Behavioral Health Partnership Oversight Council

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TESTIMONY REGARDING H. B. No. 6365 AN ACT CONCERNING THE STATE BUDGET FOR THE BIENNIUM ENDING JUNE 30, 2011

Submitted to: The Appropriations Committee

By: Judith Meyers, Ph.D. – President and CEO, Child Health and Development Institute of Connecticut (CHDI) and the Children's Fund of Connecticut; Representative Geragosian's designee on the CT Behavioral Health Partnership Oversight Council.

Senator Harp, Representative Geragosian, and other members of the Appropriations Committee, I have been asked to submit this testimony on behalf of the CT Behavioral Health Oversight Council, on which I serve as Chairman Geragoisian's designee. The Behavioral Health Partnership Oversight Council was established in legislation (PA05-280) to advise the Departments of Children and Families (DCF) and Social Services (DSS) on the planning and implementation of the statutory Behavioral Health Partnership (BHP). The BHP Oversight Council, comprised of legislators and their designees, behavioral health consumers and advocates, medical and mental health practitioners, state agencies and insurers, has the legislative mandate to assess the development and ongoing implementation of the BHP program and make recommendations to the State agencies and the CT General Assembly. One of our charges is to review and comment on policies related to the coordinated delivery of both physical and behavioral health services for the covered populations (HUSKY Part A child/parent/caregiver members, HUSKY Part B members (children) and children enrolled in the DCF voluntary services program).

With that in mind, I have been asked to provide a summary of the concerns that were expressed at the Feb. 11, 2009 Behavioral Health Partnership Oversight Council meeting related to changes in HUSKY as proposed in the Governor's biennial budget.

1. <u>The overall effect of the proposed introduction of cost sharing for premiums and co-pays for services under HUSKY B</u>. The *Kaiser Commission on Medicaid and the Uninsured* reported in their study of the impact of cost sharing in a number of states that that there were direct effects on enrollment, access to care, and provider reimbursement. As cited in their 2005 report:
   - new or increased premiums served as a barrier to obtaining and/or maintaining public coverage;
   - premiums disproportionately impacted those with the lowest incomes, but also led to disenrollment among those with incomes above 150% of poverty;
   - while some disenrollees obtained other coverage, many became uninsured;
   - cost sharing led to unmet medical need and financial stress, even when amounts were nominal or modest;
   - affordability problems stemming from increased out-of-pocket costs led to increased pressures on providers and the health care safety-net such as Emergency Departments and hospital days as well

as the total community costs of health care;

- Increases in beneficiary costs may have created savings for states, but they may accrue more from reduced coverage and utilization rather than increased revenue.

Members of the Council were also concerned that access to services may be limited for individuals/families that cannot pay the cost share because the CMS enforcement provisions allow providers to require such payment as a condition for provision of services and thereby could refuse treatment.

In sum, increasing financial obligations on low-income families may provide short-term state savings but these savings may accrue more from reduced coverage and utilization rather than increased revenue. Whether intended or unintended, the consequence are real and in the long term this does not appear to be in the best interests of the children and families served under the CT BHP program.

Providers may also bear the brunt of this arrangement as CMS requires a methodology that considers reduction of state payments to providers by the amount of the beneficiary cost sharing obligation, regardless of whether the provider successfully collects the cost share. As providers are permitted to reduce or waive the cost share on a case-by-case basis, if they do so they will have a loss of reimbursement. It is our assumption that not many providers will refuse service on the basis of a patient's inability to pay the cost share amount.

Council members also noted that there is also a lack of clarity about how the cost share would be applied for intermediate level behavioral services or medical services that require more than weekly visits.

2. The potential loss of resources available to support the excellent work that has been achieved through the CT BHP. While we very much appreciate that the biennial budget for the CT BHP program has a projected 8% increase, in a time when so much by necessity is being cut, that increase will not be sufficient to keep up with the projected increased HUSKY A enrollment of more than 16%. The SFY 10 projected monthly enrollment average is 336,608; the SFY 11 projected enrollment increases to 401,776, an increase of 65,168 (>16%). In addition, the Governor's proposed budget does not include an agreed to 2% managed care organization increase (MCO). Since the BHP program provider reimbursement was, by statute, associated with the MCO annual increase, there is the likelihood that this increase in provider reimbursement will be negated unless this is addressed.

3. The revision of Medicaid medical necessity and appropriateness definition. The revision of the definition appears to be associated with a projected savings of $ 4.5M in SFY 10 and $9M in SFY 11. Council members assume that the savings are anticipated as a result of changes in service utilization. Changing the definition does not change members' need for treatment. The BHP program has, in conjunction with the Council, developed level of care guidelines that include provider discussion with the Administrative Service Organization for prior authorization of services when their patient doesn't fit the level of care criteria (medical necessity and appropriateness of care). Changes to a more restrictive definition of medical necessity will require review of all BHP level of care guidelines.

4. Pharmacy provision changes. Changes in the pharmacy benefit coverage include co-pays, potential pharmacy refusal to fill a script when the member cannot pay their cost share, and elimination of 30 day 'temporary drug supply' when the prescriber does not obtain prior authorization. These changes may place families at risk for not beginning or continuing prescribed regimens for medical and behavioral health medications. Again there are research findings that indicate that increased cost sharing for pharmaceuticals is associated with lower rates of drug treatment, worse adherence among

existing users, and more frequent discontinuation of therapy. In some cases this could result in preventable ED visits and hospital admissions/readmissions.

In addition to concerns about the proposed biennium budget, Council members expressed concern about potential loss of anticipated funds in the current budget year (SFY 09). There were two measures that had been approved by the Council and were waiting action by the Commissioner of DSS. The concern is that since action has been delayed, these measures are now at risk: These include the following:

1. The 2% provider increase;

2. Performance incentive funds that were set aside related to improvement in the following key areas:

a) The ***impatient hospital average length of stay*** measure (funded at $300,000) was developed with the hospitals and BHP agencies. The goal of this measure is to reduce unnecessary pediatric inpatient days. Even with increased HUSKY enrollment in the 3rd and 4th Quarter of 2008, compared to 2007 the average delay days for delayed discharges in 4th Quarter 08 **decreased** from 46.5 to 25. This decrease was attributed to the collaborative performance measure development. The process was negotiated in good faith and the improvement in performance will result in a more cost effective and cost efficient community based service system.

b) ***Psychiatric Residential Treatment Facilities (PRTF)*** incentive to reduce average length of stay ($140,000 is at risk): the average length of stay in PRTFs has begun to decrease during the performance plan development, moving toward the goal of reduced institutionalization.

c) ***Emergency Room and/Emergency Mobile Psychiatric Services (EMPS)*** (total incentive pool of $400,000) that involves collaboration between hospital EDs and the EMPS teams. The goal of the performance project is to divert pediatric ED admissions through onsite community crisis interventions, shorten ED pediatric psychiatric stays and/or reduce the percentage of ED admissions to pediatric inpatient services.

d) ***Extended Day Treatment*** performance improvement initiative, which is still under review by the Council.

Loss of previously approved funding for the CT BHP program that includes quality improvement initiatives and programmatic changes in HUSKY A and B may undo the important improvements made in the reduction of institutional care and expansion of community-based services and improvement in health coverage and services in the HUSKY program.

Thank you for the opportunity to voice the concerns of the CT BHP Oversight Council. We know these are difficult times and appreciate the support the legislature has provided for this far reaching reform in the delivery of mental health services in Connecticut. Please call on us if we can be helpful in providing further information or assisting in any other way.