Written Statement for the

Committee on Finance

United States Senate

Mental Health in America: Where Are We Now?

April 28, 2016

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Chairman Hatch, Ranking Member Wyden, Honorable Members of the Committee, thank you for this opportunity to offer testimony on mental health services provided through the Medicaid program and Oregon's innovations in service delivery.

I have spent the better part of thirty years as a leader in the mental health services provider community in Oregon and abroad. I have worked as a mental health provider in the community and hospital settings, as a program administrator, and as a leader in organizational change. I have performed hundreds of consultations, both nationally and internationally, on trauma-informed care and the elimination of seclusion and restraints in psychiatric care settings (see biography below). What I have learned in this time is that behavioral health—stable mental health and freedom from substance use disorders—is simply health. In other words, "health" requires not merely the absence of physical disease but a state of wellbeing in physical, dental, social, and mental health.

Currently, I serve as Chief Medical Officer for Health Share of Oregon, the state's largest Coordinated Care Organization (CCO). Health Share is a transformative model of Medicaid managed care that brings together local health plan, provider, and community organizations to coordinate physical, dental, mental health, and substance use disorder benefits for more than 25 percent of Oregon's Medicaid enrollees.

The CCO model was created by a Medicaid 1115 Demonstration Waiver four years ago, and Health Share was a new organization created specifically to fit that model. Even in this short time, the CCO model, which provides financial incentives for improving health care delivery, has allowed us to uncover data to support a simple truth about the population we serve: the most frequent and costly utilizers of Medicaid services are adults who experienced childhood trauma.

This discovery, and the CCO model in general, has brought new attention to and appreciation of the roles of mental illness and addictions in costs and poor health outcomes. As a result, there are initiatives in communities across the state to increase access to mental health and addictions services, integrate behavioral specialists into primary care, and ensure better primary care supports to people with serious mental illness.

In this testimony, I will: explore the promise of the CCO model; describe the impetus of Health Share of Oregon's decision to focus on access to services and promotion of early life health; provide examples of upstream interventions that Health Share believes will bend the cost curve in the long-term; describe the

extant mental health system challenges that communities are addressing in Oregon and across the country; and comment on federal policy challenges in the mental health and substance use disorder space.

Medicaid Coordinated Care Organizations: the Promise of Oregon's Health System Transformation

Oregon's CCOs are regional Medicaid managed care contractors, each with a governance model that reflects its community and health services marketplace. Each CCO has at least one Community Advisory Council that is made up of a majority of CCO enrollees. All sixteen CCOs have two things in common: they are all different because they each reflect the community they serve, and they share the goals of better care, smarter spending and healthier people. There are a number of programs and incentives designed to help CCOs obtain those goals, including but not limited to:

- Integration of physical health, mental health, oral health, non-emergency medical transportation, addiction residential services, and children's wrap around services into each CCO
- Withholding 5 percent of CCO budgets to be paid based on performance on robust set of incentive metrics
- Requiring development of alternative payment methodologies and hosting "learning collaboratives" to spread successful models
- Requiring CCOs to cover some "flexible services", which are non-covered services that may be more cost effective alternatives to covered services (e.g., vacuums for families whose children suffer from severe asthma; healthy meal vouchers)
- Requiring CCOs to conduct regular community health needs assessments and implement community health improvement plans

The CCO model is already showing signs of success. This program is expected to save the state and federal governments $1.7 billion on Oregon's Medicaid program over the first five-year demonstration.

Oregon made a significant promise to CMS when it signed the current Medicaid waiver agreement—that through the CCO model, our State would decrease the expected Medicaid spending trend by 2 percent over five years, not by cutting the number of individuals served or reducing provider payment rates, but by improving the way Medicaid services are delivered. CCOs did not have much time to make good on this promise, so we began with addressing the highest utilizing and most costly members.

The Need to Work Upstream: What We Learned from the Adverse Childhood Experiences Study (ACES)

When Health Share analyzed those among our 240,000 members who used the most services and led to the highest costs, we began by asking them to describe their lives. The results were compelling. Very often these members were born into unstable housing and chaotic families, and to parents who did not intend to have children and were not ready or able to parent. Some had been in and out of the foster child system early in life; many had been sexually or physically abused. Most did not have childhoods that prepared them to be successful in school. There was often drug use and other high-risk behavior during adolescence. Often their drug use had led to brushes with the criminal justice system. Many became parents themselves when they were not yet ready or able to parent. Most had various erratic behaviors, depression, or suicidal tendencies that led them to require services in specialty mental health if they could get access, or to jails or hospitals if they could not. Many had never finished school, and many had more than one chronic physical condition.

This is exactly what the Adverse Childhood Experiences Study (ACES), published in 1998, revealed: there is a powerful relationship between adversity and toxic stress during childhood and our physical and mental health as adults, as well as the major causes of adult mortality in the U.S.

We know that almost half of children in the U.S. grow up in poverty, which is an important social determinant of health and contributes to child health and developmental disparities. Growing up in a stable and healthy home, in a language rich environment, and having access to quality preschool and regular well visits to a medical home are all critical for developing social and emotional competencies in children as they prepare to enter school. Evidence also shows that kindergarten readiness and success is linked with later educational success, which in turn is associated with better health and economic outcomes[i]. In other words, if children are prepared mentally, emotionally, and physically for kindergarten, they are more likely to be healthy adults. To be effective parents, adults need to be healthy themselves. To be healthy, they need access to physical, mental, and dental services. The cycle of poverty is one that we, in the health care community, have a role in ending.

Health Share of Oregon, in the face of such evidence, determined that if we are to move the dial on curbing Medicaid costs, we needed to move "upstream" in our efforts to improve health. We needed to build systems and communities that create effective parents and healthy, stable environments for children. To that end, Health Share is focused on helping our members: avoid unwanted pregnancies; access social, physical, and mental health supports during pregnancy; have their basic needs met in order to successfully be able to attach to their new babies; and get the support and guidance they need to be effective parents.

<u>What the Decision to Move Upstream Means for Mental Health Services</u>

Community mental health services have traditionally focused on people who have already developed chronic and severe mental illness. By adding emphasis to early childhood supports and the social determinants of health, focusing on early intervention, partnering with schools, and paying attention to the availability of mental health supports within a community, perhaps we can mitigate the tragic long term effects of the toxic stress described in the ACE study.

Nationally, people with serious mental illness die on average 25 years sooner than the general public[ii]; this statistic has been even more severe in Oregon[iii]. These early deaths are almost always because of chronic physical illnesses that are modifiable, with the right supports. Oregon's CCOs are working hard to identify those "right supports".

Senator Stabenow's *Excellence in Mental Health Act* is key to identifying those "right supports" and is, in my view, one of the most important legislative initiatives addressing mental health since the 1960s. This legislation builds on the original *Community Mental Health Act*, which described the continuum of services required to move from institutional care for people with serious mental illness to the community. Senator Stabenow's legislation now brings us to the important recognition that community mental health services also need to be providing or coordinating primary care because people with serious mental illness may not get health care anywhere else. Oregon is one of the eight pilot states, and improving care in community mental health centers fits in very well with the overall CCO model.

Moving Upstream for Special Populations: Creating Medical Models for Children in Foster Care and Addicted Mothers

Designing Health Care Systems that Work for Children in Foster Care

Through analysis of our population data, which mirror national data, we know that children ages 0-6 in the foster care system have a much higher incidence of asthma, attention deficit disorder, PTSD, and obesity than children in Medicaid who are not in the foster care system. These differences persist in older children, with the addition of much higher incidence of depression, and by late teens/early adulthood, the addition of higher incidence of schizophrenia and hypertension. The most surprising finding for us was that these differences persist, and are even higher, in children who were in the foster care system at one time but are no longer involved in the child welfare system. In other words, the experience in the foster care system was not healing, and did not provide a safe way to ensure healthy development, either physically or emotionally. We as a society need to address the root of this issue by ensuring the right supports to parents in the first place, so they keep their children in safe and nurturing families. In the meantime, we at Health Share are also focusing on developing coordination among mental health, dental health, and physical health providers for these kids, and describing what the right supports are for them in those health care arenas.

In October 2015, Health Share launched the Foster Care Advanced Primary Care Collaborative with seven of our area's clinics and clinic systems. The Foster Care APC is a year-long learning collaborative to explore and implement Foster Care Medical Home Models and interventions to better support the health needs of foster children. The collaborative consists of six half-day learning sessions held every other month that are focused on key population dynamics, such as identifying children in foster care, working with victims of abuse, neglect and trauma, understanding child welfare systems and processes, working with foster parents and biological families, coordinating with the mental health system of care, and more. Teams of four to eight staff from each clinic participate in each learning session. On the off months between learning sessions, a Steering Committee meets to help tailor the next session topic to meet needs identified by the clinics as they implement their models. The Steering Committee includes one representative from each clinic system along with a small group of local clinical and population champions from various organizations. These seven clinic systems together provide primary care to more than 1,000 foster children in Health Share's three counties and look to play an integral role in developing a system of care that meets the unique needs of this vulnerable population.

Project Nurture: Serving Pregnant Women with Substance Use Disorders

Another example of a special population that requires our immediate attention if we want to improve the health of future generations is pregnant women with substance use disorders. There are obvious fetal development risks involved with pregnant women battling addictions. These risks can be mitigated with proper treatment, but these women need to feel safe accessing appropriate medical care. To that end, Health Share funded the development of, and continues to support, a program called Project Nurture.

Project Nurture provides prenatal care, inpatient maternity care, and postpartum care for women who struggle with addictions, as well as pediatric care for their infants. Women who are enrolled also receive Level 1 outpatient addiction treatment by certified alcohol and drug counselors (CADCs), and Medication Assisted Therapy (MAT) using methadone or buprenorphine when indicated. Project Nurture's model is to engage women in prenatal care and drug treatment as early in pregnancy as possible, provide inpatient care for their delivery and follow them and their infants for a year

postpartum providing case management and advocacy services throughout. Women who participate in Project Nurture are informed of policies regarding Child Welfare reporting and we believe that this transparency facilitates a trusting relationship with providers and allows us to advocate for women and their families whenever possible.

The Importance of Health Coverage to Improving Mental Health in America

Oregon was also an early adopter of Medicaid expansion under the Affordable Care Act (ACA). This was crucial for people with serious mental illness in our state. Without insurance coverage, people could not access community mental health services except for crisis, ERs, and hospitals – the least efficient and effective times and ways to aid recovery, and the most expensive. Nearly everyone in Oregon now has better access to services, and sooner. Things are looking up for people best served in community mental health settings, but we still have a long way to go.

Mental Health System Issues: Levels of Care and Workforce Challenges

One Size Does Not Fit All: Levels of Care in Community Mental Health

Even with nearly universal health coverage in Oregon, access to specialty mental health services is still not necessarily smooth or easy, and the array of services are not as broad and varied as is necessary for optimal health. A contributing factor is glaring holes in availability of certain types of mental health services along the spectrum of levels of care for people with mental illness.

Most community mental health services are office-based outpatient programs. Many people with serious mental illness need more intensive supports initially, and then episodically thereafter.

Intensive outpatient and assertive community treatment (ACT) models offer to literally meet the person where they are, at whatever hour works best for them (a lot of people served in community mental health centers are homeless or without transportation). ACT teams, sorely lacking in many states, including Oregon, are multidisciplinary teams that are on call to the individual 24/7, and help with myriad social supports in addition to psychiatric support. Although these teams require significant up-front investment, it is clear that they are extremely effective and ultimately cost-saving for people who otherwise cannot engage in traditionally administered clinic-based services, and who end up using the most expensive settings—EDs, jails, and hospitals—as their default service systems. Health Share is proud to have funded for our community what we believe to be the first forensic ACT team in the United States—designed specifically for people with high engagement with the criminal justice system.

Independent housing, supportive housing, supported education, and supported employment are also key components of a highly functioning community mental health system. The CCO model was intended to allow Medicaid managed care entities to expand payment for these types of services, which are not traditionally covered health care services. Oregon's CCOs are still learning how to best provide access to these necessary services without reducing payment rates that are largely based on utilization of traditional medical services.

Provider Workforce Challenges

There is a shortage of psychiatrists nationally, including in Oregon; 59 percent of psychiatrists are 55 or older, and not enough physicians are being trained. Federal health authorities have designated 4,000

areas in the United States as having insufficient access to psychiatry – areas with more than 30,000 people per psychiatrist. We need to train more psychiatrists.

In community mental health, workers are often entry-level and overworked. Once experienced, they move on to private practices or hospital settings for better pay and better working conditions. We need to make community mental health more attractive workplaces.

In addition to training more psychiatrists and improving working conditions in community mental health centers, we need to broaden our idea of who provides care (including peers and community health workers) and what that care looks like. The mental health provider community is only just beginning to understand the tremendous power of peer supports in mental health treatment. People with lived experience of mental illness and recovery are often the best coaches and system navigators; they expand the workforce, give relief to over-taxed professional teams, and are extremely effective and well-liked by those they serve. Our systems are working to integrate peers into treatment settings and teams, but there is work to do. Specifically, CCOs and other payers need to develop payment models to support these types of workers.

One program that Health Share has implemented in an attempt to address workforce challenges is Project ECHO. This is a tremendously successful "tele-mentoring" model developed by Sanjeev Arora, MD at the University of New Mexico to upskill primary care providers to be able to provide treatment to people with Hepatitis-C. Health Share, in cooperation with one of our founding organizations, Oregon Health and Science University (OHSU), brought the ECHO model to Oregon. Instead of using the model to train PCPs in treatment of HCV, we began by using the technology to train PCPs in psychiatric medication management. Oregon, as noted above, suffers from a shortage of psychiatrists. We used the ECHO model to bring teaching and consultation from psychiatrists to PCPs serving our members and, eventually, across the state. Building on that success, we started a second ECHO model this year, which is upskilling PCPs in developmental pediatrics, teaching them to screen for and treat developmental issues, such as trauma, ADHD or autism.

<u>Medicaid Payment and Policy Issues: the IMD Exclusion, Mental Health Parity and 42 CFR Part 2</u>

IMD Exclusion

Experts agree that limiting institutionalization is an important policy goal. Oregon remains a national leader in providing long-term care services in home and community settings. However, it seems that the "IMD Exclusion"—the part of the Medicaid rules that prohibits use of Medicaid dollars for adult stays in "institutes for mental disease"—has lost its utility, at least in the context of limiting institutionalization.

The Supreme Court decision in *Olmstead v. L.C.* makes it clear that under the Americans with Disabilities Act (ADA), states are generally required to provide care in a community-based setting provided that the "State's treatment professionals have determined that community placement is appropriate, the transfer from institutional care to a less restrictive setting is not opposed by the affected individual, and the placement can be reasonably accommodated, taking into account the resources available to the State and the needs of others with mental disabilities." Repeal of the IMD Exclusion would not be expected to adversely impact efforts to establish community based care for, but rather to assure appropriate treatment for, those individuals needing care in an IMD.

In its recently released final Medicaid managed care rules, CMS partially lifted the exclusion for certain brief lengths of stay (15 days within a calendar month, up to 30 consecutive days over two months). CMS reasons the increased flexibility is warranted by a decline in the number of inpatient psychiatric care facilities and concerns about access issues for those who need inpatient care, and psychiatric boarding in emergency rooms. The limited length of stay, CMS reasons, would preclude the use of IMDs for long-term care, indicating that Medicaid is trying to balance the need for inpatient psychiatric beds with a desire to limit institutionalization.

For consumers, this provides more options if hospital-based care is needed. For provider organizations, this change would offer the opportunity for acute care programs with 16 or more beds to participate in the Medicaid program – and to offer more robust crisis response programs and alternatives to hospitalization.

A full reversal of the IMD exclusion is likely not fiscally practical, but revising the law even further could give providers better incentives to ensure access to the right level of care at the right time.

Allowing states to apply for waiver authority to exclude substance use disorders facilities from the IMD exclusion was a step in the right direction. The length of stay in an acute setting that is necessary for effective treatment of substance use disorders is typically longer than that needed for treatment of mental illness in an acute setting.

Allowing Medicaid payments for IMDs with average inpatient stays that exceed the current 15 day limit, such as 30 or 60 days, would be a stepwise approach to ensuring better access for Medicaid enrollees. Congress could also narrow the definition of IMDs to facilities with more than 30 or more psychiatric beds. These approaches would leave the IMD exclusion itself in place while making access to short-term inpatient care more accessible.

Mental Health Parity

Oregon was very early to ensure parity in access to mental health benefits. Part of what makes Oregon's Medicaid program unique is that in times of economic hardship for the State, rather than limiting the number of eligible Oregonians Medicaid can serve, we choose to use a public, deliberative, and evidence-based process to limit the benefit package, which we call the Prioritized List of Services. For more than twenty years, mental health conditions have been ranked amongst physical health conditions on the prioritized list. However, there are still non-quantifiable issues of parity – the need to be quite advanced in symptoms before getting access to specialty mental health and a high threshold for Medicaid enrollees to access hospitalization (dangerous to self or others). Truly effective parity still needs definition.

42 CFR Part 2: Privacy Protection and Sharing Information in a Coordinated Care Environment

Sharing pertinent health care information about our members is fundamental to providing truly coordinated care. We appreciate the concerns that lingering stigma about behavioral health issues, and substance use disorders in particular, raises for our members. Patients' trust is fundamental to their acceptance of treatment, so privacy is a particular concern for people receiving treatment for addictions. That said, SAMSHA's regulation, 42 CFR Part 2, which prohibits providers and health plans from sharing information about substance use disorder diagnoses and treatment plans with each other—and goes well beyond the privacy protections afforded to other health services through the Health Insurance Portability and Accountability Act (HIPAA)—restricts the sharing of information in a way that is detrimental to the

people receiving treatment. As the greater health care community has shown through HIPAA, we are capable of limiting the sharing of information to what is absolutely necessary to provide the best possible care. We are encouraged by SAMHSA's current proposed regulations and hope to move to a regulatory environment where substance use disorder diagnosis and treatment information is treated like any other personal health information.

The Future of Mental Health in America Looks Bright, but We Have Work to Do

I am proud of what we have already accomplished at Health Share of Oregon, and I believe that this regional, collective impact model could work in any community and with other health care payer types. Looking upstream to social determinants of health, including poverty, and preventing trauma and chronic stress in childhood will reduce the incidence of all illness—both physical and mental. I encourage Congress to continue to support the kind of flexibility in the Medicaid program that allows states like Oregon to improve the health of our population and lower costs by focusing on prevention rather than the volume of services used to treat people once they are already ill.

[i] Jones, D, et al. (2015). Early Social-Emotional Functioning and Public Health: The Relationship between Kindergarten Social Competence and Future Wellness. American Journal of Public Health. Vol. 105, No. 11, pp. 2283-2290.

[ii] Parks, J.,et al. (2006). Morbidity and Mortality in People with Serious Mental Illness. Alexandria, VA: National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council.

[iii] (2008). Measuring Premature Mortality among Oregonians. Salem, OR: Oregon Department of Human Services Addictions and Mental Health.

Maggie Bennington-Davis, MD, MMM
Biography 2016

Dr. Maggie Bennington-Davis is Chief Medical Officer for Health Share of Oregon, Oregon's largest Coordinated Care Organization (CCO). Health Share coordinates physical, dental, and mental health benefits for 240,000 Medicaid-enrolled Oregonians. Oregon is in the midst of massive health transformation, seeking more effective ways to engage and provide health care to Medicaid members.

Maggie also serves as Chair of the Incentive Metrics and Scoring Committee, the body that determines incentivized outcome measures for all CCOs in Oregon.

Maggie moved to Health Share from her position as Chief Medical and Operating Officer at Cascadia Behavioral Healthcare, Oregon's largest mental health and addictions provider with a comprehensive continuum of services, including crisis services and housing.

Prior to Cascadia, Maggie served as Psychiatry Medical Director for a regional medical center (Salem Hospital), as well as hospital-wide Chief of Staff. Maggie led development of a cultural change model for implementation of trauma-sensitive services with the subsequent elimination of seclusion and restraint on an acute psychiatric inpatient unit based on the early work of Dr. Sandra Bloom. Maggie co-authored a book, published articles and chapters on the subject, and has done numerous consultations and presentations both nationally and internationally regarding organizational change, trauma-informed, engaging environments, and leadership. Maggie has served as faculty for the Sanctuary Institute.

Maggie completed her MD and psychiatry residency at Oregon Health Sciences University where she remains on faculty, and a Masters of Medical Management degree at Tulane University School of Public Health in 2005.