ASSOCIATION OF OREGON COMMUNITY MENTAL HEALTH PROGRAMS
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Testimony in support of HB 5026 – Health Systems Division/Health Policy & Analytics Budget *Revised*

February 21, 2017

Dear Co-Chairs Steiner-Hayward and Rayfield, Members of Ways & Means Human Services Subcommittee,

On behalf of the Association of Oregon Community Mental Health Programs (AOCMHP), I support the Oregon Health Authority-Health Systems Division and Health Policy and Analytics budgets in HB 5026. We especially want to emphasize that this is not the time to cut the small percentage of the OHA budget that is non-Medicaid as this funding supports the underpinning of many key components of the community mental health system, from primary prevention and early intervention programs for the whole community to crisis and jail diversion services, supported housing and employment, peer support, and intensive treatment programs that are integral to meeting the expectations of the USDOJ-Oregon Performance Plan.

Access

One big challenge faced by the behavioral health system has been access. Access is a complicated and multifaceted problem affected by multiple factors, such as inadequate investment in the entire care continuum of community-based services, provider shortages, unequal responsibility among payers for behavioral health, unclear roles and gaps between responsibilities of system partners, and unwillingness of individuals to engage in treatment because of stigma, perceptions about the mental health system and other barriers. In a 2015 gap analysis conducted by Dale Jarvis for the Oregon Health Plan members (Medicaid recipients), 386,554 were estimated to need mental health services, but 263,735 either did not receive services or were only partially served. In order to close the gap, an additional 2,476 FTEs and over $300 million are needed for the Medicaid population alone. Likewise, for the 87,909 Oregonians with substance use disorders who received no services or partial services, 329 FTEs and over $44 million are needed to close the gap.

The solution is not just to provide more services to more people. Interventions must be customized to the specific needs of individuals, families, cultures and communities and include population based strategies as well as person-centered services. As we figure out how to share and shift responsibilities among federal, state, county and city governments, managed care, and a variety of providers and other system partners, we struggle with different and competitive ideologies. We'll need to work to build trust as we move into new roles and partnerships.

Mental Health Parity and Addictions Equity

We will not be able to transform our behavioral health system without parity in coverage and reimbursement from commercial insurance, Medicare and the Veterans Administration for essential behavioral health services and supports that are currently almost solely funded by

Medicaid, State and County GF, and federal or foundation grants. Crisis system funding is a good example of the parity problem, and is described below:

Community Mental Health Programs manage the crisis and safety net system for all residents of their counties. Components of a robust set of crisis and safety net services include 24-hour crisis lines that have a robust connection with local services, urgent assessment and triage, brief stabilization, mobile outreach, peer support, jail diversion and pre- commitment investigations. These services are contractually required of the counties in our agreements with the Oregon Health Authority and CCOs. In order to maintain continuous operations and to provide for 24-hour availability, a large investment in operating infrastructure is necessary. These services are generally not well supported using a traditional fee-for-service methodology for reimbursement as much of the service provided is non-encounterable. Non-encounterable services include crisis line interventions, outreach and engagement, and services provided to individuals in absence of a comprehensive mental health assessment.

While a majority of crisis system users are enrolled in Medicaid, anyone in the community may access crisis services, including mobile crisis teams, law enforcement collaboration, intensive transition teams, peer crisis support, and urgent walk-in programs. Individuals may have commercial insurance, Medicare, VA benefits or no coverage. Following Medicaid expansion under the Affordable Care Act, the state reduced the amount of general fund given to the counties, with the assumption that other funds would be leveraged. Unfortunately, crisis and jail diversion services are virtually not funded by commercial insurance, Medicare, or the VA. As an example, the total cost for crisis system services in the Portland metro for 2015 was $12,897,099. The total FFS revenue from CCOs was about $300,000 and the remainder was paid by State and County general funds as well as capacity funding from Health Share of Oregon. Medicare, commercially insured, VA, and Medicaid members outside of the Health Share CCO had their services primarily covered by state and local general funds.

<u>What's going well in Oregon?</u>

Community mental health programs, together with Public Safety, Education, Child Welfare, Primary Care, and other system partners have made great strides in cross system coordination. Decarceration initiatives have progressed through investments in mobile crisis and jail diversion, and are implemented across Oregon. A targeted effort to decrease the number of people who are unable to aid and assist in their own defense and are restored at Oregon State Hospital (OSH) is starting to reap return on investment:

Multnomah County and the Oregon Health Authority annually invest $768,000 in diversion for Aid and Assist (or .370) clients. An average .370 client spends more than three months and incurs $95,400 per stay at the OSH. With three months of local restoration at $11,041, the county can divert clients from the OSH and other high cost services. In FY 17 Multnomah County projects a $6 million return on investment, benefitting the state and public safety system.

Another example of lower costs resulting from appropriate investment is Benton County's Assertive Community Treatment (ACT) Team's successful decrease in inpatient care:

After 1 year in ACT, total inpatient length of stay decreased from 164 to 25 days (85%) and inpatient costs decreased from $147,296 to $27,850 (81%), while outpatient costs only increased from $73,126 to $98,736 (35%).

Together with our CCO and primary care partners, CMHPs are stepping up efforts to integrate care. There is a lot of work being done to ensure warm hand offs between primary and behavioral health care, establish collaborative relationships, share information and in the

responsibility of their members' health outcomes. We are particularly optimistic about OHA's Certified Community Behavioral Health Clinics (CCBHC) demonstration pilot for people with serious mental illness and chronic substance use disorders, children and adolescents with serious behavioral health challenges, and those with co-occurring behavioral health and physical health disorders. This demonstration pilot, which does not receive additional support from State GF, will help Oregon's health system get to where it needs to go for a smaller population, but one most in need of coordinated, integrated quality care. Taking care of this population with multiple needs will contribute to better health outcomes and relieve the cost burden on the health care system. Ten out of 13 of the CCBHC pilots are CMHPs, representing all geographic regions of the state.

The increasing evidence that prevention is cost effective

We are also advancing population health, from universal health promotion and chronic behavioral health disorder prevention, like Mental Health First Aid and suicide awareness/prevention initiatives, to secondary and tertiary prevention activities. The evidence of cost effectiveness and return on investment for prevention initiatives is growing:

Examples of Prevention Program Cost Effectiveness and Return on Investment

Program	Cost Effectiveness/Return on Investment
10 out of 12 substance use prevention programs for youth	3:1 to 1000:1.2 cost benefit ratio
SAMHSA Systems of Care initiatives	Reduction in hospital days/year: $2,777 per child Reduction of inpatient care for children by 54% Percentage of youth harming themselves or attempting suicide decreased 32% after 1 year
Good Behavior Game	50-90% decrease in disruptive or disorderly behavior in school 10-30% reduction in referrals, suspensions, or expulsions $1:$58.56 cost benefit ratio
The Triple P – Positive Parenting Program	Reduction in prevalence of conduct disorder; cost savings until prevalence reaches 7%
Life skills training for adolescents using substances	$1:$13 return on investment
Functional Family Therapy	Reduction in juvenile justice system costs, crime and recidivism; Savings of $47,776/individual/year
Multi-systemic Therapy	Reduction in juvenile justice system costs, crime and recidivism; Savings of $17,694/individual/year

Sources: SAMHSA, Institute of Medicine, National Registry of Evidence-based Programs and Practices

Other Examples of cost effective prevention initiatives from Wsipp.wa.gov/BenefitCost:

- Parent Child Interaction Therapy (PCIT) for families in the child welfare system - $19,466 savings or 1:$12.99.
- Family-based therapy $33,004 cost savings or 1:$20.56
- Functional Family Therapy $28,723 savings or 1:$9.38
- Triple P for disruptive behavior $2,387 savings or 1:$3.43

Additionally, there has been great progress made in the Children's system of care through Wraparound for children who are Medicaid eligible, as evidenced by Marion County reported outcomes from 2015:

- 41% reduction in average number of days in psychiatric day treatment
- 50% reduction in average number of days in psychiatric residential treatment services
- 58% decrease in overall use of acute and subacute care by children and adolescents
- 43% decrease in cost per client for psychiatric residential treatment

For families exiting Wraparound:

- 96% of families have a PCP for their children
- 91% of families report having family and/or a social network that helps their family
- 96% of families are satisfied with wraparound process
- 90% of youth were living in a permanent home with a family

While the Behavioral Health system may be the lead on most behavioral health care, positive health outcomes are dependent on cross system coordination with Public Safety, Criminal Justice, Education, Child Welfare, Primary Care, Housing and other system partners. It will be important to incorporate United States Department of Justice (USDOJ) agreement directives, including stable housing and supports, in OHA and other state agency budgets. It is essential that all payers participate and fund care coordination, braiding resources together and all systems pitching in to get to the agreed upon outcomes.

We look forward to working with the Oregon Health Authority, Legislature, and system partners to discuss and prioritize a set of key solutions. Thank you for the opportunity to testify on the Health Systems Division/Health Policy & Analytics portion of the OHA budget in HB 5026.

Sincerely,

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