WASHINGTON COUNTY
OREGON

March 24, 2019

Dear Senate Health Care Committee,

Washington County respectfully submits this letter in opposition to Senate Bill 137. While we appreciate the intent of the bill to strengthen the role of Coordinated Care Organizations in the management of behavioral health benefits, we believe there are a number of unintended consequences that would occur with the passage of the bill — consequences that could severely impact an already fragile community behavioral health system of care.

Coordinated Care Organizations were developed on the foundation of integrating care across physical, behavioral and dental health. A great deal of flexibility was provided so that local communities could leverage existing systems, relationships and regional assets to best serve their area. SB 137 would limit the ability of local areas to determine how to best serve their region by prohibiting CCOs from partnering with existing systems to manage the behavioral health benefit.

We believe this bill is poorly conceived and should not be passed, as there are often clear system benefits when CCOs choose to co-manage the behavioral health benefit with a contracted entity or system partner. We are also concerned that the behavioral health benefit is being singled out without similar considerations for other aspects of CCO work, including physical health, dental health, NEMT, claims administration or other elements of a CCO's scope of work.

Specifically prohibiting the Behavioral Health benefit from being managed outside of a CCO could be detrimental to the BH system of care because it would limit the ability of CCOs to partner with counties to co-manage the benefit. There are a number of benefits that may occur with county/CCO partnerships. These include:

- Counties serve as foundational infrastructures of the behavioral health system of care. Each county has statutory obligations to operate as the local mental health authority. In this role, counties operate safety net services for their respective communities and have established relationships with all systems within their boundaries. Often, counties have skills, local expertise and staff that can competently manage the benefit more effectively than the area CCO.
- Counties operate with complete transparency. All information about finances, contracts, etc. are available to the public to view. Private nonprofit and for-profit organizations do not have the same obligation and can make decisions that are not in the best interest of the local community without anyone being able to easily discover this.
- Counties follow public procurement rules which ensures local community behavioral health providers have equal opportunities to become contracted service providers. Nonprofit and for-profit health care organizations have no such obligation and can legally operate in a manner that excludes certain organizations from becoming service providers.
- Counties have no profit motives. They are driven by the needs of their local communities. Other health care organizations may not even be located in the community they serve and therefore have little motive to invest all funds into the needs of the community, especially if they are for-profit.
- Counties are uniquely positioned to understand the needs of the local community. Many systems that impact social determinants of health such as juvenile services, housing, law enforcement, corrections, public health, aging and disability services, and developmental disabilities are also operated by the counties. This allows close partnership, coordinated efforts and shared vision to occur. Many existing health care systems have not demonstrated efficacy in these areas.

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- Counties are well positioned to braid funding to develop and execute large projects. The Hawthorn Walk-In Center (urgent mental health care clinic) is one such example. Washington County had the skill, expertise and community relationships to successfully open this clinic rapidly and under budget by using both Health Share and general fund dollars. Since this clinic opened, the number of Peace Officer Custodies and civil commitments in the county has decreased by 16 percent and 50 percent, respectively (not population adjusted). This is an example of how a contractual partnership between the county and CCO can have broad community impact.
- Counties already have responsibility to coordinate with the state hospital for local community members entering long-term care. Coordinating both state hospital admissions and Medicaid benefits allows for increased efficiencies both in administrative cost and continuity of care for an individual.
- In areas where counties manage both the behavioral health benefit for Medicaid and indigent care, counties are able to use similar contract language, terms, rates and payment methodologies, decreasing administrative burden on contracted providers.

Potential unintended consequences of this bill include:

- Counties often contribute general fund dollars to fill gaps in the underfunded behavioral health system. Counties are much less likely to do this if they are only able to manage a small portion of the behavioral health system. This could lead to a significant decrease in resources for the behavioral health system.
- In areas where counties manage both the behavioral health benefit for Medicaid and indigent care, the counties are able to ensure no treatment disruption if a person loses their Medicaid for a period of time (a common experience for individuals with behavioral health conditions). If counties are banned from managing the behavioral health benefit for Medicaid, treatment disruption is far more likely to occur.
- Even when contractually required, not all CCOs have adequately supported county crisis services for their members. This was our experience when FamilyCare operated within our county. This can lead to instability of the crisis system of care and increased cost to the state as more state general fund dollars have to be used to support crisis services.

While we appreciate the goal of the bill to provide consistent management of the CCO behavioral health benefit and integration of services, we fear the outcome will be to destabilize existing infrastructure, both at the CCO and CMHP program level. We strongly believe that integration of behavioral, dental and physical health can be accomplished within the existing system and have made significant progress in this area. Furthermore, in a partner model such as Health Share, banning the CCO from subcontracting management of the behavioral health benefit will not actually result in integration of benefits, as all physical and dental benefits are contracted to Health Share partners, not managed by Health Share itself. As a result, the behavioral health benefit would be required to remain separate, as Health Share organization staff would be obligated to manage the behavioral health benefit while the physical and dental benefits would still be provided by other partners.

In conclusion, we would like to encourage members of the committee to work with CCO partners to continue movement toward integration and strengthening the behavioral health system, rather than passing an ill-conceived concept that could destabilize the system of care.

Sincerely,

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Community Mental Health Director