November 14, 2021

The Honorable Ron Wyden
Chair, Committee on Finance
United State Senate
SD-219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mike Crapo
Ranking Member, Committee on Finance
United States Senate
SD-219 Dirksen Senate Office Building
Washington, DC 20510

VIA EMAIL

Dear Chairman Wyden and Ranking Member Crapo:

Thank you for this opportunity to provide input. NAMI Oregon is the state chapter of the National Alliance on Mental Illness. Through our 15 chapters across Oregon, we deliver free education and support programs to individuals and families living with mental illness. Annually, we serve about 14,000 Oregonians.

We are affiliated with NAMI the national organization, which has weighed in separately. We write to you from the perspective of what would help most on the ground in Oregon.

Very little that Congress does actually impacts the provision of behavioral health care (mental health and substance use disorders) on the ground in Oregon. As such, our comments revolve around broader policies and investments that would truly make a difference in Oregon, across populations and across payer systems. We encourage the Committee to think globally and strategically in addition to delving into the arcane of federal policy and regulation that most congressional legislation in this area addresses.

Further, we encourage the Committee to think about actions that apply to all payers. We have tried to build a "system" solely on the back of public financing. Because of that, we have the system we have. Fragmented and ineffective, unable to even come close to meeting the need, lacking access, and certainly lacking quality. It's unrealistic to expect federal and state funding alone to build a behavioral health system that serves a state's entire population in the same manner as health care for medical/surgical. We cannot build a financially healthy and stable system that is accessible and delivers quality unless all payers contribute.

Ensuring Parity

NAMI Oregon considers advancing insurance parity requirements and enforcement as the most important and impactful action that Congress can take. The RFI letter from Sens. Wyden and Crapo cites the case *Wit v. United Behavioral Health*, which sets the modern standard by which to interpret what insurance parity actually means.

With that reference, NAMI Oregon recommends the following. That any legislation:

- Enact Wit's definition of parity, using the judge's eight-part test. In short, members of any insurance plan:
  - ✓ Have access to effective services that treat the underlying conditions that drive crises. And that they have access to those services for the duration necessary to achieve recovery.
  - ✓ Subject all payers to adopt standard level of placement assessments tools when making utilization management decisions.
  - ✓ Prohibit the use of proprietary, secret treatment criteria to guide specific treatment decisions within levels of care.
- Subject all payers to the same parity standards, including Medicare, which is the one major payer legally permitted to discriminate against enrollees with behavioral health conditions.
- Give states a role enforcing parity requirements for plans currently regulated only by the federal government, such as ERISA plans.
- Require regular assessment and enforcement around ensuring true network adequacy.
- Like Wit, acknowledge the specific needs of children and youth and enact requirements that ensure youth have access to youth-specific services.

We point the Committee to HB 3046 (linked here) from the 2021 Oregon Legislature that a coalition that NAMI helped lead passed that enacted stronger parity requirements for both commercial plans and managed Medicaid plans is an excellent model for federal legislation.

If we force payers to pay for the treatments and supports that work — treatment many cannot access now — we create an economic environment that entices health care systems to actually perform those services vs. relying on a network of poorly financed nonprofit entities.

Strengthen Workforce

Publicly funded behavioral health systems have never come close to paying the actual cost of care. Prior to state and federal parity and Medicaid expansion, many Oregonians with behavioral health conditions didn't even have coverage for such disorders.

In Oregon, we solved the coverage issue, and have taken a major step forward with modernizing parity requirements. However, there is no clear pathway for Medicaid reimbursements to increase enough to cover the actual cost of care. As such, our provider networks cannot pay a competitive wage commensurate with the education and training our workforce obtains before even entering the field.

Our recommendation in this area is simple:

- Unshakle states from byzantine federal processes that guide rate setting. Permit states, and provide funding, to dramatically increase reimbursements for behavioral health care.

Loan forgiveness and other "incentives" to diversity and grow the workforce are ineffective window-dressing if our systems cannot pay a competitive wage commensurate with the work being performed.

Increasing Access to Crisis Care

The RFI letter cites CAHOOTS as an example of a crisis response model that should be expanded. NAMI Oregon supports the CAHOOTS model and would like to see it spread to other communities. Even so, we also must acknowledge the program's shortcomings.

It is poorly funded. What funding there is primarily flows through the public safety budget. There are few health care dollars folded into the financing model, even though at its basic level CAHOOTS is delivering a health care service.

CAHOOTS and similar programs also more resemble a street response model than a true mobile crisis model that is available to serve the entire population of a given community.

Our hope is that one day mobile crisis is the behavioral health equivalent of paramedics, ambulance service, and other Emergency Medical Technician-like services. The workforce should be highly trained and professionally compensated. Like ambulance and fire emergency services, mobile crisis should be available 24/7 to the entire population.

In this area, NAMI Oregon recommends that any legislation:

- Set standards for mobile crisis that reflect NAMI Oregon's vision described above. We lack standards. As such, communities in Oregon are free to establish mobile crisis in any manner they see fit, leading to poorly designed and sometime ineffective services that still include law enforcement as a first responder in all circumstances.
- Require all payers — public and private — to contribute funding to the crisis system. A crisis system cannot be built solely on the back of state and federal funding. We believe this also is an issue of parity with medical/surgical emergency services.

Telehealth

Access to telehealth has been an unexpected boon for behavioral health services. Because of various emergency orders, telehealth was reimbursed on par with in-person visits. We learned that if the option is available, it increases our ability to attend appointments and helps to keep us engaged in services.

Fortunately, Oregon approved HB 2508 this legislative session. Access is preserved for commercial insurance and managed Medicaid coverage. However, federal regulation is necessary so requirements apply to all payers.

Telehealth cannot be a substitute for in-person visits, but it clearly is an important tool to retain post-pandemic.

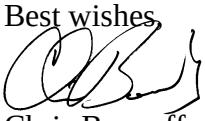
Coverage

Behavioral health is the only health care condition whereby health care providers and payers are permitted to abdicate their responsibilities. As such, it's the only health care condition where an acceptable outcome is engagement with law enforcement and the criminal justice system.

Until this is fully rectified, we must change policy to ensure both kids and adults retain coverage under Medicaid and Medicare even if they are entwined in the justice system. In that spirit, we offer the following recommendations. That any legislation:

- Ensure coverage remains in place even for incarcerated individuals, and that coverage reactivate 90 days before release. Medicaid/Medicare coverage should contribute to transitions, as people prepare to leave jail or prison, so that treatment and services are in place upon release.
- Affirmatively permit states to include specialized housing and supports in their Medicaid coverage for individuals living with serious mental illness.

Best wishes,



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