CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
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BEFORE THE
PUBLIC HEALTH COMMITTEE
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SB 1089, An Act Concerning Mental Health Services

Good afternoon. My name is Carl Schiessl, and I am the Director, Regulatory Advocacy, for the Connecticut Hospital Association (CHA). I am here today to testify in support of **SB 1089, An Act Concerning Mental Health Services**. CHA supports the bill, as it addresses improvements to the mental healthcare system in Connecticut.

Before commenting on the bill, it's important to point out that Connecticut hospitals treat everyone who comes through their doors 24 hours a day, regardless of ability to pay.

This is a time of unprecedented change in healthcare, and Connecticut hospitals are leading the charge to transform the way care is provided. They are focused on providing safe, accessible, equitable, affordable, patient-centered care for all, and they are finding innovative solutions to integrate and coordinate care to better serve their patients and communities.

During this critical juncture in the evolution of healthcare in Connecticut, proposed cuts to reimbursement and an expansion of taxes on hospitals, coupled with the other reductions impacting community providers, threaten to shred what remains of the mental health safety net at the very time Connecticut residents are demanding improvements to the mental health system. CHA believes that the legislature should not abide by these proposed actions, and that there are modest yet important steps that the legislature may take to preserve and enhance the valuable mental health services we have in place. Several of these steps are set forth in Sections 14 through 22 of SB 1089.

Every Connecticut hospital provides some level of mental health and substance abuse services to children and adults, whether through a distinct behavioral health department, a separate institution or division within the hospital system, or through outpatient services. Every hospital's Emergency Department (ED) is teeming with patients suffering from mental health and substance use disorders.

Connecticut hospitals and other providers have been engaged in a decades-long conversation about the lack of access faced by patients in need of mental health and substance abuse services in Connecticut, and the very real and negative results of ever-diminishing funding for these vital services. And, while funding levels shrink, the number of patients coming to hospitals for these services grows. Notably, we have witnessed increases in virtually every patient category.

- In 2014, more than 25 percent of all inpatient and ED visits to Connecticut hospitals were to treat patients with a principal or secondary diagnosis of a behavioral health disorder.
    - 38 percent of these visits occurred among Medicaid beneficiaries.

- When considering principal diagnoses only, Medicaid beneficiaries comprised more than 48 percent of all patient encounters with a behavioral health diagnosis.

- Between 2010 and 2014, Connecticut hospitals experienced a 31 percent increase in patient visits with a behavioral health diagnosis.

- There were more than 31,000 hospital visits for behavioral health among children and young adults ages 0-19 in 2014.
    - This represents a 13 percent increase in visits between 2010 and 2014 for this age group.

This spike in utilization is coming at a time when the system is already plagued by long waits and financial or resource limitations to accessing therapeutic/residential placement, appropriate clinical treatment services, and supportive housing.

A patient experiencing a mental health crisis is often forced to spend days, or even weeks, in a hospital ED waiting for a bed in an appropriate facility, or waiting to be transitioned to the right outpatient setting simply because there are not enough resources available to meet the constant need. Others who are struggling, but who have not yet reached crisis level, have few places to turn as a result of a failed and fractured healthcare delivery infrastructure that allows a known need to go unmet. This unmet need is not new, and is well known to hospitals, community providers, and social welfare agencies.

Extended stays in the ED, a highly stimulating and potentially stress-inducing environment, can exacerbate a patient's condition rather than improve it. This problem is particularly acute for children and adolescents, for whom the need for services greatly outstrips the number of available beds and trained specialists.

The problem of insufficient supply can be seen throughout the care continuum. It can take months to schedule an outpatient visit with an adolescent mental health specialist. While waiting for that important visit, a family is forced to rely on the hope that the situation does not escalate to the point of emergency room care, but sadly it often does.

In 2014, CHA convened a Subcommittee on Mental Health, comprising hospital behavioral health directors, emergency medicine physicians, chief executives, chief financial officers, and government affairs experts, charged with developing recommendations to improve health outcomes, relieve the burden on EDs, and improve the adequacy of funding for key mental health safety net services. Attached for your reference is a Summary of CHA's Mental Health Recommendations.

Connecticut's mental healthcare system involves a complex array of state-operated and state-funded providers for the range of services required to meet patient needs. This system includes a number of different state agencies, each with its own mission and constituency. The Subcommittee found that cooperation among all of the state agencies providing mental health services, and collaboration by these agencies with all mental healthcare providers, including state-operated and state-funded programs, are essential to achieve our goals. Sections 14 through 22 of SB 1089 include several recommendations that will help break down these silos to improve Connecticut's mental healthcare system.

Section 14 calls for the development of a program to improve health outcomes for children and adults, ensure access to services, and achieve the most efficient use of limited financial resources. CHA supports the development of a Medicaid shared savings model involving the front-line providers of mental healthcare services, including hospitals, as active participants with state agencies at every stage in the conceptualization, development, and implementation of this program.

Since the primary focus of this program is to improve access to care and patient outcomes, we ask the Committee to consider changing the language in Subsection (3) of Section 14 from "reduce costs to the state" to "provide such services in a manner that costs are reasonable and reflective of a provider operating efficiently, based on accepted economic principles of hospital cost and reimbursement." We also ask the Committee to delete the word "decrease" in Subsection (C) of Section 14 and insert the word "control" in lieu thereof.

One example of an innovation in the delivery of mental health and substance abuse treatment services to adults is known as a Behavioral Health Home (BH Home). These are not actual homes, but rather an integrated healthcare services delivery model. BH Homes are intended to facilitate access to interdisciplinary behavioral health services, medical care, and community-based social services for people with serious and persistent mental illness (SPMI).

The Department of Mental Health and Addiction Services (DMHAS) is using 13 local mental health authorities presently to implement BH Homes in a targeted manner. Section 16 proposes to expand the BH Home delivery model to allow hospitals and federally qualified health centers (FQHCs) to be designated as BH Homes. CHA believes that by including hospitals and FQHCs in the program, as is done in other states, a higher degree of community provider integration and care coordination will be achieved, since more providers will be engaged in the system. This will result in more effective patient screening, better coordination with other community care coordination activities, and improved patient outcomes. Since BH Homes serve a relatively narrow cohort of patients, specifically those with SPMI, the need for

coordination with other community care initiatives is clear, given the limited resources available to serve all patients with behavioral health needs.

Another innovative solution that is proven to achieve improved health outcomes for high-volume ED visitors, relief to behavioral healthcare providers, and potentially substantial and sustainable Medicaid savings to the state is known as a Community Care Team (CCT).

Across Connecticut, hospitals are teaming up with other community-based healthcare providers and providers of wraparound social services to establish CCTs or to engage in other related community care coordination initiatives. These teams, which meet regularly, work collaboratively to enhance patient screening, ensure timely release of information, establish patient-centered intensive case management (ICM) plans, and engage patients in housing and social wraparound support services.

In those places where CCTs have been piloted in Connecticut, patients have experienced improved health outcomes including sobriety, mental health stabilization, reduced homelessness, and re-entry to the workforce, highlighted by fewer ED visits. Hospitals have experienced a reduction in ED overcrowding, decreases in costs of care, and reduced losses for undercompensated and uncompensated care. Most notably, there has been a positive impact on the state's bottom line, since typically more than half of these patients are Medicaid beneficiaries.

Connecticut hospitals and other community healthcare and social service providers are demonstrating an unprecedented degree of dedication, cooperation, and commitment of time and resources to community care coordination. Efforts to organize CCTs have been driven by hospitals and other care providers, and have been funded primarily through the generosity of these providers. In one instance, a CCT was funded by a grant from DMHAS. Others were established pursuant to short-term initiatives such as the ED Frequent Visitor Project, sponsored by ValueOptions under the auspices of the Department of Social Services, or the Connecticut Hospital Association/Partnership for Strong Communities Opening Doors Hospital Work Group, funded by a grant from the Connecticut Health Foundation. These initiatives have demonstrated the potential value of CCTs, but we need your help to ensure statewide implementation of community care coordination.

In its 2014 report on *Hospital Emergency Department Use and Its Impact on the State Medicaid Budget*, the Program Review Committee (PRC) concluded that "the more successful initiatives, especially for frequent users of the ED who have behavioral health or substance abuse disorders, are associated with ICM programs that: (i) have more face-to-face client interaction; (ii) involve EDs in the selection of clients, and in the development of a care plan; (iii) perform ongoing, and not episodic, monitoring of clients' stability and progress, including frequent meetings of providers involved in client care and services; and (iv) demonstrate a persistence in engaging the client and managing health and psycho-social needs." The CCTs being established in Connecticut abide by the conclusions articulated by the PRC, and merit your consideration for financial support.

Sections 18 and 19 establish a grant program to provide funds to organizations that provide acute care and emergency behavioral health services. CHA has determined that an appropriation of $1.8 million and FY 2016 and $3 million in FY 2017 to DMHAS will be sufficient to support grants to hospitals across the state for CCTs and related care coordination services, specifically for administrators to manage the CCTs and navigators/intensive case managers to coordinate the mental health and social service needs of each patient.

Hospitals and other community providers will continue to provide access to the clinicians, facilities, mental health treatment, and social services required by these patients. We need this relatively modest financial commitment from the state to turn an innovative community-based solution into a statewide best practice that will benefit patients, relieve pressure on providers, and achieve savings for the state.

Also related to SB 1089, CHA supports measures to disclose and disseminate more effectively information regarding the admission criteria, admission process, and program capacity of state-funded and supported facilities and programs that offer mental health or substance abuse services. This will improve access to such resources among the broad spectrum of providers. While the annual reporting requirement set forth in Section 17 is a positive step, CHA recommends that this requirement be supplemented by a requirement that the departments present their annual report to a meeting of the Connecticut Behavioral Health Partnership Oversight Council (Oversight Council), and that they make a semi-annual progress report to the Oversight Council, to be delivered either orally or in writing, at the option of each department. This will ensure ongoing dialogue in a public forum between providers and state agencies. Connecticut hospitals also stand ready to partner with state agencies in the establishment and implementation of evidence-based quality measures designed to improve health outcomes, as described in Section 17.

It is difficult to discharge patients no longer in need of hospitalization to the appropriate level of care, and to admit people who need acute inpatient psychiatric care, due to insufficient numbers of acute, intermediate length-of-stay, and long-term inpatient beds. Sections 21 and 22 offer a means to relieve some of the short-term pressure placed on the mental healthcare system to accommodate bed need.

Intermediate-duration acute psychiatric care is an extended period of evaluation, intensive treatment, and rehabilitation over an average length of stay of 30-45 days. These beds are called Intermediate Care, or ICC beds. There presently exist two sites – St. Vincent's West Campus, formerly known as Hallbrook, in Westport, and Natchaug Hospital in Mansfield Center – that have ICC beds. CHA believes that establishing a unit of four beds in each of the three DMHAS regions that do not host a unit presently will relieve the current backup in acute inpatient psychiatric beds. We endorse Sections 21 and 22, which establish a grant program and an appropriation to fund these units. CHA recommends that the sums of $750,000 be appropriated to DMHAS in FY 2016 and $1,500,000 in FY 2017 to fund the establishment of these beds.

Consistent with the theme of interagency cooperation and state collaboration with all providers of mental health services, Section 20 provides a framework to study, assess, and accommodate the current utilization of and need for hospital beds for acute psychiatric care. CHA supports a study that will recommend the number and type of short- and longer-term inpatient beds needed, whether they should be operated by the public or private sector, and how they should be funded.

CHA respectfully suggests that the deadline to generate the report required by Section 20(b) be extended from February 1, 2016 until December 31, 2016 to ensure that there is sufficient time to complete the study.

Finally, CHA supports equitable reimbursement for mental healthcare services by taxpayer-funded programs. Section 15 would raise Medicaid reimbursement rates for behavioral health services to levels comparable to Medicare. This would better ensure that the cost of providing such services are reasonable and reflective of a provider operating efficiently, and are based on accepted economic principles of hospital cost and reimbursement.

Thank you for your consideration of our position. For additional information, contact CHA Government Relations at (203) 294-7310.

CHA Mental Health Recommendations

The Connecticut Hospital Association (CHA) supports short- and long-term solutions to improve Connecticut's mental health system. These recommendations are intended to improve health outcomes, reduce unnecessary use of emergency department (ED) services, and ensure adequate funding for key safety net services.

1. **Redesign the Medicaid Program to Support Mental Health Services.**
   A. **Establish Shared Savings:** Establish a Medicaid shared savings model for behavioral health services for children and adults, fostering improved care coordination and achieving state savings.
   B. **Achieve Equitable Medicaid Reimbursement**: Raise reimbursement rates for behavioral health services to levels comparable to Medicare. Ensure that reimbursement for hospital-based outpatient clinics is comparable to that for community-based clinics.
   C. **Expand the Behavioral Health Home Model:** Allow hospitals, federally qualified healthcare centers, and other safety net organizations to implement behavioral health homes.

2. **Improve Access to State Resources by Requiring Transparent Health Outcomes and Quality Measures.** Increase transparency when accessing state funded or operated services/providers, and establish measures for meeting evidence-based standards and improving health outcomes.

3. **Support Community Care Teams and Related Care Coordination Services**. Fund community care efforts in hospitals to enhance patient screening, ensure timely release of information, establish patient-centered community case management plans, and engage patients in housing and social wraparound support services. Funding options may include grant support based on ED volumes, case rates for identified high-risk utilizers, and similar support for community care team clinicians, administrators, navigators, and/or intensive case managers.

4. **Assess and Accommodate Short- and Long-term Bed Needs.** It is difficult to discharge patients no longer in need of hospitalization to the appropriate level of care, and to admit people who need acute inpatient psychiatric care, due to insufficient numbers of acute, intermediate length-of-stay, and long-term inpatient units.
   A. **Expand Availability of Intermediate Stay Inpatient Beds:** Expand beds in each region of the state to address the need for inpatient care for intermediate stays.
   B. **Increase the Number of Long-term Beds for Behavioral Health Patients:** Assess inpatient bed capacity for children and adults with longer-term, serious, and persistent behavioral health disorders.
   C. **Determine Short- and Long-term Bed Needs:** Study and recommend the number and type of short- and longer-term inpatient beds needed, whether they should be operated by the public or private sector, and how they will be funded.

5. **Develop Crisis Stabilization and Emergency Services for Children in Consultation With Hospitals**. Support plans to improve Emergency Mobile Psychiatric Services (EMPS) including minimum criteria for facilitating effective diversions and achieving appropriate placements for children in crisis, increase crisis stabilization resources for DCF and non-DCF children, and implement a psychiatric assessment center.

6. **Reduce Inappropriate Opioid Use.** Support a comprehensive statewide strategy featuring multi-sector collaboration among physicians, hospitals, and the state by expanding availability of opioid antagonists, enhancing prescription monitoring to assist prescribers, increasing prescriber education, and supporting evidence-based prevention programming to reduce the misuse and abuse of opioids and other prescription drugs in Connecticut.