	0.0%	239.37
John Day Umatilla Basin	84.5%	12.4%	3.0%	0.1%	0.0%	133.03
Snake River Basin	79.3%	16.1%	4.4%	0.2%	0.0%	97.52
Total	**75.2%**	**20.1%**	**4.6%**	**0.2%**	**0.0%**	**268.43**

Central Coast/Upper Willamette Basin, where Portland is located, has the highest utilization.

John Day Umatilla Basin and Snake River Basin, which have the lowest utilization and spending of services, are both located in Eastern Oregon.

Deschutes Basin has the highest mental health per member per month cost (PMPM), which will be a point of emphasis for the additional financial analysis we plan to perform in Phase II, with the goal to understand over- and under-spending across Oregon service regions.

Overview of ICD Reimbursement Study Phase II

Moving from Phase I to Phase II

- Pursue more opportunities to **strengthen ICD** service system and afford equitable access to care in all Oregon communities
- **Improve understanding** of different spending/utilization of ICD services across different regions of Oregon
- **Provide** technical support and learning opportunities for providers, and **identify** and **resolve** any administrative burden for delivering ICD services
- **Engage** managed care organization (CCOs in Oregon) care managers in the promotion and understanding of ICD services for members served

Phase II Activities in Process

- Promote integrated ICD services statewide
- Study possible causes for over- and under-utilization of ICD services
- Identify and address challenges for CCOs and providers
- Study role of care management and how it can support ICD services implementation
- Research houselessness initiatives to discover additional service coordination opportunities between HRSN resources and ICD services and supports

Why Include Houselessness?

Oregon has a **disproportionately large** population of people experiencing houselessness compared to other states

There are **high rates** of co-occurring mental health and substance use disorders among persons also experiencing houselessness

There is a **complex relationship** between houselessness and persons living with co-occurring conditions

Desired Outcomes of Phase II

- People will experience a **less fragmented** system and can depend on their providers and health plan to help them coordinate all of their support needs, including health-related social needs
- Services will **neither** duplicate treatment nor inadvertently create gaps in care
- Services will be **easily accessible**, regardless of where you live in Oregon
- Future payment models could consider **bundling**

Activity #3

At this point, you're thirstier than ever, and now you are hungry again too

Maybe you even need a bio break

You decide to ask again. This time, you'll ask David

David represents a well-integrated system

What will David say?

Questions?

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Thank you!

Mercer

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