



Service, Education, Advocacy

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Good Morning Mr. Chairman and members of the Human Services Committee. My name is Domenique Thornton. I am the Director of Public Policy for the Mental Health Association of CT, Inc., (MHAC). MHAC is a 100-year old private non-profit dedicated to service, education and advocacy for people with mental health disabilities. I would like to thank you for the opportunity to speak to you about why I believe Senate Bill 32 An Act Implementing the Governor's Budget Recommendations concerning social services will not save the state money but cost the state more in long term service costs and do more harm than good to persons with serious mental illness. People with serious and persistent mental illness have a chronic long term condition that is most efficaciously controlled by modern medications. Yet, the budget adjustments create a series of barriers for people to access medications that will cost more money downstream. For example, people with mental illnesses who go untreated are 4 to 6 times more likely to be incarcerated.¹ Costs of incarceration in Connecticut can run up to \$40,000.00 per year person. Only 25 people would have to be incarcerated before a \$1 million of savings from medications not taken would be lost. Section 33 (f) requiring prior authorization even for persons who have been stable for many years, as well as increasing co-payments to \$20 per month, will effectively deny access to needed medications that have provided stability for many persons. We know about 20% of Connecticut's prison population is currently comprised of persons with mental health or co-occurring disorders. Barriers to access to mental health medications such as placing mental health medications on a preferred drug list requiring prior authorization regardless of its past success in treating chronic illness and increasing co-payments will contribute to this trend of filling the prisons and emergency rooms and hospital beds with persons in crisis. Would the legislature require prior authorization for a cancer medication not on the PDL that had been successful for a patient? When the legislature removed the mental health exemption from the preferred drug list last year, it at least provided a safeguard of grandfathering those who were stable on current medication. Now that protection is in jeopardy. Other states that do use a preferred drug list for mental health medications also have other protections in place consisting of sub-committees, advisory boards, etc. comprised of medical

professionals and academicians to inform and advise the drug selection process to ensure a robust array of choices of medications to treat effectively treat a variety of conditions. When it comes to mental health medications, one size does not fit all.

Similarly, Section 36 proposes to change the definition of “medically necessary” and “medical necessity” to make it more difficult for people who are seriously and chronically ill to access needed medical care by eliminating the goal of restoring “*an optimal level of health*” from the definition that guides what type of care will be provided. Persons with severe and persistent mental illness can be restored to be contributing member of society with proper care. That care must include the hope of a full recovery to “*an optimal level of health.*” In addition, Section 36 would also eliminate the Medical Inefficiency Committee that was created last year to report back to the legislature on the impact of the change in the medical necessity definition on the quality of care for Medicaid recipients. SB 32 would require DSS to simply implement the SAGA medical necessity definition that is intended to apply to an essentially younger and healthier population. It would bypass the extensive work the Medical Inefficiency Committee has completed to date including a thoughtful alternative Medicaid medical necessity definition designed to comply with last year’s legislative mandate without harming access to care to chronically ill persons. The full Committee will soon be producing a report containing a recommended alternative definition that does not cause harm to seriously ill persons. **I urge you not to change the medical necessity definition until you receive and have an opportunity to review their report.**

Other barriers to care such as requiring co-payments under Medicaid medical services up to 5% of family income, eliminating vision, over the counter medications, removing non-emergency medical transport and reducing funding for non-entitlement accounts is nothing more than a **tax on the poorest of the poor by making it more difficult for them to access healthcare.** The merger of the Commission on the Deaf and Hearing Impaired will also reduce services to an already underserved and vulnerable population. I urge you to reject these budget adjustments by keeping in mind that the people behind the numbers are those most in need of your assistance.

¹ Cox, J.F., Morschauer, P.C., Banks, S., & Stone, J.L. (2001). A Five-Year Population Study of Persons Involved in Mental Health and Local Correctional Systems. *Journal of Behavioral Health Services & Research*, 28, 177-87.