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March 3, 2022

Senator Ned Claxton, Chair
Representative Michele Meyer, Chair
Members, Joint Standing Committee on Health and Human Services
100 State House Station
Augusta, ME 04333-0100

Re: LD 1968 – *An Act To Expand Access to Mental Health and Crisis Care for Individuals in Jails and Individuals Experiencing Homelessness*

Senator Claxton, Representative Meyer, and Members of the Joint Standing Committee on Health and Human Services:

This letter is to provide information in opposition to LD 1968 – *An Act To Expand Access to Mental Health and Crisis Care for Individuals in Jails and Individuals Experiencing Homelessness*. This bill is a concept draft with multiple parts. Some of these parts support directions in which OBH has been moving to improve services. However, OBH has significant programmatic and fiscal concerns about other portions of the bill, as outlined below. We are responding to the draft language from March 2, which we understand to be the intended most recent outline of the bill.

Part 1-A – Examine and remove barriers to admission to crisis care, licensed psychiatric facilities, detoxification, and recovery residences

The phrase "Examining and removing barriers…" is unclear, as is how the bill would "increase the supply of crisis facilities by setting up facilities so they can directly bill for services related to appropriate placements. This includes crisis facilities, detoxification facilities, and psychiatric facilities." We appreciate the intent to remove barriers to accessing care and are engaged in a number of initiatives to achieve this same goal:

- Through MaineCare's rate reform process currently underway, we are committed to minimizing administrative burden while still maintaining accountability, to ensuring rates support the cost of service delivery, and reimburse for aspects necessary for good care that are not currently part of reimbursement models.
- Rates for medically supervised withdrawal ("detoxification") were recently substantially increased
- An 1115 waiver to allow more licensed beds per facility was recently approved by CMS
- The Department introduced a supplemental budget initiative to increase funding for inpatient psychiatric treatment
- The Crisis Receiving Center recently opened in Cumberland county
- DHHS is engaged in a Crisis Services rate study at present, enhanced through securing a CMS Mobile Crisis Planning Grant.
- Office of MaineCare Services (OMS) has encumbered a contract for our service locator tool to provide real time availability information and self-screening tools, among other features.

- Last year, OMS promulgated rules to ensure that individuals with serious mental illness could not be refused for residential (PNMI E) or core community mental health services nor could they be discharged from same services without authorization from OBH.
- DHHS has a number of initiatives aimed at increasing or making better use of inpatient capacity, such as diverting individuals away from ED and hospitalization through our new Mental Health Intensive Outpatient MaineCare program going into effect in April
- Increased capacity of the MaineCrisisLine which will receive calls from 988 as of July 2022

Part 1-B Remove barriers and create clear pathways to the development of permanent supportive housing for this population commensurate with need within a rapid timeframe
While project-based vouchers can encourage property developers/owners to devote units for specific populations, they can be a drawback for behavioral health clients if they need to move or transition since they do not have a subsidy to take with them. OBH currently supports a limited number of project-based rental subsidies.

Regarding the language to "Provide specialized treatment centers and access to care for nonviolent jailed individuals suffering from serious and persistent mental illness when diversion is recommended by prosecutor and approved by judge." We are pleased to report the Department recently (February 2022) opened a "nearly secure" Close Supervision Community Program (located at 33 Stone Street in Augusta), what appears to meet the intent of this LD. We support the concept but are not ready at this time to expand as we intend to gather data and lessons learned from this first site to inform future directions on number of beds and facilities and where they should be located if additional facilities are indicated.

We appreciate the change from the original concept draft which proposed locked facilities. That may have required statutory and regulatory changes. If, as the language implied, these would be locked facilities, limiting admissions to non-violent individuals does not make sense, as non-violent individuals could potentially be served in a less restrictive setting, such as via community-based competence restoration or the current Close Supervision model. The wording is not clear that this applies only to individuals transferred to Department custody; as worded, it could include Department of Corrections (DOC) clients. Additionally, the Division of Licensing and Certification (DLC) does not have an active licensing program set up for a secure treatment facility. As such, rulemaking would have to be developed, which would take considerable Departmental resources away from other efforts.

Part 2 Increase the supply of community-based Intensive Case Managers
In the 1st Session of the 130th, OBH was appropriated one manager and eight new Intensive Case Manager (ICM) positions. It is too early to determine whether these new positions add sufficient capacity. A potential unintended consequence of adding 35 more ICMs is that the State could reduce demand on private case management agencies to the extent that the sustainability of these provider programs could be threatened. This would be problematic given that the State does not operate other direct behavioral health services and thus would not be able to provide continuity of care unlike private behavioral health organizations. The role of the ICM is to assertively outreach and engage challenging clients and connect them to services and provide a warm hand-off, but not maintain ongoing services. If the intent of this section of the bill is to

ensure clients are engaged and served appropriately, that may be better addressed through rule enforcement and increasing case management capacity.

Further, adding 35 ICMs more than doubles the size of the newly expanded OBH ICM program without adding any new supervisory positions. We currently have two supervisors and two managers for 24 ICMS. To add 35 new ICMs, 3 additional supervisors would be necessary.

Part 3 Require the Department of Health and Human Services report on service locator project

We appreciate the changes to this section. The original concept draft language presented multiple concerns. In the current version, the Department does not object to a report out to the Committee on our new OpenBeds platform and adequacy of treatment capacity. The Department is implementing this real time treatment locator tool and prefers voluntary provider participation. Should the Department decide to mandate participation, this could be accomplished through DLC rulemaking.

Regarding now part 3, section 3, the Department is not clear on the intended funding mechanism for jail based telehealth as many individuals would not be eligible for reimbursement while incarcerated.

Part 4 Updating 15 MRSA 101(D)(4)

As written originally written, this section could mean that when assessing a defendant for placement pursuant to 15 MRS s101-D(5), an ACT Team is one of the possible placement options. This is already happening, and there is no statutory amendment needed to continue this, as the statute currently allows “any program specifically approved by the court”. Alternatively, it could mean that collateral information should be collected from an ACT Team if the client is being served by one, which is a practice guideline.

The revised language clarifies that this is in reference to 15 MRS s101-D(4) as a placement option for Commitment for Observation. The purpose of Commitment for Observation is to “materially enhance” the State Forensic Service evaluation, which is accomplished by 24/7 clinical observation in a facility. DHHS currently offers a less restrictive placement option outside of the state hospitals via the Close Supervision Community Program, which accomplishes the needs of the State Forensic Service while also supporting defendants to live in a community setting when hospital level of care is not needed.

Part 4 (B) would require that when a court orders commitment, placement shall take place within 30 days. OBH recognizes the potential benefit of a clear, realistic timeline for which someone must be placed to avoid ambiguity for all parties and avoid unnecessary delays. However, we are concerned that this would hold the Commissioner of the Department to a timeline that is not currently feasible in this State system, including elements outside of the control of DHHS. Should the Committee move forward with this provision, the Commissioner would need discretion to make limited exceptions beyond thirty days for cause.

We appreciate that the original Part 5 re: peer support certification has been removed in the draft amendment. There are two peer certifications currently supported in Maine: Intentional Peer

Support (IPS) and CCAR Recovery Coaching. Other evidence-based peer training models already exist so we do not see the utility of the State expending resources to create a completely new certification training curriculum for peers.

We wanted the Committee to be aware of the above information as it considers this bill moving forward. If you have any further questions, please feel free to contact me.

Sincerely,

Jessica Monahan Pollard, PhD, Director
Office of Behavioral Health