**Responses to Questions Raised in Ways and Means Sub-Committee on 4/16/13**

Addictions and Mental Health Division

*April 18, 2013*

*What is the response time for EASA in the counties that have the program? (Senator Bates)*

Fidelity to the EASA model requires no wait time. For example, if someone gets a call about someone at the hospital or in crisis it is not uncommon for them to be seen that day. AMH requires all programs to have 24 hour access to triage services and rapid response, and to respond to all referrals within 2 days. Also, waiting lists are not allowed. Sometimes it takes a while to get the person engaged if they are very symptomatic, but the program will engage immediately with the parent or other support person to help them with problem solving. Access to the physician is required to be no longer than 1 week, with most programs able to respond even faster depending on need. The technical assistance center conducts fidelity monitoring to insure adherence to the standards.

*How did AMH select Portland State University as location for the technical assistance center for EASA? (Representative Freeman)*

A modified RFP, following requirements for an inter-governmental solicitation, was conducted. Three university-based research and training centers were contacted and interviewed using a standardized set of questions. Those were Oregon Social Learning Center at the University of Oregon, the Teaching Research Center at Western Oregon University, and the Regional Research Institute at Portland State University. Responses to the questions revealed that RRI has the most closely aligned mission and expertise for the EASA Center for Excellence. AMH is currently in contract negotiations with PSU and the cost of the contract has not been settled.

*There was a request for further explanation of the modeling of the Medicaid expansion. (Senator Bates)*

Please see attached document, "Effect of Medicaid Expansion on the Behavioral Health System."

*Why is Individual Treatment and Recovery Supports (ITRS)in the Addictions and Mental Health Division budget? (Senator Bates)*

Please see attached document, “Individual Treatment and Recovery Services in the Addictions and Mental Health Budget”.

**Effect of Medicaid Expansion on the Behavioral Health System**
Addictions and Mental Health Division

Mental Health Services:

Estimating the impact on state funded programs is a challenging task. While many individuals with a severe mental illness will become eligible with the Medicaid expansion, the challenges of their illness interfere with them getting enrolled. In addition, many of their services will be non-Medicaid services.[1]

Therefore, the Addictions and Mental Health Division (AMH) examined the funding for specific service categories to determine if some of the services would be reimbursable under the expansion. For those services that may be covered under Medicaid AMH estimated the percentage that could be picked up in the Medicaid expansion. The significant majority of the funding that could be picked up by Medicaid is in adult outpatient and acute care services. The estimated impact for adult outpatient treatment is 50% and the impact for acute care services is estimated to be 65%.

This information was provided to the Office of Health Analytics that calculated the savings for the 2013-15 biennium. The total biennial impact is $33.5 million.

[1]Buettgens, M., et.al., "Consider Savings as Well as Costs", *Timely Analysis of Immediate Health Policy Issues*, Robert Wood Johns Foundation and Urban Institute, July 2011

Addiction Services:

The same challenges described above related to the illness of addiction interfering with a person's enrollment in Medicaid apply to the addicted population. Many of these clients also have a co-occurring mental health condition. For this reason, when OHP Standard was at full enrollment in the late 1990s and early 2000s with an Open Enrollment policy, many addiction service providers and other organizations who interacted with addicted populations assisted them with calling the 1-800 number and completing the enrollment process. It is also challenging for seriously addicted individuals to maintain eligibility due to transitions and mobility and homelessness, interfering with their ability to receive mail on a regular basis and respond to renewal process to maintain eligibility.

Methodology used to estimate impact of Medicaid expansion on the addiction system:
AMH captures income information in the treatment data system for alcohol and drug service clients from funded providers who are approved by the division. Using data from one calendar year during the previous biennium for unique client enrollments, both outpatient and residential , the Office of Health Analytics worked with AMH to determine the portion of alcohol and drug clients whose reported incomes were at or below 138% of FPL. This percentage was then applied to the annual budget for these services to estimate the potential budget offset. The annual data was rolled up to an 18 month estimate coinciding with the Medicaid expansion implementation date of January 1, 2014. The biennial impact was estimated to be $11.5 million.

It should be noted that the enrollment policy framework for OHP enrollment was unknown during this analysis. The analysis did not consider the impact of the enrollment policy or the likelihood of churn as members go on and off of the plan.

**Individual Treatment and Recovery Services in the Addictions and Mental Health Budget**

*Addictions and Mental Health*

The role of AMH is to "direct, promote, correlate and coordinate all of the activities, duties and direct services for persons with mental or emotional disturbances, alcoholism or drug dependence (ORS 430.012)." In keeping with this role and at the direction of Bryan Johnston, then Interim Director for DHS, in 2005, AMH lead a cross divisional workgroup to analyze the impact of methamphetamine across the populations served by the Department. This analysis revealed the magnitude of the problem concerning methamphetamine addiction among parents involved in the child welfare system.

AMH began seeking opportunities to address this concern. Leading up to the 2007 Legislative Session, then Governor Kulongoski's policy advisor, Erinn Kelley Siel, contacted AMH leadership to request a proposal for use of General Fund revenues that might be available for addiction services. A proposal for $10.4 million was submitted to the Governor's Office to invest in an array of addiction and recovery support services aimed at parents who were either already involved in child welfare or at risk. The proposal was funded by the 2007 Legislature. The investment is used as a portion of the TANF match as directed by the Legislature in 2007.

- The investment supports outpatient, residential (including beds for dependent children who accompany their parents to treatment) and recovery support services.
    - A portion of the residential beds are financed with Medicaid match for individuals who are Medicaid eligible.
- AMH takes the role of administering these funds very seriously and has monitored the implementation of these services as well as the outcomes closely.
    - In 2011, 59% of child welfare parents accessing ITRS were complying with their child welfare service agreement, compared to 2008 when 49.9% were demonstrating compliance in this area. ITRS made the difference.

- ITRS is intended to fund services for parents who are not OHP eligible as well as services that are not part of the OHP benefit. AMH is able to match administrative data to avoid duplication in funding between OHP and this investment.
- Contractors are held to specific performance targets (numbers of individuals served, retention in services, and number of parents meeting DHS child welfare reunification requirements).
    - Just over 8,800 parents have accessed these services since the initiative was implemented.

AMH has established the administrative, analytical, and clinical capacity to monitor this particular investment by assigning existing staff to administer this initiative who possess expertise in addiction treatment, parenting in recovery, funding analysis, data analysis and performance management. We do this in partnership with DHS. Objectively, AMH works with child welfare to match administrative data to monitor the desired outcome associated with parent-child reunification. Roughly two years after the initiative began over 1,800 families has been reunited. With the DHS, child welfare implementation of the new data system (OR-KIDS) the data has been unavailable, however, this administrative data matching will again occur as soon as the system is functioning in a manner that allow analysts to match the data.