CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY OF
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CONNECTICUT HOSPITAL ASSOCIATION
BEFORE THE
MENTAL HEALTH SERVICES WORKING GROUP
OF THE
TASK FORCE ON GUN VIOLENCE PREVENTION AND SCHOOL SAFETY

Tuesday, January 29, 2013

My name is Carl Schiessl. I am the Director of Regulatory Advocacy at the Connecticut Hospital Association (CHA). I am here testifying on behalf of CHA and its member hospitals concerning the availability of mental health services in the State of Connecticut. Our goal is to offer you some context about the current state of mental and behavioral health services in Connecticut. We are grateful to the Working Group for the opportunity to testify today, given the critical role that Connecticut hospitals and healthcare systems have as the safety net that provides all medical services to patients in Connecticut, including mental and behavioral health services.

For years, 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 and behavioral health services in Connecticut, and the very real and negative results of ever-diminishing funding for these vital services. We share the frustration felt by many in the care continuum that, even when the key problems we face in addressing mental illness are well-defined and identified, there seems to be a paralysis in moving toward solutions. The reality in Connecticut is that there are often long waits and financial or resource limitations to accessing (1) therapeutic/residential placement, (2) appropriate clinical treatment services in the community, or (3) appropriate supportive housing.

Connecticut hospitals offer mental health services in both inpatient and outpatient settings, as well as in their emergency departments. All hospitals have some level of mental and behavioral health services—some through a distinct behavioral health department, others through a separate institution or division within a hospital system. Still others focus on outpatient and community support.

A patient experiencing a mental health crisis is often forced to spend days or even weeks in a hospital emergency department 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 emergency department, 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, where the need for services greatly outstrips the number of available beds and trained specialists. Unfortunately, at times we are forced to place children in crisis on general medical-surgical pediatric units for extended stays because there are simply no psychiatric beds or services available.

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, the 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.

Funding and Payment Structure Failure

There are longstanding defects in the payment system structure for mental health services. Psychiatric care in a hospital setting loses money hand-over-fist for the simple reason that the cost per patient is higher than the reimbursement provided. Private insurance rates are too low and lack parity with reimbursement for physical medicine services. State Medicaid rates are strikingly inadequate. And every year, it is an ever-escalating struggle for hospitals to work with managed care companies to maintain reimbursement rates for the services provided. For many hospitals, the annual loss for unreimbursed and under-reimbursed mental health services can amount to millions of dollars.

As the state has trimmed its budget in the economic downturn, resources for mental health patients—including hospital-based resources—have been among the casualties. In Connecticut, as recently as last month, hospital funding was reduced a staggering $103 million dollars. These cuts will impact Connecticut hospitals' ability to provide care for patients, including care for those who require mental health treatment programs and services.

The bottom line is that to provide mental and behavioral health programs and services, hospitals must fill the financial gap by subsidizing them with resources from other programs and services that have a stronger reimbursement structure. Sadly, this is no longer an option, as the cuts have made it extraordinarily challenging to sustain **all** hospital services, and **most particularly** subsidized mental health services—even at their current inadequate levels.

As you review and analyze the array of recommendations on a range of potential legislation aimed at ensuring the availability of such services in Connecticut, we urge you to acknowledge the very real consequences of the financial pressures being brought to bear at all levels of the healthcare system. We are at a tipping point. Hospitals are no longer able to sustain the healthcare safety net we have—let alone expand it—without additional resources that are so desperately needed.

To assist you in your analysis, we offer a brief overview of hospital utilization and mental health services in FY 2012 with respect to inpatient care and emergency services, as well as information on trends we are experiencing in acute care hospitals by age and payor mix over a period spanning FY 2008 to FY 2012. You will note that these data indicate that while funding is decreasing, the number of patients is growing rapidly, with a spike in younger patients needing mental health services.

We would be happy to provide any additional statistical information that would help you better understand the problems with the current delivery system, including the direct effects of underfunding.

Overview of Hospital Utilization and Mental Health Services

Trends by Age:

- From 2008 to 2012, **inpatient mental health discharges increased by 13 percent**, with the largest increases occurring among children aged 12 years and younger (25 percent increase) and adolescents 13-20 (26 percent increase).
- Over that same time, **ED non-admissions involving a mental health disorder increased by 40 percent**, with the largest increases occurring among children aged 12 and younger (48 percent increase).

Trends by Payor Type:

- From 2008 to 2012, **inpatient discharges with mental health diagnoses increased by 35 percent among Medicaid patients**. This compares to an increase of only 13 percent among the other payor types, including Medicare, private insurance, and other government programs such as TriCare.
- Over that same period, **Medicaid ED non-admissions with behavioral health diagnoses increased by 71 percent**. This compares to an increase of 40 percent among other payor types.
- In 2012, **Medicaid patients represented 43 percent of the ED non-admissions for mental health disorders**—the highest percentage of patients who were treated at an emergency department with a mental health disorder and then discharged.

We look forward to working with you to develop recommendations that will improve access to care, across the continuum of care, for patients in need of mental and behavioral health services in Connecticut, and that will address the very real and negative results of ever-diminishing funding for these vital services.

Thank you for consideration of our position.