Oregon Health Authority

Oregon Department of Human Services

SB 5529 Behavioral Health Budget Report

May 24.2023

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Budget Note

Background

- In 2021, Aging and People with Disabilities (APD) community partners worked with Representative Anna Williams to request assistance for individuals receiving long-term services and supports (LTSS) who were experiencing difficulties accessing behavioral health (BH) services.
- Difficulties accessing BH services were especially true for individuals:
  - Under the age of 65, found ineligible for APD LTSS, who had co-occurring needs in areas of activities of daily living and behavioral health;
  - Eligible for APD LTSS who also needed behavioral health treatment services.
- This work resulted in a budget note embedded in SB 5529.

Budget Note

In 2021, via SB5229, the Oregon legislature directed that:

The Oregon Department of Human Services and the Oregon Health Authority shall:

(1) Identify barriers that individuals served by Aging and People with Disabilities and the Office of Developmental Disabilities Services experience accessing and receiving mental health treatment services through Medicaid, and develop strategies to address these barriers; and

(2) Assess and develop strategies to remove barriers that prevent individuals with mental illness from accessing long term services and supports. The Departments shall report the results of this work to the human services committees of the Legislative Assembly no later than February 28, 2022.

Program Activities

Joint Planning

- ODHS, APD and the Office of Developmental Disabilities Services (ODDS), and the Oregon Health Authority (OHA), Offices of Medicaid and Behavioral Health developed a joint planning committee.
- The planning committee devised a plan for each program area to consult with community partners.
- Each program met with a variety of partners gathering insight into current barriers and suggestions for removing those barriers.
- The planning committee jointly wrote the report and submitted to the Legislature on February 28, 2022.
  - **Report posted on ODHS Website**

Key Barriers

Key Take Aways

- The systems are complicated
- Individuals and families often do not know how to access all supports to which they are entitled
- Delivery systems, i.e., County Mental Health Programs (CMHP), ODDS, APD case managers, do not have a clear understanding who each program can serve
- Individuals with specific needs such as IDD, physical disabilities or cognitive impairments are often refused Behavioral Health services
- Individuals with behavioral health needs are often refused assessment and funding to access K-plan services
- There is a lack of coordination between the systems; Health Systems Division, Aging and People with Disabilities, Office of Developmental Disabilities Services
- There are barriers for children and adults

Key Barriers

- Knowledge and Communication About Services
- Case Management and Service Coordination
- People with Complex Needs and Integration of Health Services
- Access to and Availability of Needed Services
- Roles, Referrals, and Responsibility for Providing Services
- Equity and Culturally and Linguistically Appropriate Services
- Provider Adequacy and Capacity
- Provider Reluctance, Discriminatory Practices, and Accommodations
- Resources
- Workforce

Please note that the comments below are excerpts from community members' feedback

Knowledge and Communication About Services

- Case managers often only know of resources or services relating to the primary service population, based on diagnosis/disability, of their own department or program and are unprepared to assist the individual or family to learn about, apply for, and use other services or community-based resources they may be entitled to.
- Hospitals, police, EMTs and other community partners are often unaware of who each program can serve, also that Medicaid is a voluntary program.
- Individuals and families perceive systems as moving slowly and unresponsive, especially when there is confusion about which agency or agencies should serve the individual.
- There is a lack of training and ongoing technical assistance across programs about benefits, services and the process to request benefits.
- Programs rely on the individual or their family to navigate and advocate across systems.

Case Management and Service Coordination

- There is a lack of understanding from OHA, ODHS, CCOs, and community partners about the difference, purpose, and function of “case management,” “care coordination,” and “benefit administration” across the programs.
- Mental health case management is perceived as crisis focus and time limited. This is different than the ODDS and APD systems.
- There is a high turnover among case managers for all three program areas. Case managers feel overwhelmed with caseloads and are unable to adequately support individuals.
- There is a lack of transparency and communication between the three programs within OHA, APD, and ODDS.
- Currently, a client can’t receive funding from both mental health (non-OHP) and ODHS services at same time.
- There is a lack of transitional case management independent of a single agency.
- There are difficulties from the services prior authorization structure, redetermination processes, and review.

People with Complex Needs and Integration of Health Services

- ODHS programs are not coordinated with behavioral health programs and are often experienced as traumatic to both the individual and the individual's family.
- APD does not serve individuals whose primary driver need is a mental illness; individuals with a mental illness cannot access the 1915(k) services.
- There are very limited numbers of behavioral health providers who are competent in providing treatment (verbal and/or non-verbal) for those who have dual diagnoses.
- Mental health residential programs don't support both ADL needs and mental health needs, often due to different funding sources.
- Both programs lack complex care competencies, causing individuals with complex care needs to fall through the cracks.
- There is a lack of understanding among APD, ODDS, and BH staff of how to work with individuals with dual diagnoses, including children and older adults.
- There is a lack of competencies and supports in co-occurring dementia, leading to frequent emergency department visits for "challenging behaviors."

Access to and Availability of Needed Services

- The Community Mental Health Programs are gatekeeping access to behavioral health related State Plan Personal Care and Residential services. This complicates access because it presupposes that individuals are enrolled in CMHP services.
- The BH program in Oregon does not provide an equivalent HCBS continuum of services at the scope and scale of ODDS/APD systems for those who need long term services and supports.
- There is insufficient capacity for delegated nursing, occupational therapy, physical therapy, and respite providers.
- There are long wait lists for diagnostic services.
- Home care or personal service workers are generally not approved for issues related to behavioral health, and yet parents need the in-home support for the child while they work and sleep.
- Mental health providers usually require that individuals attend in-person clinical sessions and participate in talk therapy which adds an additional burden for children, older adults and people with physical disabilities.
- Substance Use Disorder (SUD) programs are not able to meet the needs of individuals served by APD due to the need for personal care or supports for co-occurring cognitive impairments.
- APD and ODDS providers are not trained nor equipped to support current SUD or mental illness.
- Parents have resorted to relinquishing custody to Child Welfare for their child to access system of care through CCOs and Behavioral Rehabilitation Services through ODHS.

Roles, Referrals, and Responsibility for Providing Services

- There is a lack of clarity around program roles, responsibilities, expectations, and processes for seeking services and supports.
- Local case management entities (i.e., CMHPs, AAAs, APD, ODDS, Comagine, Kepro) and each CCO do things differently, including authorization processes.
- Referrals for youth who are close to turning 18 into ODDS-funded services is difficult because of the rate differences between adults and children (especially residential). Each program appears to think a different program is responsible rather than partnering.
- In BH, the main barrier to accessing ODDS-funded services is the lengthy eligibility process. Eligibility must be determined before services can begin and requires extensive paperwork, assessments, etc.
- OHA's 1915(i) Home and Community Based Services is very underutilized. There is not a clear process in place to access it, and it is administered statewide. There is a single contractor that administers the program, so access is privatized and is very limited.
- Package of services in 1915(i) is not accessible and there is no person-centered case management available, even though it is required under the program.

Equity and Culturally and Linguistically Appropriate Services

- Language access is a huge barrier for people with limited English proficiency or communication challenges across the entire system. No accommodations are provided to individuals to access mental health services.
- The mental health system generally struggles in serving transgender people and addressing other gender issues.
- Very few providers are people of color or multilingual.
- Youth miss opportunities to engage with more culturally matching services. This disproportionately impacts students of color. There is significant stigma around mental health in the Black/African-American community, when combined with historical experiences, leads to extreme reluctance to engage in services.
- There is a lack of culturally responsive services, translation, Spanish language services, and of understanding that family involvement is essential for Latinx families.
- There is a lack of culturally specific intensive outpatient programs and SPMI culturally specific programs.

Provider Adequacy and Capacity

- Families must sort through many providers to find someone who is willing and available to provide services. Rural areas are particularly short of providers.
- Lack of provider capacity is also exacerbated by confusion, lack of transparency and consistency across different coverage options, like OHP/Medicaid and private insurances.
- Many providers do not take clients covered by Medicare/Medicaid, or those individuals experience longer waiting time.
- Overall provider capacity needs to be improved for everyone to make services more accessible and reduce or eliminate wait times.
- There are not enough providers for the 1915(i) services, so even if one gets through the hoops to enroll, it is difficult to find providers.

Provider Reluctance, Discriminatory Practices, and Accommodations

- Individuals with I/DD face barriers to behavioral health services because of:
  - Discriminatory practices, such as IQ score requirements to access supports
  - Mental health professionals' reluctance in serving the I/DD population
  - A persistent belief that the general population has mental health issues, and the I/DD population has behavioral issues. Inaccurate beliefs that people with I/DD cannot benefit from MH therapies and treatments
  - Lack of accommodations
- Individuals eligible for APD services often struggle to access BH services and supports because:
  - Providers are unwilling to go to facilities or individual’s home, but individuals cannot get to clinics
  - Once someone has a cognitive decline, the mental health system does not believe that individuals can participate in behavior health services

Resources

- There is a lack of adequate funding for the necessary services and supports
- There is an inadequate supply of guardianship resources.
- There are very limited resources in rural communities.
- There is a gap between the time of discharge from juvenile detention and obtaining a mental health assessment to get services which sets up children for potential failure.

Workforce

- The BH system faces a chronic shortage of providers, especially providers who are trained to serve older adults with mental health and substance use concerns.
- Additionally, due to the limited nature of the OHA BH in-home program, there is a lack of personal care attendants
- Training is needed for the workforce in both I/DD and mental health: DMID 2, TTT, Summit, Developmental adaptations.
- While families in the I/DD system have access to brokerage services, they are not always able to access them because of the current issues surrounding workforce shortage.

Recommendations

Report Recommendations

- Immediately issue a specific policy from ODHS and OHA, and improve enforcement of existing policies, to prevent discrimination in all programs and treatment provider systems to ensure full inclusion of individuals with I/DD, older adults, and people with disabilities. Determine processes for ensuring compliance.
- Work to develop stronger communication pathways between APD, ODDS, OHA, CMHPs, and other contracted case management entities.
- Develop processes and procedures to ensure BH services are delivered in a person-centered manner and are culturally and linguistically appropriate, including appropriate accommodations, interpreter services, Activities of Daily Living supports, and provided where individuals are comfortable in receiving the services.

Report Recommendations

- Support existing efforts to address the ongoing workforce shortage.
- Develop methods to coordinate services for people with complex needs and facilitate local dialogue on coordination and integration.
- With community partners, explore strategies to coordinate different Medicaid authorities to ensure all individuals receive appropriate services and support through a person-centered plan that meets all their needs, and present those strategies for consideration by the legislature in 2023.
- Request an ongoing discussion with the legislature and community partners about the prioritization in state statute for mental health services and the restrictions on APD to serving individuals with mental illness

Potential Policy and System Changes

- Provide short term-targeted case management team co-managed by APD and Medicaid Directors
- Eliminate the APD exclusion of serving people with mental illness
- Require OHA to implement the 1915(k)
- Require/train CMHPs and BH providers to meet Medicaid requirements
- Develop a pilot to serve individuals with BH conditions needing a nursing facility level of care
  - APD would determine eligibility, pay for services and provide ongoing case management
  - OHA/HSD would ensure that behavioral health services would be made available

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Questions?