Comments in Support of SB 137 with NAMI-Proposed Amendments
From Chris Bouneff, Executive Director, NAMI Oregon
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Senate Health Care Committee

I'm Chris Bouneff with the state chapter of the National Alliance on Mental Illness. We are a grassroots, membership-governed organization that provides education and support programs through 15 chapters across Oregon. Last year, we served some 13,000 people through our free NAMI signature programs.

We also are an organization that advocates. Sometimes cooperatively. And sometimes irritatingly. I dare say some people will argue that NAMI is here as an irritant today as we propose Senate Bill 137 with our amendments.

In truth, we're here because of the personal narratives that were shared today. And the personal narratives that were shared with you on Feb. 25, when three of our members were invited to present informational testimony to the Committee.

And for all the narratives, both in favor and in opposition, that were shared a week ago with the Senate Judiciary Committee on SB 763, a bill that touches on Oregon's civil commitment process. And the personal narratives that were shared on Thursday before the Senate Human Services Committee on SB 1 and SB 221, which fund significant improvements for children and youth with complex needs that you, Chair Monnes Anderson, and Sen. Knopp heard. And the narratives we at NAMI hear every day, day-after-day, all across Oregon.

We have all this evidence of barriers and failings and lost opportunities. And we don't have much to show in the way of improvement after seven years of health transformation.

Part of our lack of progress is understandable. We should remember that we started with next-to-nothing not too long ago. It wasn't until Legislative action in 2005, with the enactment of mental health insurance parity in statute, that we gained access to behavioral health benefits in commercial health insurance. And it wasn't until 2014 and the Affordable Care Act that we expanded Medicaid to tens of thousands of individuals and families with behavioral health needs.

We haven't been doing this very long — we haven't had the coverage until recently. So it's no surprise we don't do this business very well. But we don't have the time to wait for systems to evolve organically. NAMI membership has been clear to our leadership — the time do so something that creates real change is now.

We at NAMI followed a model we've used in the past to develop policy proposals — we brought together professionals from around the state. Two hospital systems, two CCOs, two county commissioners. People with substance use disorder expertise. Primary care, and providers who serve youth and adults. And, of course, advocates and people with lived experience. In all, 18 people from across the state. We named the group the NAMI Brain Trust.

We met monthly. We talked, we debated, and we explored other states. We turned to technical expertise provided by the Well Being Trust and Dr. Ben Miller, the trust's chief strategy officer and a nationally respected systems thinker. You'll find his testimony on OLIS. We realized early on something that Dr. Miller captured in his written testimony: "Trying harder is not going to work. Many of the changes needed are structural and fall upon policymakers and community leaders to begin to set forth a new vision of mental health."

And that is why we are before you today in your role as legislators and community leaders, proposing SB 137 with our amendments as developed with the input of the NAMI Brain Trust. Immediately following this testimony is the synopsis of SB 137 as we intend to amend it.

I alluded at the start to other pieces of legislation -- SB 763 around civil commitment and SB 1 and 221 for kids with highly complex needs. These are important bills that help us on the back end to work with people already highly acute. SB 137 is purposefully preventative by addressing barriers we encounter up front. And it is purposefully designed so that we intercede at our earliest opportunity, so a single crisis doesn't become a series of crises. This sets the bar for what mental health is supposed to look like so we reduce the likelihood someone will ever need SB 763 or SB 1.

Objections we've run into are understandable. Some of this is already in contract, it's already in rules, it's already supposed to be done, you shouldn't put stuff like this in statute. If any of this were existing already, if we experienced this day-to-day, we would not be here. We believe SB 137 is necessary because we must create basic standards and expectations that carry the full weight of the state of Oregon — standards and expectations that are non-negotiable and that live beyond a contract cycle and agency staff changes.

Thank you for this opportunity to describe Senate Bill 137 and our amendments, and thank you for your time.

Summary: Senate Bill 137 with Amendments

SECTION 2

Makes the "coordinated" in the name coordinated care organization a more practical reality. Modeled after a highly successful and often touted integrated program in Arizona Medicaid.

- Mirrors language in the new CCO contracts around delegation of risk. They cannot fully delegate risk to another entity. This means that the CCO is ultimately responsible for the outcomes expected for mental health provision. No more delegating risk or responsibility to another entity, which often further complicates what families and providers must do to get good mental health care.
- Permits risk sharing, contracting, and partnerships.
- Clarifies that there are essentials that must be held at the plan level — management of utilization of services, care coordination, and grievances and appeals. This is modeled after Arizona's requirements.
- Gets at a perpetual issue for us — denials. Too often, when we most need an intensive service, it's either denied outright. Or we're forced to fail at some other level of care first, even though our clinicians recommend a more intensive service that meets our needs.
- In issuing a denial, the plan must provide a clear description. And in our most urgent circumstances, the plan has an obligation to help us find an alternate service if they are denying what we've been prescribed.
- And if what we need isn't available locally, the plan has an obligation to help us find an alternate service that matches our needs or allow us to enter a higher level of service, if clinically appropriate, so we don't get less than what we need.

SECTION 3

Directs OHA to develop rules that will impact access.

- We direct OHA to establish rules as to which services can be subject to prior authorization or other utilization management so Oregonians clearly know what can and cannot be accessed regardless of where we live.
- We direct OHA to go through the process that DCBS did when developing rules to measure network adequacy for commercial health insurance. This is an essential element to have in place for all payers. How we evaluate access should apply to all payers.

SECTION 4

Makes it clear that the CCO shares a financial responsibility to fund a functional crisis response system.

SECTION 8

We add to existing statute to make clear that care coordination is truly offered to us at our most vulnerable and critical moments so that we continue with treatment and supports that lead to long-term health. Includes ER visits, inpatient care, kids at risk of entering juvenile justice system, and CCO members on probation or parole (community corrections).