I wish to express my gratitude to all of the elected representatives who continue to make mental health care a concern. I am pleased that so many of you continue to address the flaws that exist in Oregon's mental health care system, and hope together we can make changes for the betterment of all. My apologies that I cannot be with you in Salem today, as Wednesdays are my major clinical day,and I have numerous appointments scheduled today.

To provide you with some context, I have served as the Associate Medical Director of Cascadia Behavioral Healthcare for the past 11 years. As you may know, Cascadia is a large provider of mental health care in Multnomah, Washington, and Lane counties, providing services including therapy, medication support/management, case management, housing, supported housing, crisis services, and a variety of other supports. Our agency works primarily with clients insured via Medicaid and Medicare. While I am not writing on the behalf of Cascadia today, but as a concerned individual, my employment includes addressing mental health care issues not just for the individual clients I work with, but also advocating for these clients as well as their care providers, and addressing larger system issues.

In my experience, any obstacle to a client obtaining medication makes care more difficult. I fear that HB 2421 will create such obstacles. At present, the current formulary system works well enough, as most providers are aware of which medications are routinely covered by OHP, and which will require prior authorization or have other limitations on their availability. Allowing each CCO to create their own formulary would be confusing, as providers often have no easy way to discover which clients are covered by which CCO's. As such, I fear that passage of HB2 2421 would create even more situations in which prescriptions would be rejected for being "off formulary," requiring additional paperwork for the provider, and additional wait time for the client. As the wait time for a prescription to be approved goes up, the time the client needs to suffer their symptoms increases, and the odds that the client will pick up the prescription (once approved) goes down. As these wait times can often run 7-10 days, this is a long time for a client in crisis to wait for relief.

In addition, restrictive formularies often force clients to fail a "preferred medication" (usually meaning a less expensive option) before being able to access a medication that will be more acceptable to them. In my work as the psychiatrist for the Multnomah County EASA team, I can assure you that sometimes a provider gets only one chance to prescribe a medication. If a client has a bad experience with the first medication trial, they often refuse to try other medications. While I certainly try to use generic options as my first choice of medication in general, I fear passage of HB 2421 would result in the creation of more restrictive formularies than currently exist. I fear those restrictive formularies would force me to prescribe a clinically less preferable medication. As a clinician, I would like the latitude to prescribe the most appropriate medication, not just the least expensive one, first. As an administrator, I believe costs could be contained by educating providers as to the financial burden of different medications, and encouraging them to start with cheaper/generic medications if at all appropriate, and reserve use of more expensive brand-name-only medications to situations only when/where it is truly preferable.

Finally, allowing CCO's to have individual formularies creates inequities in the care system. I currently have clients who are unable to access certain types of treatment based on their CCO coverage, while other clients assigned to a different CCO can access those treatments without a problem. I have difficult accepting that clients with essentially the same insurance (OHP) have differing care options based solely upon their covering CCO (to which they are often randomly assigned!). I fear differing CCO formularies would similarly create inequities in medication coverage, with the client often having no choice in addressing these inequities.

In brief, while our current OHP formulary system is not perfect, I believe HB 2421 would not improve the situation. In fact, I fear it would create more confusion, and decrease the quality of care received by clients. While I agree that formulary issues need to be addressed, I believe HB 2421 is not a good solution to the problems.

Thank you for your time, and for considering my opinions.

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