Behavioral Health: Increase Access and Coordination
Regional Health Improvement Plan Workgroup

Join Zoom Meeting
https://us02web.zoom.us/j/88698019171?pwd=e1M0SEE5aFl4K3BXbXBMaUtSTm1qdz09

Join by phone:
+1 719 359 4580
Meeting ID: 886 9801 9171
Passcode: 300638

June 21, 2023
1:00-2:30 pm

Aim/Goal

Increase equitable access to skilled and coordinated care between specialty behavioral health* and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.

*Specialty behavioral health: behavioral health, substance abuse, and developmental services that are delivered outside of primary care.

Future State Metrics

1. Increase availability of behavioral health providers in marginalized areas of the region.
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health.
3. Standardize screening processes for appropriate levels of follow-up care across services.

AGENDA

1:00 - 1:10 PM Welcome, Land Acknowledgement & Guiding Principles, Announcements.

1:10 - 1:55 PM Oregon Health Authority presentation
   • Behavioral Health Needs of Dual Eligible Populations
     • Jennifer B. Valentine, Heather N. Uerlings and Steph A. Baer

1:55 – 2:25 PM Council of Aging of Central Oregon (CoA) presenting “Caring Connections”
   • Jamie Lacore

2:25 - 2:30 PM Wrap Up and Next Steps

Working Document: https://docs.google.com/presentation/d/1jx7QDra_SVxVYXNkJt9No7ODu_dGeDhXfJ4CsBa-Oo0/edit?usp=sharing

Workgroup Budget: https://docs.google.com/spreadsheets/d/1Gw9dL6iRe1olGhJRmIoxg9pEUofJ-KzU5WnsxBbEX8/edit?usp=sharing
Behavioral Health: Increase Access and Coordination  
Regional Health Improvement Plan Workgroup

<table>
<thead>
<tr>
<th>Future State Metrics – Full Detail</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. By December 2023, improve the availability of behavioral health providers in the marginalized areas of the region (La Pine, Madras, Redmond) to exceed the Oregon average for rural areas of 0.62 in 2019 as measured by ‘mental health providers per 1,000 population’</td>
</tr>
<tr>
<td>2. By December 2023, a method is developed to measure timeliness and engagement with specialty behavioral health referred from primary care.</td>
</tr>
<tr>
<td>3. By December 2023, a method is developed to standardize screening processes to assure clients receive the appropriate level of care and follow-up across various services in Central Oregon.</td>
</tr>
</tbody>
</table>
Land Acknowledgment

We recognize and acknowledge the indigenous land on which we live, work, learn, play, and grow. This is the land of the Warm Springs, Wasco, Northern Paiute, Tenino, Klamath, Molalla, and Yahooskin. We acknowledge them as the past, present, and future caretakers of this land. It is on their traditional land that we partner to improve the health and well-being of Central Oregonians. We aspire to be good guests honoring the concept in the Warm Springs culture: “This land is for you to know and live upon and pass on to the children.”

Behavioral Health: Increase Access & Coordination

RHIP Workgroup Virtual Meeting
Regional Health Improvement Plan (RHIP) Workgroup

Guiding Principles

Shared Focus
We come together to improve the health and well-being of individuals living in various and diverse communities throughout Central Oregon region. We use the Regional Health Improvement Plan (RHIP) as our guide. It is our region’s shared vision of current problems and our aims. As workgroup partners we develop agreed-upon actions to solve the issues and keep the needs of our communities as the main focus.

Shared Metrics
We measure progress, process and outcomes through a shared lens. We use the Regional Health Assessment (RHA), Regional Health Improvement Plan and community dashboard.

Partner with Priority Populations
The individuals living in our diverse Central Oregon communities are the center of our work. We make every effort to include people from every part of the region in our workgroups, discussions, processes and decisions.

Collaborate to Solve Complex Issues
Inviting diverse perspectives from throughout the Central Oregon region deepens our shared understanding of complex issues and propels us toward better progress and outcomes. We practice frequent, structured, open communication to build trust, assure shared objectives, and create common motivation. We respect the privacy and sensitivity of information partners share.

Coordinate Collective Efforts
We are made up of diverse partner organizations and individuals with unique strengths, skills, and resources. We coordinate our efforts and use our unique strengths and skills to meet the goals of the RHIP.

Learn and Adapt Together
We embrace shared learning and a growth mindset. We create a space that allows for mistakes, failures, second changes, and a celebration of brave attempts. We adjust and apply our learnings to the complex and changing landscape of health and well-being in Central Oregon.
# Five-Year Investment Overview

All Workgroups

January 2020–December 2024

<table>
<thead>
<tr>
<th>Workgroup</th>
<th>Spent</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address Poverty</td>
<td>$941,993.79</td>
<td>$1,058,006.21</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>$1,954,157.00</td>
<td>$45,843.00</td>
</tr>
<tr>
<td>Physical Health</td>
<td>$1,117,158.56</td>
<td>$882,841.44</td>
</tr>
<tr>
<td>Stable Housing</td>
<td>$1,129,654.00</td>
<td>$870,346.00</td>
</tr>
<tr>
<td>Substance and Alcohol Misuse</td>
<td>$617,494.69</td>
<td>$1,382,505.31</td>
</tr>
<tr>
<td>Upstream Prevention</td>
<td>$1,424,126.00</td>
<td>$575,874.00</td>
</tr>
</tbody>
</table>

| Budget                  | $12,000,000 | Spent     | $7,184,584.04 | Available  | $4,815,416 |

## BEHAVIORAL HEALTH
### 2023 Budget

<table>
<thead>
<tr>
<th>Overview</th>
<th>Budget</th>
<th>Spent</th>
<th>Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-Year</td>
<td>$2,000,000</td>
<td>$1,954,157.00</td>
<td>$45,843.00</td>
</tr>
<tr>
<td>Cycle to Date</td>
<td>$1,500,000</td>
<td>$1,954,157.00</td>
<td>-$454,157.00</td>
</tr>
<tr>
<td>Yearly</td>
<td>$500,000</td>
<td>$45,000.00</td>
<td>$455,000.00</td>
</tr>
<tr>
<td>Yearly Mini-Grant</td>
<td>$17,966</td>
<td>$5,000.00</td>
<td>$12,966.00</td>
</tr>
<tr>
<td>Yearly Standard Grant</td>
<td>$482,034</td>
<td>$40,000.00</td>
<td>$442,034.00</td>
</tr>
</tbody>
</table>

### By Future State Measure (5 year)

<table>
<thead>
<tr>
<th>FSM</th>
<th>Budget*</th>
<th>Spent</th>
<th>Available</th>
<th>Currently Allocated</th>
<th>Projected Available</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Providers</td>
<td>$1,027,338.00</td>
<td>$1,027,338.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
<tr>
<td>Timeliness Engagement</td>
<td>$554,450.00</td>
<td>$594,450.00</td>
<td>-$40,000.00</td>
<td></td>
<td>-$40,000.00</td>
<td></td>
</tr>
<tr>
<td>Screening Method</td>
<td>$265,335.00</td>
<td>$265,335.00</td>
<td>$0.00</td>
<td></td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

*Budget for each FSM reflects the agreed upon 5 year 'soft budget' minus the portion contributed to shared minigrant budget.

### 2023 Investments

<table>
<thead>
<tr>
<th>Organization</th>
<th>Process</th>
<th>Project</th>
<th>Award</th>
<th>Decision Date</th>
<th>Future State Measure</th>
<th>Latest Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nami Central Oregon</td>
<td>Mini-Grant Application (2020-2023 RHIP)</td>
<td>NAMI Ending the Silence - Presentations in High Schools</td>
<td>$5,000.00</td>
<td>1.26.23</td>
<td>drawn from shared minigrant budget</td>
<td>Improve availability of behavioral health providers in marginalized areas (La Pine, Madras, Redmond)</td>
</tr>
<tr>
<td>Creach Consulting</td>
<td><strong>Standard Grant Measure</strong>&lt;br&gt;Development for Behavioral Health Specialty Care and Primary Care (2020-2024 RHIP)</td>
<td><strong>Advancing Integrated Care: Timely Access and Engagement Metric Development Addendum</strong></td>
<td>$40,000.00</td>
<td>05.17.23</td>
<td>Measure timeliness and engagement when referred from primary care to specialty behavioral health</td>
<td></td>
</tr>
</tbody>
</table>
Behavioral Health: Increase Access and Coordination

**Background: Why are we talking about this?**

- **1990s**
  - Mill Closures / Timber Industry Decline
  - State Hospitals Deinstitutionalized
  - US Wars impact on Veterans
- **2000s**
  - Population Growth in Central Oregon
  - Housing shortage
  - Rising suicide rates
  - Tech Advancement & Screen Time

Mental health affects how we think, feel, and act. It determines how we handle stress, relate to others, and make choices. Mental health challenges can increase the risk of physical health problems such as stroke and heart disease. Individuals benefit significantly from intensive coordination of care and outreach activities, which are less available in remote areas of Central Oregon.

**Current Condition: What's happening right now?**

- Approximately 1 in 4 adults over 55 in Central Oregon reported a diagnosis of depression
- Percentage of students who reported feeling sad or hopeless has been generally trending upward
- 64% of individuals who died by suicide visited their primary care provider within one year prior to their death

**Current State Metrics:**
1. Availability of behavioral health providers is less in the rural areas of the region
2. No way to measure timeliness and engagement with specialty behavioral health when referred by primary care
3. No standardize screening processes for appropriate levels of follow-up care across services

**Goal Statement: Where do we want to be in 4 years?**

**Aim/Goal**
Increase equitable access to skilled and coordinated care between specialty behavioral health and the larger health system, including primary care, while decreasing barriers to ensure an effective and timely response.

**Future State Metrics - By December 2023:**
1. Increase availability of behavioral health providers in marginalized areas of the region
2. Increase timeliness and engagement when referred from primary care to specialty behavioral health
3. Standardize screening processes for appropriate levels of follow-up care across services

**Analysis: What's keeping us from getting there?**

- Care is culturally inappropriate and unresponsive
- Behavioral Health Careers are undervalued, underappreciated and not at parity with medical health
- Siloed communication and coordination across systems and agencies
- Behavioral Health Conditions are viewed as a character weakness
- Systemic undervaluing & underfunding of Behavioral Health
- Disjointed systems do not address whole person care

**Strategic Direction: What are we going to try?**

- Strengthening and Expanding the Behavioral Health Workforce
- Improving Coordination and Access to Culturally Responsive Behavioral Health Care
- Normalizing and Destigmatizing Mental Health Across the Lifespan
- Advocating and Lobbying for Behavioral Health Funding at Parity with Physical Health

**Focused Implementation: What are our specific actions? (who, what, when, where?)**

<table>
<thead>
<tr>
<th>Future State Measure</th>
<th>What</th>
<th>When</th>
<th>Who/How</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Standardize screening processes and communication to assure clients receive the appropriate level of care and follow-up</td>
<td>2022-2024</td>
<td>Addendum to Timeliness and Engagement Project</td>
</tr>
<tr>
<td>2</td>
<td>Identify, create or adapt regional measure for timeliness and engagement and integrate into payer models</td>
<td>2021-2024</td>
<td>Consultant, Creach Consulting Group, LLC.</td>
</tr>
<tr>
<td>1</td>
<td>Create a community-driven behavioral health workforce development pipeline prioritizing rural areas</td>
<td>2022-2025</td>
<td>Behavioral Health Consortium; St. Charles Health System</td>
</tr>
</tbody>
</table>

**Follow-Up: What's working? What have we learned?**

{insert}
| Root Cause Barriers: What is blocking us from moving toward our future state measures? |
|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|
| Care is culturally inappropriate and unresponsive | Siloed communication and coordination across systems and agencies | Systemic undervaluing & underfunding Behavioral Health | BH careers are undervalued, under-appreciated and not at parity with medical health | BH conditions are viewed as a character weakness | Disjointed systems do not address whole person care |
| Cultural barrier of trust with minority groups (Persons of Color, veterans, etc) | Systems & policy do not support care coordination | Funding lessons from COVID (billing codes, purchase of phones/tablets) | Limited pathways to BH careers in region (recruitment of HS, minority & Bilingual) | Culture of individualism (pull yourself up by your bootstraps) | Basic needs (housing, transportation, communication) trump behavioral needs |
| Insufficient knowledge of dyadic therapies for children/families | Needs assessments differ between groups | High cost of living/insufficient reimbursement rates | Education & training for providers from marginalized groups | Stigma: neuroscience vs. Flawed character | Insurance limitations for undocumented & incarcerated people |
| Insufficient knowledge of dyadic therapies for children/families | Organizations are siloed/don’t communicate | Prioritization of screening tools which are reimbursed | Career trajectory out of agency work leaving a “brain drain” | Unaffordable and inaccessible technology |
| Screening processes are not humanistic | Behavioral health operates in silos | Insurance reimbursement policies | Incentives for rural providers, practice & communication |
| Dysfunctional Provider Directories | Need for more residential beds | Remote location work not incentivized |
| HIPAA/Privacy Myths | Services are not political priority | Wages don't match cost of living |
| Mental Health dollars cannot cross county lines | Need for bilingual BH specialists |
| Funding Payor Issues |
# STRATEGIC DIRECTIONS: What Moves Us Toward Our 2023 Practical Visions

<table>
<thead>
<tr>
<th>Promote Comprehensive Staffing Retention Models</th>
<th>Expand, Train, and Support the Workforce</th>
<th>Develop and Pay Traditional Health Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incentivize providers to work in rural areas</td>
<td>• Pursue OHSU psychiatric resident rotation for child psychiatrists</td>
<td>• Develop a “Promotora program” within the different community groups</td>
</tr>
<tr>
<td>• Pursue incentivizing local psychiatric nursing jobs with COCC, OHSU, Linfield</td>
<td>• Having Mental Health be developed as a career path in large and small communities, by educating high school students about career</td>
<td>• Train people from local neighborhoods into THW, CHW jobs in those communities. Churches as a source of contact</td>
</tr>
<tr>
<td>• Pay to Stay programs through PacificSource to support providers working in rural and underserved communities</td>
<td>• Early recruitment of a diverse workforce – start in elementary and middle schools</td>
<td>• Develop and highlight BH opportunities for peer delivered services</td>
</tr>
<tr>
<td>• More hiring incentives and research around our veterans.</td>
<td>• Develop shadowing program of BH careers for high schoolers</td>
<td>• Pilot project for employing and reimbursing THW and Peer Support Specialists</td>
</tr>
</tbody>
</table>

## Increase Coordination and Access

<table>
<thead>
<tr>
<th>Increase Coordination and Access</th>
<th>Increase Cultural Responsiveness of Service Delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Connect CHW with Latinx community to better connect care to communities</td>
<td>• Build community coalition capacity to address health inequities related to substance use and mental health</td>
</tr>
<tr>
<td>• Build centralized streamlined referral hub or team</td>
<td>• Use Culturally and Linguistically Appropriate Services (CLAS) Standards</td>
</tr>
<tr>
<td>• Not just about access but about quality of services received; could be measured, e.g. completion of treatment</td>
<td>• Cultural needs assessment for BH</td>
</tr>
<tr>
<td>• Host monthly provider meetings</td>
<td>• Have experience engaging with Latinx parents, supporting them in accessing behavioral health services</td>
</tr>
<tr>
<td>• Develop method to measure timeliness and engagement with specialty behavioral health</td>
<td>• Project where seasoned providers attempt to reach specific populations based upon culture, diagnosis, etc. and provide culturally-based treatment</td>
</tr>
<tr>
<td>• Develop closed loop referral processes</td>
<td>• Provide same sex interpreter and/or traditional health workers for women patients</td>
</tr>
<tr>
<td>• Offer transportation to and from Central Oregon Communities</td>
<td>• Behavioral Health screening at intake in the individuals’ primary language</td>
</tr>
<tr>
<td></td>
<td>• Communicate in a more meaningful, basic, and understandable way.</td>
</tr>
</tbody>
</table>

## Strengthening & Expanding the Behavioral Health Workforce

## Improving Coordination and Access to Culturally Responsive Behavioral Health Care
### Promote Mental Health for All across the lifespan

- Identify and implement strategies to work collaboratively with organizations whose activities advance health equity and promote Health in All Policies
- Destigmatize by putting on a program for junior high and high school students. Partner with Younity.
- Partner with NAMI of Central Oregon (National Alliance of Mental Illness) to host an event to destigmatize mental illness
- Provide monthly rotational community events to destigmatize mental health
- Host a Zoom presentation on a topic that would cover destigmatization
- Utilize high level speakers strategically to dispel the myth that mental health is a character weakness.

### Advocate for Better Funding

- Pay for insurance advocate to advocate for higher reimbursement for Behavioral Health services
- Lobby at the state level for funding for providers
- Advocate to have (BIPOC) traditional approaches reimbursed
- Create value based contracting that has metrics tied to access, engagement and outcomes
- Value based contracting
Presentation Outline

- Who are Dual Eligibles, and what benefits do they receive?
- What are the risk factors Dual Eligibles face?
- Medicare – Medicaid Alignment
- Medicare Specific Coverage of Behavioral Health
- New 2024 Medicare Provider Types
- What BH Can Be Billed Directly to Medicare
- Oregon Adult Behavioral Health Initiative programs & services
- Behavioral Health Investments – including Services from Measure 110 Grant Agencies
- 988 and Suicide Prevention
- Oregon Legislature 2023
- Questions?
- Supplemental Slides
Dual Eligibles: Vulnerability & High Needs

About one in four Medicare beneficiaries live with mental illness — conditions such as depression, anxiety, schizophrenia, and bipolar disorder — but only 40 percent to 50 percent receive treatment.1

Mental illness is experienced most by those beneficiaries under age 65 who qualify for Medicare via disability, as well as by low-income beneficiaries dually eligible for Medicare and Medicaid.3 It is also more pervasive in beneficiaries from American Indian/Alaska Native and Hispanic communities relative to other racial and ethnic groups.4

Now 12 Million +

3 Million Dual Eligible Beneficiaries are Covered by Both Medicare and Medicaid

Medicare 37 Million

Dual Eligibles 9 Million

Medicaid 51 Million

Total Medicare Beneficiaries, 2008: 46 million
Total Medicaid Beneficiaries, 2008: 60 million

SOURCE: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey, 2008, and KCMU and Urban Institute estimates based on data from the FY2008 MSIS.
Disparities in Access to Care for Dual Eligibles

- Dually eligible individuals are: Less likely to have a regular source of care\(^1\)
- Less likely to have a primary care physician as a regular source of care\(^1\)
- Less likely to live in a county with an adequate supply of primary care physicians\(^2\)
- Less likely to access specialist care\(^1\)
- Less likely to receive home-and community-based services\(^3\)
- Less likely to receive hospice care\(^3\)

Forecasting Medicare Population Growth

Figure 1
Distribution of U.S. Population Ages 65 and Over, by Race/Ethnicity, 2012 and 2040

- **White, non-Hispanic**: 79.3% (2012), 66.7% (2040)
- **Hispanic**: 8.8% (2012), 11.5% (2040)
- **Black**: 7.3% (2012), 14.7% (2040)
- **Asian**: 3.8% (2012), 5.9% (2040)
- **Other**: 1.5% (2012), 2.7% (2040)

Population Ages 65 and Over:
- **2012**: 43.1 million
- **2040**: 79.7 million

NOTE: Categories sum to more than 100% in both years because Hispanics may be of any race. "Other" includes American Indian and Alaska Native, Native Hawaiian and other Pacific Islander, and people reporting two or more races.

## Dual Eligibles: How Many & Types in Oregon [Dec.2022]

<table>
<thead>
<tr>
<th>Full Dual Eligible QMB Plus –72,089</th>
<th>Full Dual Eligible SLMB Plus--27, 261</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB with Medicaid –plus cost-sharing</td>
<td>SLMB with Medicaid</td>
</tr>
<tr>
<td>Also get LIS for Part D &amp; Medicare premium paid by Medicaid</td>
<td>Also get LIS for Part D &amp; Medicare premium paid by Medicaid</td>
</tr>
<tr>
<td>OHP Benefit Package: <strong>BMM</strong></td>
<td>OHP Benefit Package: <strong>BMD</strong></td>
</tr>
</tbody>
</table>

QMB stands for Qualified Medicare Beneficiary, SLMB stands for Specified Low-Income Medicare Beneficiary, QI –Qualified Individuals

<table>
<thead>
<tr>
<th>Partial Dual –QMB Only--29,514</th>
<th>Partial Dual –SLMB Only--14,027</th>
<th>Partial Dual –QI--11,782</th>
</tr>
</thead>
<tbody>
<tr>
<td>QMB-cost sharing, no Medicaid</td>
<td>No Medicaid</td>
<td>No Medicaid</td>
</tr>
<tr>
<td>get LIS for Part D &amp; Medicare premium paid by Medicaid</td>
<td>get LIS for Part D &amp; Medicare premium paid by Medicaid</td>
<td>get LIS for Part D &amp; Medicare premium paid by Medicaid</td>
</tr>
<tr>
<td>OHP Benefit Package: <strong>MED</strong></td>
<td>OHP Benefit Package: <strong>SMB</strong></td>
<td>OHP Benefit Package: <strong>SMF</strong></td>
</tr>
</tbody>
</table>

HEALTH SYSTEMS DIVISION  
[https://www.medicare.gov/medicare-savings-programs](https://www.medicare.gov/medicare-savings-programs)
Figure 2

Medicaid Enrollees and Expenditures, FY 2011

Disability 15%
Elderly 9%
Adults 27%
Children 48%

Elderly 21%
Adults 15%
Children 21%
Disabled 42%

Enrollees
Total = 68 Million
Expenditures
Total = $397.6 Billion

SOURCE: KCMU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, MT, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels.
National Key Findings on Dual Eligibles:

- Number of simultaneous chronic conditions (co-morbidity) among dual eligibles is common and more likely for older duals.

- ICRC Reports That Of Dual Eligibles
  - 70% have been diagnosed with three or more chronic conditions
  - 41% have a behavioral health disorder
  - Over 40% use long-term services and supports

- Co-morbidity of physical and mental health conditions increases care complexity and poses additional problems in coordination and access to needed services.

- Many dually eligible individuals also have social risk factors,
  - 33% live alone
  - 66% have either no high school diploma or a high school diploma only
  - Dually eligible individuals are significantly more likely to have a disability and have more medical, social, cognitive, and functional risk factors than their peers with Medicare alone
Behavioral Health Conditions Are Highly Prevalent among Dually Eligible Beneficiaries

Behavioral health conditions are more prevalent among dually eligible beneficiaries under age 65 than among those age 65 and older.

<table>
<thead>
<tr>
<th>Behavioral Health Condition (CY 2013)</th>
<th>% Under 65</th>
<th>% 65 and Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety Disorders</td>
<td>24%</td>
<td>15%</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>15%</td>
<td>3%</td>
</tr>
<tr>
<td>Depressive Disorder</td>
<td>33%</td>
<td>22%</td>
</tr>
<tr>
<td>Schizophrenia and Other Psychotic Disorders</td>
<td>13%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Dually Eligible Beneficiaries with Mental Health Conditions Have High Physical Health Comorbidity Rates

<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip/Pelvic Fracture</td>
<td>61%</td>
</tr>
<tr>
<td>Other Metabolic Disorder</td>
<td>55%</td>
</tr>
<tr>
<td>Stroke</td>
<td>54%</td>
</tr>
<tr>
<td>Lung Disease</td>
<td>52%</td>
</tr>
<tr>
<td>Anemia</td>
<td>47%</td>
</tr>
<tr>
<td>Musculoskeletal Disorder</td>
<td>46%</td>
</tr>
<tr>
<td>Kidney Disease</td>
<td>45%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>42%</td>
</tr>
<tr>
<td>Heart Condition</td>
<td>42%</td>
</tr>
<tr>
<td>Neoplasm</td>
<td>40%</td>
</tr>
<tr>
<td>Eye Disease</td>
<td>39%</td>
</tr>
</tbody>
</table>

- Physical health comorbidities are prevalent among individuals with mental health conditions
- One or more mental health conditions were found to co-occur in over 50% of those with:
  - Hip or pelvic fracture
  - Metabolic disorder
  - History of stroke and
  - Lung disease
Oregon Health Authority
Office of Health Analytics
Fact Sheets on Individuals with Dual Eligibility

Percentage of Persons with Behavioral Medical Conditions
Dual Eligibles vs. Medicaid Population
May 15, 2015

Data Source: MMS/DSSURS; Date: May 15, 2015 snapshot

<table>
<thead>
<tr>
<th>Condition</th>
<th>Total Population</th>
<th>Dual Eligible Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bipolar Disorder</td>
<td>2.3%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>0.2%</td>
<td>0.9%</td>
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<tr>
<td>Chemical Dependency</td>
<td>3.7%</td>
<td>5.5%</td>
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<tr>
<td>Depression</td>
<td>3.6%</td>
<td>8.2%</td>
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<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>3.3%</td>
<td>5.9%</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>1.2%</td>
<td>7.7%</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>7.7%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>
Comorbidity in PS Central Oregon Population of LTSS with Chronic Conditions, SPMI & Chemical Dependency

Long-term Services and Supports [includes Home and Community-Based Services and Long-Term Care] members with identified complexity of issues including SPMI and Chemical Dependency

OHP Members with LTSS & Other Conditions

- LTSS & 4+ CC
- LTSS & SPMI
- LTSS & CD

DUALS
Non-DUALS

PacificSource Central Oregon
Statewide Average
Comparison of Characteristics of Dual-Eligible Medicare Beneficiaries and All Other Medicare Beneficiaries

Percent of beneficiaries:

- 3+ chronic conditions: 70% Dual-eligible, 63% All other
- Cognitive/mental impairment: 56% Dual-eligible, 25% All other
- Fair or poor health: 48% Dual-eligible, 22% All other
- Under age 65: 39% Dual-eligible, 11% All other
- Long-term care facility resident: 17% Dual-eligible, 2% All other

$12 billion
Preventable readmission Costs  [Potentially preventable 30-day hospital readmissions cost Medicare about $12 billion annually.]

1%
Hospital payment penalty
As of October 1, 2012, Centers for Medicare and Medicaid Services may reduce payments by 1 percent to hospitals whose readmission rates for patients with certain conditions exceed a particular target.

30%
Reduction in readmissions
[A care transitions intervention reduced 30-day hospital readmissions by 30 percent in a large integrated delivery system in Colorado.]

39%
Reduction in patient costs
[A care transitions intervention reduced readmission costs by 39 percent per patient in six hospitals in Philadelphia.]

Risk Factors for Discharge Failure

A host of social and medical problems put patients at risk for ED discharge failure. Social factors include:

- Lack of insurance or inadequate insurance,
- Homelessness,
- Low income,
- Lack of a primary care provider (PCP),
- Poor comprehension or health literacy, and
- Race/ethnicity.

Medical factors include:

- Alcohol dependence,
- Drug use,
- Psychiatric illness,
- Physical or cognitive impairment,
- Various medical conditions and chief complaints,
- Advanced or young age, and
- Male sex.

AHRQ, 2014 Emergency Department Discharge Process Environmental Scan Report

For More Best Practice: Institute for Healthcare Improvement (IHI), How-to Guide: Creating an Ideal Transition Home

--The Commonwealth Fund, 2009
What is Medicare – Medicaid Alignment & How Do We Get There?

Key Areas To Impact Outcomes

- Communication
- Population Health Management (Using Data!)
- Care Coordination
- Care Transitions
- Health Promotion
- Member Engagement
- Health Equity & Social Determinants of Health Lens

Across All These Areas
Building Connections: Medicare – Medicaid

- Ensure members understand benefit of alignment and coordination such as:
  * Ease of ability to navigate health system,
  * Plans working together for member health outcomes and goals
  * Integrated Provider Network
  * One-stop for support on finding providers, questions on benefits, getting rides to healthcare appts., etc.
  * Ease of review of requests for services, new use of integrated denial notice in some cases
  * SDOH Supports
- Continue to build on processes to improve communication with Long-Term Care and Long-Term Services and Supports to streamline care planning, care transitions and reduce duplication
Many full duals are not currently in alignment

Many dual eligibles may not know about options for aligning Medicare with their current CCO. National and Oregon specific data shows increased alignment can improve care outcomes for members in managed care. OHSU report highlights better outcomes for aligned duals!

<table>
<thead>
<tr>
<th>Plan Configuration</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Medicare fee-for-service</td>
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<td>Medicaid fee-for-service</td>
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<tr>
<td>Medicaid managed care</td>
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</table>

April 2023 MMA Enrollment Report, OHA Health Analytics

March 2023 –Central Oregon Alignment #s: PacificSource CCO Central Oregon

*54% of Full Duals are in Aligned MA plan here
**36% of Full Duals are in Medicare FFS
Medicare Coverage & Behavioral Health

Things to know

- Part B covers mental health services and visits with these types of health professionals:
  - Psychiatrists or other doctors
  - Clinical psychologists
  - Clinical social workers
  - Clinical nurse specialists
  - Nurse practitioners
  - Physician assistants
  - Medicare only covers the visits if you get them from a health care provider who accepts assignment

Part B covers outpatient mental health services, including services that are usually provided outside a hospital, in these types of settings:

- A doctor’s or other health care provider's office, A hospital outpatient department, A community mental health center

How has Medicare coverage for mental health services expanded in recent years?

• **Lower cost sharing for outpatient mental health services.** --coinsurance for both mental health and general medical care was capped at 20 percent since 2014.

• **More consistent access to medication.** The Medicare “donut hole” in Part D prescription coverage was closed in 2020.

• **Free wellness visits.** The Affordable Care Act secured free annual wellness visits for all Medicare beneficiaries in 2011. Depression screening is a required part of the first annual visit and can be included in subsequent years.

• **Integrated care billing.** Integrating mental health care into general medical settings can improve mental health treatment delivery and outcomes. In 2017, the Centers for Medicare and Medicaid Services (CMS) introduced billing codes that allowed general medical providers to bill Medicare for mental health care planning and management services.

• **Telehealth coverage.** While Medicare has always covered mental health diagnosis, evaluation, and treatment delivered via telehealth technology, this coverage was significantly expanded through COVID-19 public health emergency rules and subsequently made permanent.
Critical Gaps That Remain in Medicare

- **Inpatient day limits.** Medicare beneficiaries are limited to 190 days of inpatient psychiatric hospital care in their lifetime. People with chronic mental illness — particularly younger beneficiaries who qualify for Medicare because of disability — may exceed this limit, and they face high out-of-pocket costs for necessary inpatient care.

- **Limited Medicare Advantage mental health provider networks.** Research shows that Medicare Advantage beneficiaries often lack access to in-network mental health providers and instead must turn to more expensive out-of-network care.

- **Supervision Requirements.** To be reimbursed in outpatient rehabilitation facilities, partial hospitalization programs, and other treatment settings outside of a psychologist’s own office, Medicare requires clinical psychologists to be supervised by a psychiatrist. This is a significant barrier to care delivery in regions with psychiatrist shortages. As of September 2022, Congress is considering legislation to remove this supervision requirement.\(^{24}\)

- **Lack of coverage and Medicare Advantage plans for serious mental health needs.** Medicare does not cover psychiatric rehabilitation, assertive community treatment, or peer support services — although Medicaid covers many of these services for dual-eligible beneficiaries.
Billing for Dual Eligible Individuals

• (1) As described in OAR 410-120-1280 (8), when an individual has both Medicare and coverage through Medicaid, providers shall make reasonable efforts to obtain payment from other resources including Medicare or other Third Party Liability (TPL).

• (2) In accordance with OAR 410-120-1280 (f), OAR 410-141-0420, and OAR 410-141-3420, behavioral health providers may bill the Division directly and may not be required to bill Medicare under the following circumstances:
  • (a) For behavioral health services that are never covered by Medicare or another insurer;
  • (b) For behavioral health services that are not covered when rendered by the following provider types:
    • (A) Qualified Mental Health Professional (non-licensed) as defined in OAR 309-019-0105;
    • (B) Qualified Mental Health Associate as defined in OAR 309-019-0105;
    • (C) Professional Counselor or Marriage and Family Therapist licensed by the Oregon Board of Licensed Professional Counselors and Therapists;
    • (D) Certified Peer Support Specialist as defined in OAR 410-180-0305;
    • (E) Recovery Assistant;
    • (F) Certified Alcohol and Drug Counselor.
New BH Provider Types Allowable in Medicare in 2024

• After more than a decade of working to secure Medicare coverage for counselors’ services an omnibus package, which includes language from the Mental Health Access Improvement Act (S. 828/H.R. 432) that expands coverage of licensed professional counselors (LPCs), addiction counselors, marriage and family therapists (MFTs), peer recovery specialists and others under Medicare Part B, was signed into law by President Biden on Dec. 29, 2022. –stay tuned for rules and full list of behavioral health professionals who can enroll and provide services

• Coverage of MHCs and MFTs under Part B of the Medicare program will begin Jan. 1, 2024..

• The Centers for Medicare & Medicaid Services (CMS) will now develop specific rules on how counselors can apply for provider status, receive a Provider ID number, and bill for services. The rules will be developed in 2023 ahead of the Jan. 1, 2024, implementation.
Behavioral Health Services in Central Oregon

July – Dec. 2020

- Assertive Community Treatment **

<table>
<thead>
<tr>
<th>CCO</th>
<th>SPMI</th>
<th></th>
<th>ACT</th>
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<td>4.6%</td>
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<td>0.7%</td>
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- Peer Delivered Services ++

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<tr>
<td>PACIFICSOURCE CENTRAL</td>
<td>4,715</td>
<td>4.6%</td>
<td>457</td>
<td>9.7%</td>
</tr>
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</table>

Question to ask—are Full Dual Eligibles receiving these services?
CCOs important to Primary Care Home Enrollments

Integrated BH services in primary care can provide less stigma and be easier to access for seniors
Integrated Care Billing Models

For detail see MLN document.

- Care planning by the primary care team, jointly with the beneficiary. Treatment may include pharmacotherapy, psychotherapy, and/or other indicated treatments
  - 70 minutes of behavioral health care manager time the first month
  - 60 minutes subsequent months
  - Add-on code for 30 additional minutes any month
- Regular case load review with psychiatric consultant:
  - The primary care team regularly (at least weekly) reviews the beneficiary’s treatment plan and status with the psychiatric consultant
  - The primary care team maintains or adjusts treatment, including referral to behavioral health specialty care, as needed.

Chronic Care Model

- New Care Management Codes for Chronic Pain Management (CPM) and General Behavioral Health Integration (GBHI)
- Payment for Mental Health Visits via Telecommunications for FQHCs continues post-COVID
- Advance Care Planning
- https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Care-Management

Comprehensive Care Management
- Assess the patient’s medical, functional, and psychosocial needs.
- Make sure the patient receives timely recommended preventive services.
- Oversee the patient’s medication self-management.

Comprehensive Care Plan
- Create, revise, and monitor (per code descriptors) a person-centered, electronic care plan based on physical, mental, cognitive, psychosocial, functional, environmental (re)assessment, and inventory of resources and supports.
- Comprehensive care plan for all health issues with focus on managing chronic conditions.
- Provide patients and or caregivers with copy of the care plan.
- Electronically capture care plan information and make it available promptly both within and outside billing practice with individuals involved in the patient’s care, as appropriate.

Enhanced Communication Opportunities
- Provide patients and caregivers enhanced opportunities to communicate with their practitioners about their care by phone and through secure messaging, secure web, or other asynchronous non-face-to-face consultation methods (like email or secure electronic patient portal).
Medicare Coverage & Behavioral Health

Opioid use disorder treatment services
Medicare covers opioid use disorder treatment services in opioid treatment programs. The services include medication (like methadone, buprenorphine, naltrexone, and naloxone), counseling, drug testing, individual and group therapy, intake activities, and periodic assessments. Medicare covers counseling, therapy services, and periodic assessments both in-person and, in certain circumstances, by virtual delivery (using audio and video communication technology, like your phone or a computer).

Alcohol misuse screening & counseling Medicare covers one alcohol misuse screening each year for adults (including pregnant individuals) who use alcohol, but don’t meet the medical criteria for alcohol dependency. If your health care provider determines you’re misusing alcohol, you can get up to 4 brief face-to-face counseling sessions per year (if you’re competent and alert during counseling). You must get counseling in a primary care setting (like a doctor’s office). If you have a substance use disorder or a co-occurring mental health disorder, you can get telehealth services from home. Visit Medicare.gov/coverage/alcohol-misuse-screenings-counseling for more information.
Billing OTP

Medicare pays enrolled OTPs bundled payments based on weekly episodes of care.  
• Professionals who can provide substance use counseling and individual and group therapy included in the bundled payment may include:
  • Licensed clinical social workers
  • Licensed professional counselors/mental health counselors
  • Licensed marriage and family therapists
  • Licensed clinical alcohol and drug counselors
  • Certified peer specialists or others permitted to give this type of therapy or counseling by state law and scope of practice
• There’s NO copayment for OTP services for Medicare patients but the Part B deductible does apply. Check your patient’s Medicare eligibility.
Medicare Updates 2023 for OTP

- **New for 2023**
- The CY 2023 Physician Fee Schedule final rule does the following for Medicare-enrolled OTPs:
  - Revises pricing methodology for drug component of methadone weekly bundle and add-on code for take-home methadone supplies
  - Modifies payment rate for individual therapy in non-drug component of the bundled payments for episodes of care
  - Allows OTP intake add-on code to initiate treatment with buprenorphine provided via 2-way, interactive, audio-video technology or audio-only technology when audio-video technology isn’t available and all requirements are met
  - Extends the flexibility through the end of CY 2023 to provide periodic assessments via audio-only when video isn’t available, when authorized by SAMHSA and DEA
  - Clarifies OTPs can bill for medically reasonable and necessary services provided via mobile units
Office-Based Opioid Use Disorder (OUD) Treatment Billing

CMS included new coding and payment for a monthly bundle of services for the treatment of OUD that includes:

- Overall management
- Care coordination
- Individual and group psychotherapy
- Substance use counseling
- Add-on code for additional counseling

- **Office/outpatient E/M visit codes (PDF)**, psychotherapy, and any other code that is medically reasonable and necessary — ADD-ON CODE FOR PROLONGED VISITS, ADD-ON CODE FOR VISIT COMPLEXITY


<table>
<thead>
<tr>
<th>HCPCS Code for Office-Based OUD Treatment</th>
<th>Description</th>
</tr>
</thead>
</table>
| G2086                                     | In the first calendar month:  
  • Developed the treatment plan  
  • Coordinated care  
  • Provided at least 70 minutes of individual therapy and group therapy and counseling |
| G2087                                     | In a subsequent calendar month:  
  • Coordinated care  
  • Provided at least 60 minutes of individual therapy and group therapy and counseling |
| G2088                                     | • Coordinated care  
  • Provided more than 120 minutes of therapy and counseling  
  Note: Bill each additional 30 minutes separately and include the code for primary procedure |
# Medicare Billing Codes - Office-Based Opioid Treatment

## Opioid Use Disorder Bundled Physician Fee Schedule Payments

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>G2086</td>
<td>Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month</td>
<td>70 MIN</td>
</tr>
<tr>
<td>G2087</td>
<td>Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month</td>
<td>60 MIN</td>
</tr>
<tr>
<td>G2088</td>
<td>Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure)</td>
<td>120 MIN</td>
</tr>
</tbody>
</table>

**Note:** Don’t bill HCPCS codes G2086–G2088 more than once per month per patient. These codes describe treatment for 1 or more SUDs.
Medicare Billing Codes - Opioid Treatment Programs

OTPs can provide substance use counseling and individual and group therapy services through audio-only interaction (for example, phone calls) in cases where audio and video communication isn’t available to the patient, including circumstances where the patient isn’t capable of, or doesn’t consent to, using devices that permit a 2-way audio or video interaction, provided all other applicable requirements are met.

There’s no copayment for OTP services for patients with Medicare.
Medicare OTP Bundled Payment

Medicare pays OTPs through bundled payments for OUD treatment services for people with Medicare Part B (Medical Insurance).

- Under the OTP benefit, Medicare covers:
  - U.S. FDA-approved opioid agonist and antagonist MAT medications
  - Dispensing and administering MAT medications, if applicable
  - Substance use counseling
  - Individual and group therapy
  - Toxicology testing
  - Intake activities
  - Periodic assessments

There are 14 billable OTP-only HCPCS G-codes (G2067 through G2080) for opioid treatment services on Medicare Part B claims. Only OTPs can bill Medicare using the specific codes for OTP services. No other provider or supplier type except for an OTP can bill for OTP services (billed using HPCS codes G2067-G2080).

See handout for Coding for Medication Assisted Treatment (MAT) and Add-On Codes
Opioid Use Disorder: Part D Treatment Drugs Medicare drug plan (Part D)

• **Part D sponsors must cover OUD Part D treatment drugs**, when medically necessary, by including them on the formulary or by exception. Coverage isn’t limited to single entity products (for example, buprenorphine) but must include combination products when medically necessary (for example, buprenorphine naloxone and long-acting naltrexone).

• **Part D sponsors must have a transition policy** to prevent interruptions in Part D therapeutic treatment drugs when new patients transition into the benefit. This transition policy, along with CMS’s non-formulary exceptions and appeals requirements, helps ensure all patients have timely access to medically necessary OUD Part D drug therapies.

• A pharmacy can dispense a Part D drug only upon prescription if the drug is helping treat a medically accepted indication. The Medicare Prescription Drug Benefit Manual, Chapter 6 has more information. Since January 1, 2021, you can prescribe a Medicare Part D Schedule II, III, IV, or V controlled substance electronically according to the electronic prescription drug program requirements.

• **Methadone isn’t an OUD Part D drug because a retail pharmacy can’t dispense it for treatment.** 42 CFR 8.12(h)(2) has more FDA-authorized OUD investigational use medication information, and 42 CFR 8.1 has more OUD medication-assisted treatment information.

• Note: Methadone is a Part D drug when indicated for pain. State Medicaid Programs may include the Methadone costs in their bundled payment to qualified Opioid Treatment Programs (OTPs) or hospitals dispensing OUD methadone. Section 10.8 of Medicare Prescription Drug Benefit Manual, Chapter 6 has more information.
Screening: SBIRT, Annual Alcohol Screening & Depression Screening

Medicare Part B covers: One depression screening per year. The screening must be done in a primary care doctor’s office or primary care clinic that can provide follow-up treatment and referrals.

Medicare and Medicaid cover screening, brief intervention, and referral to treatment (SBIRT) services.


Medicare Alcohol Annual Screening: HCPCS & CPT Codes

G0442 — Annual alcohol misuse screening, 5 to 15 minutes

G0443 — Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes

[https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#ALC_MISUSE](https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html#ALC_MISUSE)
Medicare Billing Codes - SBIRT

Medicare Telehealth Includes SBIRT Services
You can provide SBIRT services via telehealth if you meet all requirements.

Billing Medicare SBIRT Services

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>G2011</td>
<td>Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 5-14 minutes</td>
</tr>
<tr>
<td>G0396</td>
<td>Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and brief intervention 15 to 30 minutes</td>
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<tr>
<td>G0397</td>
<td>Alcohol and/or substance (other than tobacco) misuse structured assessment (e.g., audit, dast), and intervention, greater than 30 minutes</td>
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</tbody>
</table>

**Note:** If you diagnose your patient with opioid use disorder (OUD), we cover treatment services, including office-based treatment, in addition to the comprehensive treatment provided by an OTP.
Oregon Project Independence (OPI)

- Oregon Project Independence (OPI) is a needs-based program and it is funded by the state of Oregon. To get help through Oregon Project Independence you have to:
  - live in Oregon
  - have a disability or be age 60 or older
  - not receive full Medicaid (financial and medical) help
  - need help from another person with Activities of Daily Living, such as walking, eating, going to the bathroom, and bathing
- This program allows a certified home care worker to be hired and paid as the personal care provider. Addresses home safety and home-delivered meals
- There is a sliding scale fee for this program. The cost is based on monthly household income minus household’s monthly medical costs.

Contact Central Oregon Council on Aging
Oregon Transforms Behavioral Health Care

In 2021, the Oregon Legislature appropriated $1.35 billion to transform Oregon's behavioral health system. These investments represent a turning point for behavioral health in Oregon. Oregon Health Authority (OHA) looked at its services and prioritized five areas for transformation and funding:

- **Aid and Assist**: Funding to provide treatment, housing and other supports for people who are not competent to face a criminal proceeding due to the severity of their mental health issue.
- **Behavioral Health Crisis System and 988**: Funding to improve Oregon's system for crisis care and support, including development of a 24/7 hotline for people experiencing a behavioral health crisis.
- **Ballot Measure 110 implementation**: Funding for drug treatment and recovery services in Oregon counties.
- **Behavioral Health Housing/Social Determinants of Health**: Funding for expansion of residential settings for people with serious and persistent mental illness.
- **Behavioral Health Workforce Initiative**: Funding for behavioral health providers for staff compensation, workforce retention and recruitment.
- **Investment/Innovation**: Funding to better coordinate access to care, incentivize culturally and linguistically specific services, invest in workforce diversity and support staff recruitment.
Services from Measure 110 Grantees

Senate Bill 755 (2021) established Behavioral Health Resource Networks (BHRNs). A BHRN is an entity or group of entities working together to provide comprehensive, community-based services and supports to people with substance use disorders or harmful substance use. Each Oregon county and Tribal area has at least one BHRN. Detailed information on funding for the statewide service networks can be found on the Measure 110 Behavioral Health Resource Network (BHRN) dashboard.

- For more information or fact sheets
Measure 110 Grantees & Services

Each BHRN must provide trauma-informed, culturally specific and linguistically responsive services. Services include but are not limited to:

• Screening for health and social service needs
• Screening and referral for substance use disorder and appropriate outside services
• Individualized intervention planning
• Low-barrier substance use disorder treatment
• Harm reduction services
• Peer support services
• Housing supports
• Referral to appropriate outside services

It is the policy of the State of Oregon that screening, health assessment, treatment and recovery services for drug addiction are available to all those who need and want access to those services.
Integrated Co-occurring Disorder Treatment (COD)

House Bill 2086 (2021) directed Oregon Health Authority (OHA) to:

- Reimburse for COD treatment services at an enhanced rate based on clinical complexity and the education level of the treating provider.
- Provide one-time start-up funding for programs that provide Integrated COD treatment.
- Study reimbursement rates for COD treatment, including treatment of co-occurring I/DD and gambling disorder.
- To do this work, OHA worked with community partners to establish the Integrated COD program for Oregon Health Plan (Medicaid) members.

The program will also:
- Offer training, support and resources for provider agencies and staff to provide integrated COD treatment.
- Use a single payment model for integrated treatment services.
- Develop a specialty clinical endorsement/credential for Integrated COD treatment and support providers.
- Advance higher quality care to meet the needs of all Oregonians dealing with COD.
OHA Older Adult Behavioral Health Initiative (OAHBI):

- Tip Sheets
- Training Modules
- Resources & More

https://oregonbhi.org/

The Behavioral Health Initiative for Older Adult and People with Physical Disabilities, has professionals who specialize in behavioral health for older adults and people with disabilities in local and regional community mental health programs around the state.

Crook, Deschutes, Jefferson Counties:
Amar Singh,
amar.singh@pacificsource.com
541-330-2514
New Adult Suicide Prevention Plan

*Adult Suicide Intervention & Prevention Plan

- [https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le130274.pdf](https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le130274.pdf)

Debra Darmata, M.S.

- Adult Suicide Prevention Coordinator
- Health Systems Division, OHA
- [debra.darmata@oha.oregon.gov](mailto:debra.darmata@oha.oregon.gov)
- Mobile: 503-602-2597
988 Crisis Line for Behavioral Health Crisis

*Contacting 988*

- The **988 Suicide & Crisis Lifeline** is available 24/7. The Lifeline is for people in any type of behavioral health crisis, such as:
  - Mental health-related distress,
  - Thoughts of suicide or self-harm, or
  - Substance use crisis.
- **People can get help by:**
  - Calling 988,
  - Texting 988 or
  - Chatting online at [988lifeline.org](https://988lifeline.org).
- The Lifeline answers calls in **English or Spanish**, with interpretation services for more than 250 languages.
- Text and online chat are in **English only**.


HEALTH SYSTEMS DIVISION
Behavioral Health Workforce Shortages

Figure 6. Oregon mental health - health professional shortage areas, by county

Source: Health Resources & Services Administration
Sine Die: June 25, 2023

• Pending bills and OHA budget
• Continuing Resolution for existing budget through September with no action by Sine Die.
• Additional BH workforce investment bills and Measure 110 are also in the wings.
• Agreements have things moving as of 6/15/2023

Some Key Behavioral Health Bills

• **SB 1044**: This bill includes over $70 million in new behavioral health investments—in Joint Ways & Means

• **HB 2395**: This bill ensures that test strips are not considered drug paraphernalia, and ensures OHA has authority to prescribe naloxone through standing orders which increases access for many partners working on the front lines of the opioid epidemic. It also provides authority for EMS providers to dispense naloxone.

• **HB 2397**: HB 2397 is the funding vehicle for the clearinghouse to ensure access to naloxone throughout Oregon
Questions?

Jennifer.B.Valentine@oha.Oregon.gov
heather.n.uerlings@oha.oregon.gov
steph.a.baer@oha.oregon.gov
Resources & Background Section

• We hope these additional slides will assist in providing more in-depth background on dual eligible populations, Medicare and important resource links.
Two primary ways to qualify for Medicare

A. Age 65 & Older: Generally, Medicare is for people 65 or older, Part A normally free—have to have worked otherwise may be able to buy-in

B. Disability, ESRD or ALS: You may be able to get Medicare earlier if you have a disability, End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant), or ALS (also called Lou Gehrig’s disease).

- 24 month waiting period for those who start receiving SS Disability before becoming Medicare eligible

Medicare Choices:
Original Medicare vs. Medicare Advantage

Choice counseling for Medicare available at Council of Aging of Central Oregon or at https://shiba.oregon.gov/Pages/index.aspx
Medicare Coverage

What Is Covered?

- While Medicare and Medicaid provide many overlapping services, Medicaid is the payer of last resort. For dual eligible beneficiaries, services are covered as follows:
  - **Medicare Part A** covers hospitalization, related care in skilled nursing facilities and, in some cases, home services.
  - **Medicare Part B** covers physician visits.
  - **Medicare Part C**, offered by private insurers, combines the coverage of Medicare A and B.
  - **Medicare Part D** covers drugs.
  - **Medicaid** covers long-term care, certain behavioral health services, hearing, vision and dental costs, and related transportation expenses. In Oregon, any service approved by HERC that is not covered by Medicare. Also cost-sharing for Medicare Qualified Medicare Beneficiaries (QMB) on any Medicare paid coverage.
Medicare Inpatient

• **Hospitalization:**
• **Benefit periods:** A benefit period begins the day you’re admitted as an inpatient in a general or psychiatric hospital. The benefit period ends after you haven’t had any inpatient hospital care for 60 days in a row.
• **Lifetime limit:** Part A only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.
• As a hospital inpatient, you pay these amounts in 2022:
  • ■ $1,556 deductible for each benefit period
  • ■ Days 1–60: $0 coinsurance per day of each benefit period
  • ■ Days 61–90: $389 coinsurance per day of each benefit period
  • ■ Days 91 and beyond: $778 coinsurance per each “lifetime reserve day” after day 90 for each benefit period (up to 60 days over your lifetime)
  • ■ Beyond lifetime reserve days: all costs
  • ■ 20% of the Medicare-approved amount for mental health services you get from doctors and other providers while you’re a hospital inpatient Visit Medicare.gov/basics/costs for the most up-to-date costs.
Medicare Inpatient

• **Partial hospitalization** Part B may cover partial hospitalization in some cases, if certain requirements are met and if your doctor certifies member would otherwise need inpatient treatment. Partial hospitalization is a structured program of outpatient psychiatric services provided to patients as an alternative to inpatient psychiatric care. It’s more intense than the care you get in a doctor’s or therapist’s office. This type of treatment is provided during the day and doesn’t require an overnight stay.

• **Medicare helps cover partial hospitalization services when they’re provided through a hospital outpatient department or community mental health center.** Along with your partial hospitalization services, Medicare may also cover: ■ Occupational therapy that’s part of your mental health treatment ■ Individual patient training and education about your condition Visit Medicare.gov/coverage/mental-health-care-partial-hospitalization for more information.
CCO coverage types

Some OHP members are enrolled in a CCO for only some of the services they receive. Each coverage type has a short acronym in our systems, for quick reference.

Coordinated care organization coverage types

CCOA - medical, dental, and mental health services
CCOB - medical and mental health services
CCOE - mental health services only
CCOG - dental and mental health services
CCO F – dental services

Link to OHA Brochures for Duals – Form 1424
https://sharedsystems.dhsoha.state.or.us/forms/
Types of Duals – Partial

• Partial dual eligibles are not eligible for full Medicaid benefits but may receive some Medicaid assistance.

  • For instance Medicaid pays for Medicare premiums and cost sharing i.e. deductibles, copays, and coinsurance for QMB clients (MED).

• For SMB and SMF clients Oregon pays for Part B premiums.
Medicaid Navigation & Supports-LTSS & Care Coordination

Full Duals – Either CCO or Fee-For-Service (FFS) Care Coordination
- Keypro provides FFS Coordination
- Comagine provides 1915i waiver supports –specific to those with BH and challenges/needs assistance with two Instrumental Activities of Daily Living (IADL) due to the symptoms of a behavioral health condition
- Developmental Disability Programs – 1915 c programs for children & adults
- Medicaid 1915 programs –LTSS –K-plan and 1915 j
  - Contact APD/AAA in your region for assessments
  - Some folks will gain Medicaid medical [OHP] at higher FPL% when in LTSS programs
  - Home and Community Based Services [HCBS] and Long Term Care [LTC] Programs
- CCOs receive both Hospital and Skilled Nursing Facility Notifications via EDIE/Collective Platform
Medicaid Navigation & Supports

• Keypro contact: Kepro main phone line is 1-800-562-4620
• Comagine contact: Comagine main phone line: 1-888-416-3184
• Local Developmental Disability Programs
  – Community Developmental Disabilities Program (CDDP)
    • https://www.oregon.gov/dhs/SENIORS-DISABILITIES/DD/Pages/county-programs.aspx
  – CDDP/Support Services Brokerage (Brokerage)
• Local APD or AAA
  Jefferson --Madras APD
  Crook --Prineville APD
  Deschutes –Bend & Lapine APD, Bend Council on Aging of Central Oregon
Opportunity to Address Unmet Behavioral Health Needs: --Screenings and Assessments and Links to Treatment

- Comprehensive BH Assessment Tools,
- Specific Tools (i.e. recognized cognitive assessment tools) that might be indicated for specific needs like Dementia; Suicide Assessment
- Screening for adequacy of supports in the home
- Link to screening for Medicaid funded LTSS services
- Screening for medically appropriate and evidence-based treatments for those with both substance use and mental illness
- SBIRT screening points of contact
- Crisis Management System
- Link to ICC/ICCP, Medication Management
- Transitions of Care
- SDOH
- Health Equity

Collaborative Relationships Are Key to Serving Duals!
New Traditional Health Workforce Roles ARE HELPING with member engagement and cross-cultural outreach

1. Outreach and Mobilization
2. Community and Cultural Liaising
3. Case Management, Care Coordination and System Navigation
4. Health Promotion and Coaching

Peer Support in the Patient - Centered Medical Home and Primary Care Conference Report, 2015,
American Academy of Family Physicians Foundation, the Patient-Centered Primary Care Collaborative (PCPCC),
National Council of La Raza (NCLR)
CCO 2.0 Alignments & Expectations for Full Benefit Dual Eligibles (FBDE)

- All CCOs to have MA alignments for 2020 to meet contractual requirements:
  
  Some examples include:
  - address billing crossovers,
  - review of authorization requests to limit delay of needed services,
  - integrate care coordination with LTSS and Medicare benefits,
  - ensure access to behavioral health, integration of Medicaid/Medicare benefits
  - monitor preventive service and screenings, including those for behavioral health
  - ensure providers are following balance-billing rules,
  - ensure providers address disability & language access
  - provide members with communication about integrated care alignment opportunity
  - where possible develop and use integrated Medicaid/Medicare member materials;
  - work to ensure smooth transitions of care
  - build models that incorporate social determinants of health focus

- Processes to achieve greater alignment to be further discussed at CCO CMS Alignment meetings
Types of Medicare plans for dual eligibles

1. **Medicare Advantage (MA or MA-PD) (Part C)**
   MA plans can offer additional services beyond traditional Medicare. For example, vision care is often included in MA benefits. Each year a list of MA plans and out-of-pocket costs is provided so you can help members choose the plan that is the best for them.

2. **Medicare Dual Special Needs Plans (D-SNPs) (Part C)**
   DSNPs are unique types of MA plans required to have contracts with OHA to ensure care coordination and low out-of-pocket costs for dual eligibles. They can also offer additional services beyond traditional Medicare to members. They keep out-of-pocket costs low and also all cover Part D prescription drugs.

3. **Medicare FFS ((or Traditional Medicare)**
   Fee-for-service is still an option, but not all doctors in Oregon accept new members into their practice.

4. **PACE** is an integrated Medicare-Medicaid option for members with LTSS needs in the geographic region served by two Oregon PACE programs: Providence Elderplace and AllCare. Maybe more?
More about Dual Special Needs Plans (D-SNPs)

- D-SNPs are special types of Medicare Advantage plans that must have a contract with OHA to coordinate benefits for Medicare-Medicaid members (Full dual eligibles).
- All D-SNPs have Part D drugs within the plan, so no separate Part D plan required.
- These plans are required to keep out-of-pocket costs for members at a minimum by CMS rules.
- Oregon D-SNPs are required to ensure information sharing for Medicaid and Medicare benefits and work to facilitate communication for care coordination and care transitions with network providers and facilities for all full dually-eligible members. (contract specific requirements from OHA)
- Move to implement SDOH screening requirement and more supplemental benefits.
Q: Why does it matter if a dual eligible has aligned Medicare and Medicaid benefits? Oregon Data

- Duals with aligned Medicare Advantage and Medicaid managed care (CCO) experienced an improvement in health service use and quality of care between 2011 and 2014.
- When we compared duals with aligned plans to those with nonaligned Medicare Advantage and Medicaid managed care plans; we found that while care differed minimally between these two groups at baseline, it changed in a more desirable direction over time for duals with aligned plans. (highest percent of alignment in CCOs with DSNPs).
- By the end of our study period, duals with aligned plans had lower emergency department visit and hospitalization rates and higher primary care visit rates, compared with those with nonaligned Medicare Advantage and Medicaid managed care plans. They were also more likely to receive diabetes HbA1c testing and LDL cholesterol screening.
- Aligned Medicare and Medicaid programs might have a greater incentive to coordinate care and save costs to benefit both programs over time.

"Comparing Care for Dual-Eligibles Across Coverage Models: Empirical Evidence From Oregon” Kim, Charlesworth, McConnell, Valentine, and Grabowski, Medical Care Research and Review, 1-17, 2017
Figure 12
Distribution of Race/Ethnicity of Medicare Beneficiaries By Medicaid Enrollment (Dually Eligible), 2011

NOTE: *denotes statistically significant difference at the 95% confidence level from same racial/ethnic group in the non-dually eligible population. Estimates may not sum to 100% due to rounding.
Enriched Understanding of High Need Members: Duals documented to have high SDOH needs & trauma history

• The relevance to health of Adverse Childhood Experiences (ACE): troubled lives lead to troubled health over a lifetime; people get derailed early in life and one bad thing leads to another.

• Complex care needs to address social determinants (housing, food, transportation, etc) as well as the effects of trauma

• Creating systems of care that ensure screening, support, SDOH, outreach

Mechanism by Which Adverse Childhood Experiences Influence Health and Well-being Throughout the Lifespan

Trauma-Informed Care https://traumainformedoregon.org/
Total per capita spending increases with dementia and number of chronic conditions

Note: Analysis includes all full year dual eligible beneficiaries who qualify for full Medicaid benefits.
Program Overview: Caring Connections, through the Council on Aging of Central Oregon (CoA), is a social engagement program designed to combat social isolation and loneliness. Caring Connections matches a volunteer with a client who is 60 or older and who would like to receive a friendly weekly phone call. These phone calls serve as an opportunity to socialize, a wellness check, and a link to other CoA resources. Some of these matches go on to spend time together in-person and the special relationship that develops between a client and a volunteer enables the client to have greater social interaction to maintain healthy, independent living.

Caring Connections was developed and launched in November 2020 during the height of the pandemic in direct response to the escalating problem of social isolation and loneliness in older populations. During its first year, the program grew successfully in Deschutes County and after receiving the COHC Behavioral Health grant in 2021, CoA has been working to expand the program into rural areas of Crook, Jefferson and Deschutes Counties.

In the first year of the program, the primary enrollment strategies have been based on referrals from CoA case managers, recommendations from volunteers who interact with CoA clients, and self-referrals from clients who participate in other CoA programs. We have recognized a need to expand our recruitment efforts of both clients and volunteers, particularly in the rural communities where we have seen slower growth. So the current referral system has expanded by offering virtual and in-person presentations to community partners, public tabling events, targeted marketing, visits to senior living communities, and community outreach in Crook, Jefferson, and rural Deschutes counties to increase program awareness and encourage referrals external to CoA.
Goal #1: Expand the program to include in-person socializing while ensuring the safety of volunteers.

Challenge: When a client receives other CoA services, a case manager makes an at-home visit and while doing so, assesses the safety of their living situation. If they have not received a home visit from a case manager, then we do not have adequate information to assess whether it would be considered safe for a volunteer. Many of our clients lack transportation, so at-home visits are often the most accessible option for in-person socializing. A case management home visit also serves as an assessment that helps determine whether the program is a suitable fit for the client—i.e. Their cognitive limitations, mental health condition, presence of dementia, etc.

Questions: What kind of in-home assessment can we create that will allow us to assess the safety of an individual’s home, in addition to better understanding the individual’s mental health needs, cognitive limitations, or presence of dementia?

Goal #2: Evaluate how our program can be used by individuals with more complex mental health issues and cognitive impairments by enhancing our referral system and providing more volunteer training.

Challenge: Caring Connections offers the consistent camaraderie of a volunteer who is there to listen and relay needs/requests of their match back to CoA, but the volunteer may not have the skills to support an individual struggling with mental health issues or dementia. This program is designed to support individuals who are struggling with social isolation which studies have shown can be associated with depression, anxiety, increased risk of dementia, suicidal ideation, etc. Recognizing this correlation means that our volunteers are likely to encounter individuals who are struggling with mental health issues and volunteers may not have the tools to respond appropriately. An example of this is that we have increased our recruitment outreach to include Veteran Services Offices in Central Oregon, but worry that volunteers may be unable to offer the scope of support that a veteran may need.
Questions: What are some enrollment questions that would help us better assess an individual’s mental health and whether the program can support their needs? What additional resources or training can we provide to our volunteers in order to better support individuals struggling with mental health issues? Are there any facets of this program that can be better developed to help support these individuals?

Goal #3: Enhance data collection to better gauge the impact that the program is having on an individual’s sense of wellbeing.

Challenge: We currently use the UCLA 3-Item Loneliness Scale as a measurement tool for gauging the participant’s level of loneliness. Each participant is surveyed by phone before beginning the program and every 6 months subsequently during participation. While the UCLA scale is widely recognized as a reliable measurement tool, it seems limited in its ability to measure the program’s specific impact on an individual, as well as the factors (such as COVID or geographic isolation) that may contribute to an individual’s feelings of social isolation.

The UCLA 3-Item Scale is a set of 3 questions that measure three dimensions of loneliness: relational connectedness, social connectedness, and self-perceived isolation. The questions are:

1. How often do you feel that you lack companionship?
2. How often do you feel left out?
3. How often do you feel isolated from others?

The scale uses 3 response categories that are coded. The scores of all 3 questions are added together that fall within a range from 3-9. Researchers have grouped individuals in the range of 3-5 as “not lonely” and individuals with the score between 6-9 as “lonely.”

- Hardly ever = 1
- Some of the time = 2
- Often = 3

We also ask additional questions specific to the impact the program is having on the individual’s social isolation and loneliness, such as “Does participating in Caring Connections help you feel less lonely? Please explain how it does or does not help you feel less lonely.”
**Question:** What reliable measurement tools or additional questions can we add to our surveys to better capture the factors that are contributing to social isolation and the impact that the program is having on an individual?