

**Pre-Application Technical Assistance Reports for the
Access to Recovery Grant Program**

Report on Technical Assistance to Oklahoma

May 2004

Prepared under

Center for Substance Abuse Treatment
Contract No. 277-00-6400, Task Order No. 277-00-6403
Consulting Order No. 010383

By

The Performance Partnership Grant
Technical Assistance Coordinating Center



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

Consultation between Cynthia M. Wiford and Oklahoma Department of Mental Health and Substance Abuse Services

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Introduction

The State of Oklahoma (the State) requested technical assistance from the Center for Substance Abuse Treatment (CSAT), indicating a need for guidance in the areas of rate setting and methods of evaluating costs of recovery support services in preparation for their application for Access to Recovery (ATR) grant funds. The State has had some experience with determining rates for clinical treatment services, but desired assistance with setting rates and evaluating costs for recovery support services covered by vouchers under the ATR grant. Under Task Order with CSAT, the American Institutes for Research (AIR) contacted Cynthia “Syd” Wiford to assist the State. In an initial conference call, ATR program staff suggested that the consultant could provide help to the State on how to develop a marketing survey (or the State could propose to do this in the proposal) to inform the rate-setting exercise. It was determined that a request of this nature would be in keeping with the parameters for technical assistance that have been developed by CSAT for the ATR pre-application period to ensure fairness to all applicants.

Methodology for Technical Assistance

Technical Assistance was provided via telephone conference calls, research and email correspondence over the course of approximately a month-long time period from April 26, 2004- May 20, 2004. Representatives from the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) involved in one or more of the teleconferences with Ms. Wiford included: Ben Brown, Steve Davis, Sheila Tillery, Jennifer Glover, June Elkins, Melissa Lang, Tracy Leeper, and Meridith Martin.

Content of TA Discussion

Overview of the Oklahoma ATR focus: The State’s ATR proposal will focus on two pilot county areas: Oklahoma and Caddo Counties. One is rural and the other urban. The focus of the State’s proposal will be an attempt to expand treatment capacity through the inclusion of faith-based and tribal affiliated providers for all adults who meet the State’s eligibility criteria, with a focus on the target populations of pregnant and parenting women. State’s strengths include the following existing infrastructure supports to implement the ATR program: a web-based system that collects information on the agency, the staff, the client and each service funded by the Department including a payment structure which reimburses providers on a fee for service based upon data provided. The web based system tracks clients over time and across agencies throughout

the system. The system will be modified to expand and collect the data required for the administration of the ATR project.

Questions for TA discussion:

1. Oklahoma: We would like to have a discussion and brainstorming session on what an incentive program for assessors, case managers, treatment providers, and recovery support providers would look like.

Discussion centered on rate setting and the State's ability to think outside of its current rate structure to allow the existing provider network and new providers to identify services, clients, and processes that would move the voucher clients to the front of the line while putting enough money into the services to create an incentive to have reports, data collection processes, and follow-up information (GPRAs) completed. Potential incentives the State could consider included the following:

- a. Withholding a portion of the payment for services until all data related to the admission was completed satisfactorily and turned into the State.*
- b. Providing a reasonable bonus to providers who had produced aggregate outcomes the State outlined as important; i.e. accessibility, increased capacity, demonstrated sobriety.*
- c. Providing a bonus to the top 10% of the programs whose data demonstrated 50% or greater sobriety among its voucher recipients.*

There was some discussion about insuring the incentives would happen on a regular basis, perhaps quarterly or monthly, as opposed to annually to insure that the providers stayed motivated and could realize or earn the incentive on a real and current basis.

2. Oklahoma: What outcomes should incentives be based on? For example, if you wait on the follow-up surveys, there could be response bias, gaming, etc. and not a representative sample by agency.

Discussion centered on creating incentives for the SA service providers and timing the incentives in order to reward providers in phases rather than all or nothing.

3. Oklahoma: What are some eligibility determinations for recovery support service providers?

Discussion centered on networks that currently exist in Oklahoma, or may have existed previously, that could be used as a model on which to build. The Oklahoma team identified that the State had created a network of providers with special eligibility standards to deal with emergency MH/SA services connected to the Oklahoma City bombing incident.

4. Oklahoma: How would you determine rates for recovery support services? What are some types of services that seem appropriate to purchase?

Discussion centered on new, expanded Medicaid type definitions of community support services that could serve as an existing model for a new recovery support

services type of definition in Oklahoma. Consultant agreed to research some existing models and rate structures and forward links to information available on the Internet.

Follow-up information

States that have these types of Medicaid reimbursable services providing this type of comprehensive wrap around services include:

- 1. Ohio for both MH and SA (since 1989),*
- 2. Georgia for both MH and SA (since 2002), and*
- 3. Texas for MH (consultant was uncertain whether it is being used in the Texas SA side).*

A. Clarification on the operative definition:

The building block upon which Community Support is based is assisting the client to develop skills in all life areas. The service providers should be asking themselves, "How can I help this client obtain the skills necessary to achieve the goals on their care plan/ treatment plan/ case management plan?" The current Medicaid definitions do not allow for the provision of the actual childcare, transportation, and skill building services but do arrange for the client to obtain these services. While it would not provide childcare or transportation, it would assist the client in working through the process necessary to figure out how to obtain or have those services in their lives. For example, having the client make an appointment for Vocational Rehabilitation, contacting a child welfare worker about how to obtain childcare, or exploring with the client all their options for transportation are the kinds of wrap around definitions that may serve as the building block for Oklahoma's ATR program. The State could use a definition like this and expand it to provide for those recovery supports through your voucher process.

Clarification on the billing side:

The level of professional who is paid to deliver the service determines the billing rate or unit rate for reimbursement. The State determines the type of professional who will most likely deliver the service and the supports needed for that professional to deliver the service (for example, a paraprofessional/ peer mentor if you utilize unlicensed/ non-certified individuals, as may be the case with employees from a faith-based organization). The rate for this type of wrap around service would need to include some level of acceptable supervision for your system. With Medicaid services of this type currently in existence, the service is billed in 15-minute increments. However, keep in mind that you can build your rate structure and reimbursement structure to fit whatever will work most effectively for the situation in Oklahoma. Of the three States offering this wrap around service, the rates range from \$60.00-70.00/hour for reimbursement for the service. The reimbursement rate is only for the wrap around care management services and not for the actual provision of the recovery support services like childcare, GED classes, and transportation. If the recovery support

services included these actual types of recovery supports, your rate structure would need to be modified to accommodate these additional types of services.

5. Oklahoma: What is an example of a market survey or proposal for marketing study?

Discussion centered on who the State would survey, what questions would be asked and a review of current services and rates to determine if a starting base exists upon which to initiate the market survey. For the application, the funds to support the development and initiation of the market survey instrument could be built into the start up costs. Potential market survey instruments which were discussed included surveying collecting cost and service data from other similar State Departments like Social Services and Child Welfare, who regularly contract for childcare and transportation services and have established histories with purchasing those types of supports services; developing a market survey tool for the two specific counties targeted for the project to collect provider availability, unit costs for potential contract services, and the existing provider network's accessibility and availability to offer services to the intended voucher populations.

6. Oklahoma: What are some examples to prevent waste, fraud and abuse?

Discussion centered on existing examples in the current system and how that is set up to prevent waste, fraud, and abuse. The State reps discussed how the web-based database could accommodate the ATR process and how checks and balances could be built into the web-based application. One model discussed focused on using the existing local county provider network to contract with faith-based and community organizations to provide the recovery support service. Employing a model like this would assist the state in building on a system that already has checks and balances for waste, fraud, and abuse and could provide new organizations with the administrative supports necessary to handle the ATR voucher program requirements. Other potential safeguards that were discussed included identifying those provider eligibility issues that would assist the State office in insuring that the provider organizations could operate with Federal and State funds and handle the financial side of the ATR program within acceptable legal boundaries. These include:

- requiring a clean financial audit as an eligibility criteria,*
- implementing annual reviews by a contracted auditing service from the County or State office which would review the financial processes related to the ATR grant,*
- conducting regular site visits by the State office to review monthly/ quarterly/ semi-annual financial statements related to the operation of the ATR program,*
- developing a client feedback mechanism which would report on a regular basis the client's satisfaction with, quality of, and responsiveness of the services received from the provider.*

7. Oklahoma: Do you have an example of an MOU we could use rather than a contract?

*Ms. Wiford could not provide an example of an MOU but did brainstorm with State reps about existing MOUs currently in use by the State office and what elements would be necessary to include in an MOU document for the ATR purpose. Ms. Wiford issued a caution to the state regarding the MOU process. Since the State's goal is to expand the network of providers, she suggested that the MOU only include the essential basic elements of an agreement. An existing sample MOU template which may be the basis for the development of the ATR MOU may be the draft *Qualified Service Organization Agreement (QSOA)* agreement available from the Legal Action Center's handbook pertaining to 42 CFR, Part 2. The group also discussed the pertinent aspects to an MOU that might be most applicable to the ATR voucher program context. These included: eligibility criteria for the providers, clinician qualifications for ATR providers, any overview or review process the State would identify for the provider network for the ATR program, minimum insurance requirements required by the State for providers, ATR requirement of not refusing any referrals, insuring the clients' free independent choice in providers, reporting and client outcome data requirements and timeframes, and any additional requirements the State thought important to add.*

8. Oklahoma: How do you handle clients going from one provider to another, i.e., they're unhappy with a provider and change to another one? Is this part of client choice or does it need to be capped at some point?

Discussion centered on some ways to structure the voucher process that would potentially minimize this effect from occurring including the implementation of a time limit during which the voucher would have to be acted upon, and naming the provider on the voucher to whom payment would be given. This would potentially set up a care manager structure whose role would be to manage the care process and any changes that occur during the course of treatment and recovery support services.

Recommendations

Ms. Wiford proposed the following recommendations to Oklahoma:

- a. The State should consider the use of a model that worked effectively in the Oklahoma City bombing incident, which allowed the State to suspend the usual provider requirements and solicit emergency mental health and substance abuse providers to accommodate the need for services. This model utilized existing State structures to build a network of non-traditional providers to deliver a specific set of services.
- b. Consider expanding upon Medicaid-type definitions of community support services to serve as the model for a new recovery support service prototype which could be expanded to include specific transportation, childcare, and any other service identified by the State which would increase the access, follow through, and accessibility for the identified client group to be served by the ATR program in Oklahoma.

- c. Consider using the Legal Action Center’s QSOA (Qualified Service Organization Agreement) as a potential draft MOU agreement. The existing QSOA would have to be modified to accommodate Oklahoma’s ATR guidelines and program requirements.
- d. Develop a market survey approach that includes other State divisions/ departments who have established purchasing guidelines and unit costs for those services identified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as integral recovery support services such as childcare and transportation.

Outcomes

Ms. Wiford provided additional research on existing models of recovery support services and rate structures. Examples are provided herein. The State will take the information provided under consideration in designing their proposed ATR system.

Consultant Background

Cynthia “Syd” Wiford, MRC, CCS, CSAS is an Assistant Clinical Professor at the School of Social Work, University of North Carolina at Chapel Hill and serves as the Coordinator of the Behavioral Healthcare Resource Program. In her role, Ms. Wiford provides technical assistance, consultation and training to the State of North Carolina Division of MH/DD/SA services and the State of Louisiana Office for Addictive Disorders on clinical best practice in addictions, public addiction program design, workforce development, and consumer advocacy and empowerment issues. Additionally, Ms. Wiford designs web-based competency interactive training sessions for addiction, mental health, and social services professionals. Ms. Wiford has been working in public addiction and mental health programs for over 25 years.