



Insurance & Real Estate Committee Public Hearing

Tuesday, March 17, 2015

Beacon Health Options

Testimony offered regarding

SB 1085 AAC Health Insurance Coverage for Mental or Nervous Conditions.

Good afternoon Senator Crisco, Representative Megna, members of the Committee, my name is Lori Szczygiel, Senior Vice President of Beacon Health Options (Beacon), formerly Value Options (VO). I'd like to thank you for the opportunity to provide comment today on behalf of our organization regarding SB 1085. I believe that I have a unique perspective on the state's mental health landscape, having served as VO's top executive of the Administrative Services Organization (ASO) under the Behavioral Health Partnership (BHP) from 2005-2013. I am proud of the work we did and continue to do here in Connecticut in partnership with DSS, DCF and DMHAS to transform the system.

For the last year and a half, I have taken on a national role for Beacon working with states and health plans all over the country as they strive to meet the mental health and substance use challenges of their members. As a clinician, in addition to an administrator experienced in population health, I look at public policy through a multi-focal lens.

First, let me say, I have nothing but the utmost respect for the Healthcare Advocate whom I understand may have asked for your consideration of this proposal. I consider Vicki not only a respected colleague, but also a strong colleague "in arms" as we work together to improve the delivery system for individuals and families struggling with serious emotional disturbance and other behavioral health challenges.

I applaud the state's movement to ensure that there is a robust community delivery system defined by the programs and services included within this bill. This will assist individuals and families on their recovery journey. A robust community system is a necessity.

With that said, measures to ensure coverage and access are not enough. We must be concerned about accountability and outcomes as well.



In my experience that means we need to ensure that providers have the resources needed to meet the demand, but that we also need to make sure that the financial incentives are aligned appropriately. The state's SIM effort is taking a close look at these issues by virtue of their payment reform task force and we support the continued dialogue in that venue.

The one area of the bill where I urge caution and continued conversation is around mandated length of stay and the absence of utilization management for inpatient and crisis services. On the surface, this is positive and assures access to important levels of care; however, utilization review plays a very important role in the delivery of quality services:

- Importance of Utilization Review (medical necessity determination)
 - Determine the **appropriate level of care**.
 - Ensure **limited higher level of care resources** are used for the most appropriate members (moving members who need less intensive services to more appropriate levels of care).
 - The **right amount of treatment** for the right duration.
 - Ensures use of **evidenced based practices**.
 - Ensures **coordination of care**.
 - Ensures **coordination of discharge plans and follow up**.

 - Other issues for consideration:
 - There is **no bed capacity to care for all the individuals with emotional disturbance or mental illness** for unlimited amounts of time.
 - Under the per diem model, there is **no incentive for facilities to provide active, effective care** because the longer they keep patients, the more money they get.
 - Inpatient hospitals have **no incentive** in an unmanaged setting to step patients down to just as effective, less costly levels of care.
 - **Treatment will drift away from being individualized**.
 - There is **no evidence** that the unmanaged (or relatively so) state of the 1980s yielded **better outcomes** than the current managed state, but certainly was more costly.
 - Evidence shows that **less restrictive levels of care for longer periods of time are just as or even more effective** than higher levels of care.
 - **Care will drift toward the dollar**, and will be less based on evidence based practice and least restrictive setting.
 - **Claims cost will increase** as no opportunity for even retrospective review so non-acute days normally based on medical necessity would be paid.
 - **Documentation and quality care may be at risk** as the opportunity for identifying such instances will no longer be available through the utilization review process.
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When I arrived in Connecticut in 2005 the inpatient lengths of stay for children were significant, individuals were waiting inordinate amounts of time (days) in the emergency rooms waiting for care and readmissions were high. After a concerted effort led by the CT BHP, state agency staff, providers and community stakeholders, length of stay decreased, admissions to inpatient increased, connect to care rates improved and dollars were saved. The right level of care for the right amount of time improves outcomes and assures efficient utilization of precious resources. I understand the frustration that might lead up to this type of policy, however, I believe it's the wrong direction for the state to take. Evidence points to the success of keeping children and adults in their communities where they are near family and are able to participate in life's daily activities. The longer we remove individuals from their everyday lives, the more difficult the transition is back to community.

The BHP has been the recipient of a lot of praise over the last few years, and again, I'm extremely proud of our current system within the Medicaid program. However, this system came about over several years with untold hours spent by VO, its' partner agencies, providers, hospitals and others working together. Quality should always be the prominent driver lest we settle for the lowest common denominator. The move in the marketplace is towards health care analytics whereby facilities are looked at through various different lenses: how they compare to their peers, how well they incorporate discharge planning into their daily operations, whether they are an outlier in terms of lengths-of-stay which could - be valid or invalid - but which should be evaluated.

I respectfully offer the following recommendations to the Committee:

1. Assure the full continuum of community based services to be used as an alternative to more restrictive levels of care, insuring timely access wherein someone does not need to "fail" to access needed community services.
2. Continue efforts centered on payment reform (SIM) to allow payers and providers to expand the delivery of service, increase flexibility in the provision of service and assure accountability and outcomes.
3. As an interim step, consider additional behavioral health reporting and outcome tracking to use data to inform policy change and direction. The Governor's bill, HB 6847, creates a working group to discuss behavioral health and substance abuse reporting measures and we support its passage.
4. Continued transparency and dialogue with all stakeholders to continue to move the system forward.

Thank you for the opportunity to offer my comment.
