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Minnesota Department of **Human Services**

Report to the 2010 Legislature:

STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT PROJECT PROPOSAL

January 15, 2010

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An Equal Opportunity and Veteran Friendly Employer

Cost to Prepare Report
Minnesota Statutes, Chapter 3.197 requires disclosure of the cost to prepare reports. The approximate cost of this report was $13,365.

Executive Summary

The 2009 legislature passed legislation that allows CD County Pilots, Chapter 79, ARTICLE 7 Chemical and Mental Health, section 26. The legislation authorizes the establishment of a chemical health care home pilot project to test a service delivery redesign with appropriate flexibility that ensures timely access to services as well as better aligning systems and services to offer the most appropriate level of chemical health care services to the client. Parameters under which the pilot is to be developed include:

- Maintenance of eligibility requirements for the CCDTF
- Continue to meet requirements of Rule 25 (MN Rules 9530.6600 to 9530.6655)
- Continue to meet requirements of Rule 31 (MN Rules 9530.6405 to 9530.6505)
- Must not risk current or future federal funding
- Report back for approval of two potential pilots, one metro & one non-metro.

A workgroup comprised of county and MACSSA staff and staff from the Alcohol and Drug Abuse Division of the MN Department of Human Services was convened before July 15, 2009. MACCSA brought forth to DHS two pilot locations for consideration -- one in the metro (Washington County) and one in the non-metro (the counties of Dodge, Fillmore, Goodhue, Houston, Mower, Olmsted, Steele, Wabasha, Waseca, Winona.)

The workgroup has been regularly meeting to determine eligibility criteria for persons in the pilot, initially defined as heavy service users for whom the usual service model is not working. The legislature directed the development of this pilot in the absence of any specific allocation. As the result of further CD pilot work group meetings, a detailed fiscal note will be developed.

I. Background and Purpose

The 2009 legislature passed legislation that allows CD County Pilots, Chapter 79, ARTICLE 7 Chemical and Mental Health, section 26. (see Appendix). The legislation authorizes the establishment of a chemical health care home pilot project to test a service delivery redesign with appropriate flexibility that ensures timely access to services as well as better aligning systems and services to offer the most appropriate level of chemical health care services to the client. Parameters under which the pilot is to be developed include:

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- Continue to meet requirements of Rule 31 (MN Rules 9530.6405 to 9530.6505)
- Must not risk current or future federal funding

The purpose of the pilot project – a partnership between the Department of Human Services and participating counties - is to promote greater accountability, productivity, and results in the delivery of state chemical dependency services.

The pilot projects attempts to provide expanded flexibility, while ensuring timely access to needed services, and better aligning systems and services to offer the most appropriate level of chemical health care services to the client.

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The workgroup has been regularly meeting to determine eligibility criteria for persons in the pilot, initially defined as heavy service users for whom the usual service model is not working. The legislature directed the development of this pilot in the absence of any specific allocation. As the result of further CD pilot work group meetings, a detailed fiscal note will be developed.

This report completes the requirement to report back to the legislative committees with jurisdiction over chemical health by January 15, 2010, for potential approval of one metro and one non-metro pilot project.
If approved, projects will be implemented on or after July 10, 2010. An evaluation report will be prepared by the Department of Human Services to address the efficacy and feasibility of the pilot projects. Expansion of pilot projects may occur only if the department's report finds the pilot project(s) to be

effective. Please refer to Section X. Next Steps and Timeline for proposed changes to the evaluation timelines

II. Overview of the SE MN and Washington County Pilot - Model of Care

The Chemical Health pilot counties are requesting the Department of Human Service, Alcohol and Drug Division, to allow them to assume full financial risk in providing entitled chemical health care services by allocating pilot counties a capitated amount of dollars based upon a 3-year average of total spending (CCDTF & County MOE). Pilot counties assume full risk of costs over the capitated amount, but the counties will be allowed to use the funds flexibly, through the "Navigator" function, an intensive case management activity, for a portion of the clients eligible for these funds whose needs are not addressed through the traditional chemical dependency treatment programs.

The services provided to these clients will be based upon a comprehensive outcome-driven treatment/case plan that will help clients access all of the service offered through the funding systems. The Behavioral Health approach is holistic and incorporates primary health, social health, mental health, chemical health and correctional health. The goal is to have someone to assist the individual and their families with navigating the various systems toward achieving desired or identified outcomes focused on recovery based principles. The vision is to create a system that integrates all health needs with social services and move away from our current fragmented, payment driven referral based model.

Two key components of the proposal support the chemical health care home concept as part of a service delivery redesign – the use of a "Navigator" and the regional efforts to provide services through "hubs".

Pilot counties will be allowed to reinvest any dollars made available by under-spending the capitated amount in additional services for the eligible persons. This also allows counties to reserve some dollars (i.e. Risk-Based Capital) for fluctuation in spending from year to year. In order for pilot counties to manage their risk, using a risk-based capital pool strategy, authority for counties to roll over unspent dollars from one year to another will be essential.

Payment for services will be done on a fee-for-service basis. But the funding for the pilot will utilize the capitation model. This will allow us to work toward aligning the incentives and risk. Financing reform is what is at the core of this pilot to improve and achieve our desired outcomes.

CCDTF will be the primary payer for treatment and the payer of last resort for any services where there is other funding that also could be used.

The years of dollar amount to review will be most recent three years to accurately address more current placement activity, adjusted for current appropriation limits.

Amounts funded by the state will include state CCDTF dollars only. Counties maintain responsibility for the county share. The amount of county share is determined by the state. We would factor the county dollars into the annual capitation amounts.

Cost savings will be found in a variety of ways and not just specifically in CCDTF. The counties are actively pursuing this pilot to find ways to impact costs for detox, law enforcement, courts, medical costs, etc.

III. Target population

All individuals will be determined eligible through both the Rule 24 and Rule 25 process. We will plan to continue using the existing assessment networks that exist.
The scope of the pilot needs to be further defined by estimating the average number of people served each year. It needs further refinement to determine what percentage is covered through a managed care organization. Pilot counties may contract with Managed Care Organizations for specific services. Individuals on Medical Assistance will have access to all of the services currently available as well as the ability to access services available through the pilot.

IV. Intake Process

A. Eligibility

The first step to access funding for treatment through the Consolidated Chemical Dependency Treatment Fund (CCDTF) is to determine financial eligibility. The pilot project in SE MN and Washington County will use the annual allocation bulletin to determine financial eligibility for Tier 1 clients. The client will be provided access to a Rule 25 Assessor for a Rule 25 assessment.

B. Assessment and Placement Services

The Rule 25 assessment uses the Minnesota Matrix – 6 Assessment Dimensions to determine functioning on scales which are rated based on severity. This assessment will indicate service need according to the rating on each dimension. Most of the clients assessed will indicate a need for treatment that will be met through

one of the licensed treatment programs that are currently available in the continuum of services. These clients will be authorized to receive treatment by an appropriate treatment provider. Other clients will indicate a need for more intensive services whose assessments have ratings of 3 on two or more dimensions, and they have had two or more treatment episodes within the last two years for adolescents, additional considerations could include corrections involvement, open children's/adolescent mental health case, and/or out of home placement. These clients will be referred for comprehensive treatment planning by a Navigator. The Navigator may access some of the traditional treatment services but will continue to work with the person through treatment, discharge, and into the community on an on-going basis.

V. Navigator Services

Navigator services will be a critical component of the Behavioral Health Care Home Pilots. In addition to the traditional treatment services funded through the CCDTF, Navigator (Case Management) services will also be available to those individuals that have not been successful in achieving their individual recovery goals through the existing options and/or have specialty needs that cannot readily be addressed with available treatment and/or services.

The Navigator's purpose is to reduce harm of substance use disorders and promote recovery. Decisions about when and how these services would be made available to identified individuals will be the responsibility of the Placement Authority. Navigator services will be provided either as a stand-alone service or concurrently with other needed services and/or treatment.

Due to the high intensity of contact expectation, the level of complexity of integration needed and in order to insure good recovery outcomes for the individuals served, the number of individuals that each navigator will be limited and based on best practice models in the mental health and homelessness program areas. It is anticipated that caseloads will range from 10 – 16 individuals.

Navigator responsibilities would include:

1. In-depth functional assessment of needs
2. Advocacy for those recovery goals that have been established by the individual
3. Integration and coordination of all the individual's needs, including mental health, family services, primary healthcare, social services and other identified needs
4. Support the individual to "navigate" the service system

5. Document assessments, individual service plans, ongoing contacts and outcome measures

In order to achieve the best possible outcomes, staff responsible for the Navigator duties must be skilled in the practical application of recovery principles as to how they apply to the individual's identified personal future and recovery goals. These staff must also have a high level of competency in advocacy, motivational interviewing, relationship building, engagement, co-occurring (MI/CD) needs treatment, adolescent development, family systems theory, and they must also have local services awareness.

We have begun work on the development of a job description for the Navigator position. We envision that mental health practitioners and those who have experience with case management along with recovery principles will be candidates for this position. This is another area for a smaller workgroup.

VI. New Support Services Proposed to be paid by the CCDTF

One of the goals of the pilot is to move beyond just treatment in order to get to recovery. We need to find ways to maximize or leverage the resources available through all the various funding streams.

Peer Support

Peer support is a service that will be newly developed through the pilot project. Peer support services will be used to help individuals develop life skills including sobriety. It is an in-home service that will be utilized as part of the treatment plan developed by the Navigator. There are efforts underway within the Mental Health division to develop this and it is being promoted as best-practice by SAMSHA.

Family Engagement and Support

In cases involving adolescents, engagement and involvement of the family in the youth's treatment and recovery process is critical.

Housing Support

This service will be used to provide support to adult individuals who are residing in a Group Residential Housing (GRH) program. It will be used to support providers to offer enhanced services to this population that is not covered through the board and lodging rate. This service is provided as part of the treatment plan developed by the Navigator. This service will be developed from the ground up with a focus on harm reduction.

Rent Subsidy

This is meant to be a short term (up to 3 months) rent subsidy to assist individuals to transition out of residential treatment. Frequently, individual's lives change while in a treatment program and the client is unable to return to their residence. These individuals do not need the level of support provided by GRH; however, they have completed treatment and need a place to reside while they find employment. This service is provided as part of the treatment plan developed by the Navigator.

Supported Employment

This service is meant to augment the Workforce Centers services. The provider of this service will be knowledgeable about behavioral health issues (chemical health and mental health) and can assist the individual in carrying out the plan developed with a Workforce Center counselor. This service is provided as part of the treatment plan developed by the Navigator. We want to purse evidenced based practice efforts to work with behavioral health issues and focus on the person-centered goals.

Independent Living Skills Development [adolescents]

Assessment of independent living skills and coordination with adolescent independent living skills programs in the community will be part of the support plan for adolescents.

VII. Additional Components

As we get started initial efforts will go into training staff. Areas to be covered will include such things as:

- Behavioral health care focus that brings together all aspects of chemical health and mental health
- Regionalization efforts that include mapping out services by hubs and centralization of funding. The service delivery hubs for SE MN will integrate with those used within the CREST project. A list of counties included in each hub can be found at the end of this document for reference.
- Addition of the Navigator model focused on the chronic substance abusers.
- Developmentally appropriate adaptations of the project to meet the specialized needs of adolescents.

We will also need to have ongoing discussion with the provider community on how the pilot will impact them. Areas to be covered will include such things as:

- Recovery outcome focus
- Role of Navigator
- Potential impact on billing

VIII. Outcomes

With the focus on recovery outcomes we will need to work through how the data will be collected and reported.

For those individuals who access the new service options the following outcomes are being considered by the workgroup to measure the success of the pilot:

- Cost Effectiveness (Pre/Post cost analysis of CCDTF & MAXIS claims data)
- Reduced contact with Law Enforcement (Pre/Post data collection from local law enforcement data base and jail days)
- Improved school performance [adolescents] attendance records, academic performance
- Increased Housing and Employment Stability (POSR, Pre/Post actual days housed, # of housing addresses 2 yrs. pre, and 2 yrs. post, # of days employed, and average/hourly salary pre/post – self report and employment records)
- Reduced Hospitalization (POSR, MAXIS claims data - 2 years pre/post)
- Reduced use of Detox (County payment claims - 2 years pre/post)
- Reduced out of home placement [adolescents] pre/post actual days in out of home care
- Reduced Substance use and Symptoms of MI and Increased Functional Capacity (GAF, POSR using predefined intervals)
- Improved Ability to Direct Own Services (Self Report and Satisfaction)
- Timeliness of service delivery (Access To Recovery Monitoring System)

IX. Coordination of the Pilots

The two pilots, Washington County and SE MN would like to continue to use the MMIS system to authorize services using coding that would identify the services unique to the Pilots. This would allow for data collection on expenditures for comparison purposes on both pre and post implementation of the pilot service delivery model. All information agreed upon to be provided to the DHS and all reasonable requests made by DHS for additional information will be honored.

The request to pool the State and County funding from the CCDTF for the SE MN pilot would require a regional fund management approach similar to the process that the same counties use for the Adult Mental Health Initiative (AMHI). One county would be designated as the Fiscal agent. That county would be responsible to receive the entire allocation as determined by the DHS ADAD and would work closely with the Human Service Directors from the 10 counties to determine appropriate budgets for the 3 Hubs that are responsible for service delivery at the local level. SE MN is divided into

three Hubs in the AMHI, generally organized around the counties served by the Region's four Community Mental Health Centers. With the implementation of the SE MN Pilot, that system would also become responsible for managing the CCDTF funds. Under no circumstances will the funding provided through the AMHI be co-mingled with the resources provided through the CCDTF for this Pilot Project. The Fiscal Agent would then inform the Hubs of the designated allocation. Placement and service authorizations would continue to be the responsibility of the individual counties.

The western hub includes Dodge, Steele and Waseca counties.
The central hub includes Fillmore, Goodhue, Mower, and Olmsted
The eastern hub includes Houston, Wabasha, and Winona.

X. Next Steps & Timeline

Workgroups are being developed to bring more detail to the pilot in the areas of:

- Fiscal issues including capitation and payments, operational costs to DHS & counties.
- Service development including eligibility for new services along with integration of chemical and mental health.
- Outcomes and Measurements.

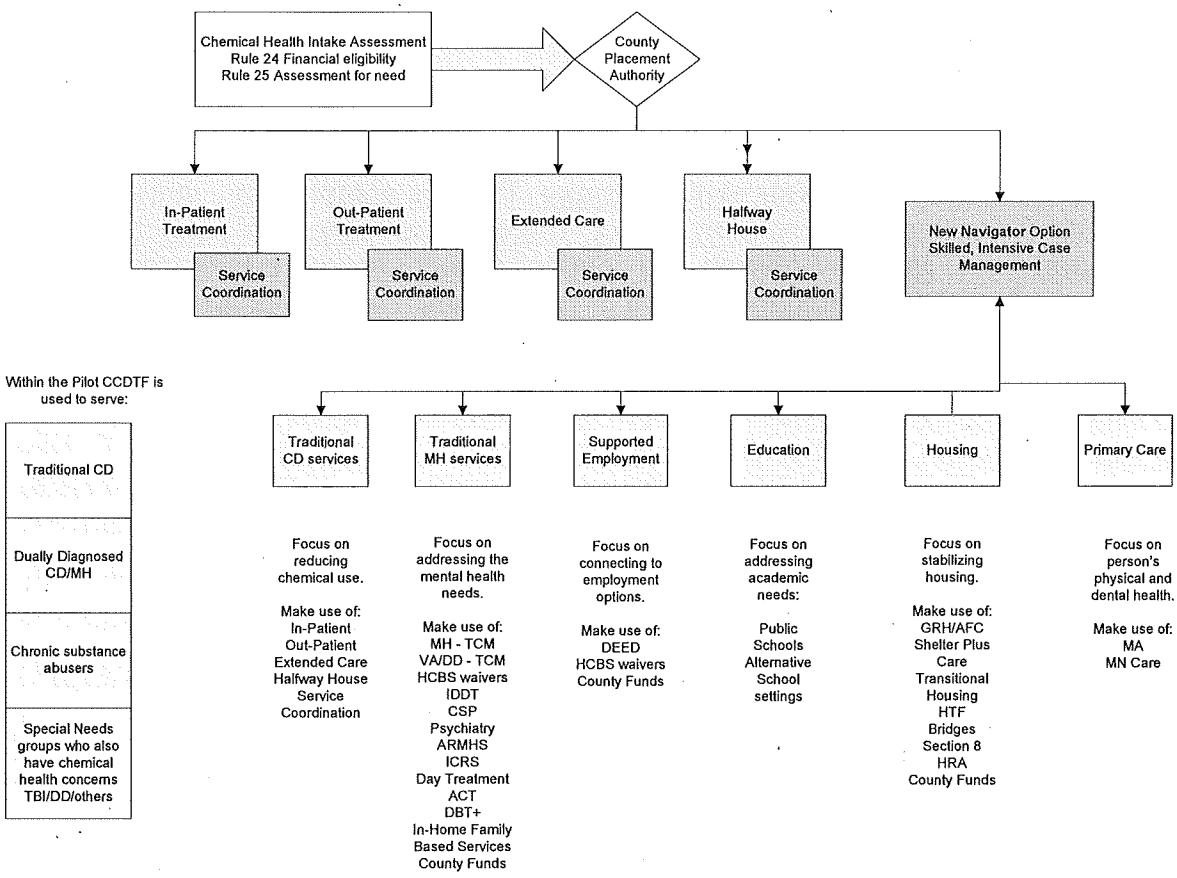
As the workgroups complete their tasks it is expected that legislation will be brought forward. Allowing for a full two years of operation will allow for a more fully developed model and adequate time to evaluate the project outcomes. The state and county pilots are working closely together in the development of this effort, and the workgroups will bring forth more specific recommendations for operationalization and needed legislation. Please see attachments.

XI. Schematic of the vision for the pilot

See diagram attached.

Overview of Options for Behavioral Health Care Home Pilot

Revised December 2009



APPENDIX

Legislative language:

Chapter 79 Sec. 26. **STATE-COUNTY CHEMICAL HEALTH CARE HOME PILOT PROJECT.**

Subdivision 1. **Establishment; purpose.** There is established a state-county chemical health care home pilot project. The purpose of the pilot project is for the Department of Human Services and counties to authentically and creatively work in partnership to redesign the current chemical health service delivery system in a way that promotes greater accountability, productivity, and results in the delivery of state chemical dependency services. The pilot project or projects must look to provide appropriate flexibility in a way that ensures timely access to needed services as well as better aligning systems and services to offer the most appropriate level of chemical health care services to the client. This may include, but is not limited to, looking into new governance agreements, performance agreements, or service level agreements. Pilot projects must maintain eligibility requirements for the consolidated chemical dependency treatment fund, continue to meet the requirements of Minnesota Rules, parts 9530.6600 to 9530.6655 (also known as Rule 25) and Minnesota Rules, parts 9530.6405 to 9530.6505 (also known as Rule 31), and must not put at risk current and future federal funding toward chemical health-related services in the state of Minnesota.

Subd. 2. **Workgroup; report.** A workgroup must be convened on or before July 5, 2009, consisting of representatives from the Department of Human Services and potential participating counties to develop draft proposals for pilot projects meeting the requirements of this section. The workgroup shall report back to the legislative committees with jurisdiction over chemical health by January 15, 2010, for potential approval of one metro and one nonmetro county pilot project to be implemented beginning July 10, 2010.

Subd. 3.**Report.** The Department of Human Services shall evaluate the efficacy and feasibility of the pilot projects and report the results of that evaluation to the legislative committees having jurisdiction over chemical health by June 30, 2011. Expansion of pilot projects may occur only if the department's report finds the pilot projects effective.

Behavioral Health Care Home Pilot:
Financing Workgroup Charge & Scope of Work

Guiding Principles around financing the pilots:

- Any and all funding must be aligned with outcomes.
- The overall funding strategy will be to leverage other streams of resources whenever and wherever possible (i.e. mental health, housing, employment, etc.).
- Establish a pilot payment methodology that pays for desired outcomes/quality vs. quantity of process. Increased benefit/payment for success and decreased payment for not achieving agreed upon outcomes. Needs to be about aligning the incentives toward outcomes and penalty toward not achieving agreed upon outcomes.
- CCDTF Funding is primary for *treatment* and secondary for *supportive services.*
- Pilots will not jeopardize federal funding.

Payment and mechanics of financing the pilots that require attention:

- Each "Pilot" is funded through a pool of dollars that is arrived at by taking a 3 year annualized average of CCDTF spending per participating county. SE Minnesota counties will look at the possibility of pooling all the counties amount into an aggregate total that will be managed as one fund with actual expenditures tracked back to each county (i.e. similar to the Adult Mental Health Initiative). Therefore, DHS will be working with 2 financial entities vs. 11 separate counties.
- Do we look to a per person capitation amount or more of a general pool per county or per project?
- The break out will have to differentiate between state CCDTF funds and MA funds. This may be done by a percentage or another agreed upon methodology.
- MA funds will only be used to pay for already approved services (i.e. inpatient, outpatient, extended care, ½ house services, service coordination, limited detox). Tracking the expenditure of these specific funds may require a "modifier" in the billing system for accountability purposes.

- MMIS will remain as the primary tool for billing all services paid for by participating county pilots. We will need to establish billing codes for non-traditional services agreed upon for the pilot that have not previously been set up in MMIS.

- Develop an operational model for managing funds at state and local level.

- Identify state changes necessary for pilot implementation.

- Identify any fiscal impacts streaming from this initiative (i.e. state and county admin costs).

- Look at *Federal* requirements under CCDTF fund per MA Waiver.

- Adherence to federal standards.

- Determine legislative action to be taken or not taken and/or see what Commissioner of Human Services has the authority to waive.

- Governing factors assigned to the pilots

- What needs to happen so we can adhere to carryover fund statute in pilots?

- Discuss and recommend a "payment methodology" that aligns the incentives with CD inpatient/outpatient providers to achieve our desired outcomes that align with the current provider payment reform underway.

- Will need to set the parameters and establish an agreement for reinvesting dollars not spent under the aggregate amount. Minimally, they must be reinvested in the behavioral health care service delivery system consistent with the pilot.

Parking Lot Issues for later attention:

- Look into the concept of a "cash card" that could be loaded with "X" dollar amount based upon service level need that an eligible person could choose to purchase care from. Like a service option menu in which they choose to purchase the outcomes from different care models?

- How might we look to integrate primary health care into a few of the pilot counties in the SE given they are also involved in county-based purchasing?

Behavioral Health Care Home Pilot:
Services Workgroup Charge and Scope of Work

Guiding Principles

- Service delivery will be based on Recovery Principles as outlined by SAMHSA
- Individuals will direct their own services whenever possible
- Services must be integrated with other health and social service needs
- Services will be provided regionally
- Resources from the CCDTF will be the primary payer for CD treatment and a secondary payer of any new services
- Minimize the fiscal impact

Services Workgroup Expectations-

- Operationalize the service delivery model.
- Explore the concepts of a Chemical Health Home and their implications.
- Define the eligibility determination process for the overall pilot project.
- Describe the Navigator role.
- Develop appropriate credentials, a position description and core competencies for the Navigator role.
- Detail critical experience, knowledge and skills that the Navigator job needs to have in place.
- Provide a curriculum of training that would be required and/or suggested for the Navigator.
- Describe the process that will be used to determine who will receive Navigator services.
- Outline how the responsibility of integrating chemical health with mental health, primary care and social services will be accomplished by the Navigator.
- Provide details of the conditions that must be met in order for services such as housing, supported employment and transportation would be paid for through the CCDTF as a last option.
- Define start-up costs.
- Provide budget details and a contract rate for Navigator services.
- Analyze all applicable rules, statutes, etc and identify impact on the proposed service delivery model. (Including but not limited to: Rule 24/25, Rule 31, VA, Commitment, Data Practices).
- Propose any recommended changes in Legislation and/or waivers that may be required to implement.

Behavioral Health Care Home Pilot
Outcomes Workgroup: Charge and Scope of Work

Guiding Principles:

- Measures must be sufficient to determine the impact of the project on the lives of the clients, the service delivery systems and the Consolidated Chemical Dependency Treatment Fund.
- The data collection requirements must be chosen with consideration to the impact of collection and analysis on administrative burden
- Data collection will rely on existing instruments and systems whenever possible

Expectations of the Outcomes workgroup:

- Define the scope of the outcomes measurements.
- Identify existing resources for data collection, such as POSR, ATM, DAANES, MMIS
- Identify any modifications needed to existing systems
- Identify any data collection instruments that need to be developed for this project
- Identify the cost of modifying or developing data collection instruments
- Identify the cost of data collection
- Identify roles, responsibilities and timelines related to reporting and analysis of outcome and accountability data
- Consider and make recommendations regarding the usefulness and efficacy of the following measures:
  - Cost Effectiveness (Pre/Post cost analysis of CCDTF & MAXIS claims data)
  - Reduced contact with Law Enforcement (Pre/Post data collection from local law enforcement data base and jail days)
  - Improved school performance [adolescents] attendance records, academic performance
  - Increased Housing and Employment Stability (POSR, Pre/Post actual days housed, # of housing addresses 2 yrs. pre, and 2 yrs. post, # of days employed, and average/hourly salary pre/post – self report and employment records)
  - Reduced Hospitalization (POSR, MAXIS claims data - 2 years pre/post)
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  - Reduced out of home placement [adolescents] pre/post actual days in out of home care
  - Reduced Substance use and Symptoms of MI and Increased Functional Capacity (GAF, POSR using predefined intervals)
  - Improved Ability to Direct Own Services (Self Report and Satisfaction)
  - Timeliness of service delivery (Access To Recovery Monitoring System)