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Madame Chair and Members of the Sub-Committee,

I'm Marshall Peter, The Executive Director of Direction Service in Eugene, OR. Thank you very much for affording me the opportunity to address you regarding the integration of physical and behavioral health services, particularly as it is unfolding in Lane County with Trillium Community Health Plan, our CCO. I was asked to talk about what is working well and especially areas of potential concern. While I Chair Lane County's Community Behavioral Health Consortium and asked our members for input and similarly sit on the Trillium Board and also asked folks in Behavioral Health at Trillium for input, I speak only for myself.

I believe that there is a lot that's working very well in the pursuit of integration in Lane County with a dizzying amount of high quality work accomplished in a very short period of time. This is not surprising given that Lane County has a group of highly capable, passionately driven folks working at Trillium and volunteering on the board and an amazing array of committees and work groups. The level of expert, energetic attendance you see by unpaid participants at 7:00 AM meetings is unprecedented. Lane County's behavioral health providers are enthusiastic and embody the qualities you would hope to find in a partner for a very complex and demanding undertaking. Structures and administrative processes are increasingly in place that enable integration and ensure that the right people are involved in making and implementing important decisions. Trillium quickly accomplished administrative integration and developed

contractual partnerships with Lane County HHS, Public Health, and Behavioral Health. Expanded risk models have been created to achieve shared financial risk with providers across all pools. Significantly enhanced data analytics and using real time data in decision making will increasingly allow us to identify service line outliers or inefficiencies and create community standards of care with clinical guidelines for different conditions that support the achievement of the Triple Aim. People are talking about effective care and thinking about how services can not only be integrated but can work synergistically.

As I look around there is broad appreciation for the essential role behavior health providers can play in the quest for achieving better health outcomes while saving money. Behavioral health is at the table, represented and respected at every level of the system. There has not only been "conceptual" consolidation of services, but a true "co-location" of the behavioral/physical health staff at Trillium into Oregon Research Institute's beautiful new facility.

The legislative requirement for each CCO to create a transformation plan has helped communities define regional targets for system improvements. Local discussions have promoted data driven committees to define strategic approaches to better meet the Triple Aim. Trillium has a physical health/behavioral health transformation committee, composed of 7 physicians and an equal number of behavioral health and community representatives that has identified depression as the first area of focus with the goal of establishing a CCO wide depression screening and treatment guideline. There have been dedicated allocations for prevention; the first year focus has been on tobacco use reduction and vaccination rate increase.

There are a number of over-arching questions that we are struggling with that will color our work in the future. How much effort can you devote to long-range investments in a system that's trying to achieve significant short term returns? What is the appropriate role for CCOs to play in community health that extends beyond covered lives? What's the appropriate mix of dollars being committed to physical health vs. behavioral health vs. dental

care? How many community health workers does a community need and is there a recommended ratio of CHWs to covered lives? The urgency of the timelines and enormous financial pressures makes it harder to experiment and adds to the pressure to get it right the first time.

In Lane County it's challenging for some providers to adjust to the reality of contracting with a for-profit CCO after years of experience with the public information and competitive processes that occur when contracting with a governmental entity. Creating transparency and trusting relationships while staying on the right side of Federal anti-trust laws and protecting proprietary interests is a formidable undertaking. The staff at Trillium is working hard at build trust with behavioral health providers, offering high levels of access to decisions and decision-makers and seeking opportunities to be accommodating. While there has been some lag in payments for behavioral health services, it's assumed that this is related to the "start-up" and will resolve over time. Trillium referrals are quick to process as the system to check benefits is accessible, swift, and easy to use.

Developing a functional shared care plan that is used by all service providers to assure effective communication and real time service coordination is an important and demanding goal. CCOs can use continued legislative support in addressing tort reform and liability issues. Until some of these issues are resolved, medical provider comfort in working in a shared "medical risk" environment with shared care plans across real or virtual treatment teams is diminished.

A continuing struggle that we will face is how we design and deliver culturally specific services. Special efforts will need to be devoted to identifying effective approaches and ensuring that we have sufficient numbers of providers who are culturally and linguistically proficient.

Timely access to dental care also continues to be a significant problem in Lane County with misuse of the emergency room and individual horror stories being told including one about an individual who was in such pain

that he pulled his own tooth,-the wrong one. Bringing dental care to the table with physical and behavioral health is essential to our success.

CCOs and communities support a global budget and the development of alternative payment strategies that lead to service efficiencies that will achieve the Triple Aim. We are concerned about how this will be funded; where will the capitalization for innovation come from? Capitation is currently paying for medically necessary treatment services for members. System improvements require substantial investments and a period of time where new services are being developed before old services can be tapered. Prior to the transition to Trillium, LaneCare, the County operated MHO in Lane County, funded transformation grants that have underwritten innovation and supported program retooling to help behavioral health organizations move toward the delivery system of the future. Major behavioral health initiatives that were partially funded by these grants are going forward among providers including same day access initiatives, collaborative documentation work and development of groups aimed at addressing physical health problems with behavioral components including tobacco cessation, obesity, diabetes management, chronic pain and depression. How will we create the venture funding needed to underwrite innovation, particularly in an environment where the pressure is on for short term savings? Many of the most important investments we can make will only generate savings over a longer term.

Prior to the advent of the CCO, Lane County had a high-performance behavioral health chemical dependency treatment network that by most measures worked extremely well. In order to continue this tradition we need stability in the continuum of care, particularly as it effects special populations. For example in Lane County we are gravely concerned about instability in the continuum of services for people with Substance Use Disorders and the looming loss of critical sobering and de-tox services. Another at-risk population, people who have severe and persistent mental Illness, require costlier community based services to remain stable in the community. Supported housing, supported employment, and other community based wrap around supports may not neatly fit into traditional reimbursement and authorization mechanisms. How can we minimize the

adverse effects of rules, requirements, and bureaucracy that interfere with flexible approaches that save money while producing better outcomes and higher levels of client satisfaction and engagement? Billing and payment mechanisms deserve the same degree of scrutiny as clinical and treatment services, ensuing that accountability *and* efficiency are both carefully considered and valued. Money should move as effortlessly and quickly as possible to providers who are addressing critical health needs.

Creating functioning primary care medical homes with teams to manage complex patient needs more effectively is extremely complex. Having an on-site behavioral health therapist improves engagement outcomes vs. having a coordination system with multiple steps and locations for the patient to be involved with in order to access behavioral health services. From what I understand in Lane County and from Central Oregon, primary care physicians like this arrangement and Medicaid funded consumers are increasing their use of behavioral health services, presumably with improved outcomes. Embedded behavioral health providers, while anecdotally creating significant value, face spending significant amounts of time delivering unbillable services or providing services to patients where co-pays are prohibitive or reimbursement rates are less than the cost of the service. Medicare reimbursement rates do not work! Multiple payer sources and the intricacies of accessing the mix of funds needed to sustain an out-stationed behavioral health specialist create a significant barrier to co-location and rapid access. Developing sustainable mechanisms for funding will be an ongoing challenge.

The provider community appreciates the work accomplished by the ISSR workgroup to improve and streamline the requirements in the ISSR rule that define behavioral health services and documentation. We support the ongoing effort of this workgroup to address credentialing and licensure concerns so that a seamless integration of behavioral health and physical health services can be achieved. Currently many mental health providers approved to treat Medicaid members are not licensed and able to treat individuals with commercial insurance. It is difficult to get a clinic licensed as a mental health site and the ISSR rules that speak to the documentation requirements for a mental health site are very rigorous and can be a

stumbling block for physical health practices. In many cases a single therapist working in a medical home is not be able to treat all patients. I appreciate the work the committee is doing to recommend solutions to these problems.

A substantial portion of my career has been focused on how you organize services around children with disabilities and their families, creating potent collaborations that cut across formal and informal support systems, public and private organizations. The ultimate goal is comprehensive, flexible approaches that are built around individual need rather than the constraints of bureaucratic requirements and regulations. It quickly becomes apparent that responsibilities and funding sources that can meet these childrens' needs not only include physical/behavioral/dental health but also education, housing, DHS, voc rehab, law enforcement, recreation and other private and personal resources. For kids, the integration of medical and behavioral health is a huge step forward. It is also an opportunity to meaningfully link the other services that children and young people are involved with: e.g., schools, juvenile justice, child welfare, developmental disabilities. In addition to reduced health care costs over time, savings that are generated from the work of CCOs should translate to valued outcomes in other areas including improved educational outcomes and reduced demand on the criminal justice and child protection systems. Ultimately, in the long game, it will become important to get a bigger table that allows you to engage these systemic beneficiaries in the work and allows you to assign costs and measure benefits in more global terms. I know that this is an interest that you and the governor have.

The challenges of making CCOs work in an amazingly compressed timeline are enormous. In Lane County we have an exceptional group of folks who are donating significant amounts of time to this "work". We're clear about the urgency of the timelines and excited about the possibility of really getting this right. Thank you for your leadership, for authorizing and facilitating these efforts and for the opportunity to address you today.