AOCMHP Testimony on SB 5526

Dear Co-Chairs Senator Bates and Representative Nathanson, and Members of the Joint Ways & Means Human Services Sub Committee,

On behalf of the Association of Oregon Community Mental Health Programs (AOCMHP), I would like to express our support for the OHA/AMH and MAP budgets. After hearing the discussions among the Committee members and state agency presenters over the past week on the community mental health system, I have the following observations for your consideration.

1. Multi-payer agreement needed

It is great that Oregon has expanded Medicaid and that about 95% of our state has some form of health insurance coverage, but one of the problems leading to gaps in services and programs is inconsistent coverage among payers. Many capacity-based crisis services are not covered by Medicaid, Medicare, Veterans Administration insurance or commercial insurance. The services and supports needed to keep people in the community are covered by a mix of State and County General Funds, SAMHSA block grants, other federal grants, and beer and wine tax revenue. In fact, nearly $49 million was contributed through County General Funds and direct federal grants to the community mental health system. These different funds are critical for core infrastructure to provide crisis services, partner with Law Enforcement on jail diversion, and to maintain system response. This revenue is used to keep existing services in place, while leveraging Medicaid to support the crisis system. Our flexibility to leverage other funds to create blended programs helps us get the most for the money.

The community mental health system payers must move away from a Fee-for-Service model of payment to a multi-payer agreement to pay for value (health outcomes) rather than encounters. Continuing with Fee-for-Service will not sustain the integrated care model we are trying to implement in Oregon. In order to decrease long term costs to payers and negative health consequences for the people we cover, the delivery system must be able to provide practical models and system reform initiatives that incorporate social wraparound services and emerging or evidence-based practices. Specifically, we must align payment with completion of core performance measures, incorporate case rates for preventive care to avert suicides and other bad outcomes, and address payment structures that create barriers to integration of care, such as policies that prevent same day billing for multiple health care services. There are many examples of services and programs that do not fit in a medical, Fee-for-Service model of payment, but here are a few examples:

- Medication assisted treatment for addictions - Ensure that approved medications for treating addiction are covered in all insurance plans, including naloxone for opioid overdoses. Inappropriate limitations on dosage or duration and outright exclusions of particular medications should be eliminated.
- Discharge and transition services for people experiencing behavioral health crises - Increase coverage for continuity of care to ensure that appropriate services are in place

for individuals with behavioral health conditions recently discharged from emergency departments, acute care units, and inpatient psychiatric units. Patients discharged from these settings have been shown to have the highest risk of suicide of any population.

- Early Psychosis intervention (Early Assessment and Support Alliance) case rate coverage – Covering capacity based and health team services will support recovery in the community and prevent crises, higher and more expensive levels of care (e.g., hospitalization), and suicide.

Invest in Public Safety-Mental Health system partnerships

Community based alternatives to incarceration are tried and true but under-resourced. There are examples of communities across the nation and in Oregon that are doing good work and seeing positive outcomes. Unfortunately, funding for these services has been spotty without targeted investments in building the necessary systems and supports. We enthusiastically support a second round of targeted legislative investments to fully fund the community mental health system, including services for people who are justice involved or at risk for incarceration.

A robust array of crisis services, crisis intervention training for Law Enforcement, Assertive Community Treatment, respite services, supported housing and sobering stations - along with meaningful collaboration between Behavioral Health, Criminal Justice and Public Safety systems - are key to successful community based alternatives to incarceration. This service array is supported by the USDOJ in its recent letter of 3-11-15 to the State of Oregon: "It is vital that the State work collaboratively with local agencies to develop strategies to address services for individuals experiencing mental health crises and to prevent their unnecessary hospitalization and incarceration."

Cost avoidance/benefit data collection for jail diversion programs is just beginning in Oregon; there have been studies across the nation that show better outcomes and lower cost, however, and one in Washington State revealed that for those individuals with criminal justice involvement who receive addictions treatment, the re-arrest rate is 33 percent lower than for those who do not receive treatment. This translates to $2.05 in taxpayer benefits per dollar of cost and the largest savings are associated with reduced health care costs.

Early innovators around the country have published outcome measures, cost benefit data, and return on investment information. As I've reviewed the various outcome measures and looked especially closely at the Bexar County, TX and Salt Lake County, UT models, the core measures appear to be:

- Reduce incarceration of individuals with MI or SUD
- Reduce recidivism
- Reduce arrests, ED visits, ambulance rides, and bookings
- Successful implementation should also show cost savings and return on investment

Several counties have started collecting this data and have enhanced community capacity to provide treatment alternatives to incarceration, including increased use of community competency restoration programs, FACT and other intensive, wraparound services. We will work with our Public Safety partners to more effectively track the data to show successful outcomes for our justice-involved population.

Invest in Behavioral Health Workforce

In order to fully integrate physical and behavioral health care, and reach the health outcomes we have set for Oregon, we must invest in our behavioral health workforce, licensed and unlicensed, from peer support specialists to psychiatrists. We already have some promising and successful practices with peer mentors, cross-system coordination between Public Safety and Mental Health, and between Primary Care and Mental Health, and telepsychiatry. We also have challenges in recruiting enough behavioral health providers, especially in rural and frontier areas, and we have some specific training needs for older adult mental health and addictions care and for co-occurring treatment of mental illness and substance use disorders.

Additionally, there are federal issues we need to resolve: 1) Expand Medicare and Veterans Administration reimbursement to other providers in addition to social workers; and 2) Revise 42 CFR Part 2 to improve integrated and coordinated care by allowing health information exchange between providers.

Support for System Mapping and Gap Analysis

AOCMHP supports the concept of developing improvements to the community mental health system through a comprehensive mapping and gap analysis across the State. A gap analysis was recently conducted in Washington State and revealed that 65% of those needing ambulatory mental health service did not receive care in 2014. A five-year plan to move from serving 35% of the need to 75% of the need has been developed. Managed care entities, working with state and local partners, will identify the most important gaps in the delivery system, determine the evidence-based practices that can be used to effectively address these gaps, and leverage the new resources to successfully implement the improvements. We recommend following this process in Oregon.

Thank you for the opportunity to testify and we look forward to working with you on improving the community mental health system in Oregon.

Sincerely,

Cherryl L. Ramirez

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