CONNECTICUT HOSPITAL ASSOCIATION

TESTIMONY
OF
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CONNECTICUT HOSPITAL ASSOCIATION
PUBLIC HEALTH COMMITTEE
Tuesday, February 4, 2003

SB 835, An Act Concerning Mental Health Services

SB 423, An Act Concerning Daily Data Collection On The Number Of Patients With Psychiatric Diagnoses Held In Hospital Emergency Departments

Good morning Senator Murphy, Representative Feltman and members of the Public Health Committee. My name is Carrie Brady and I am Vice President of Patient Care and Regulatory Services of the Connecticut Hospital Association. I appreciate the opportunity to testify this morning on two bills before the Committee.

The Connecticut Hospital Association (CHA) supports the intent of **SB 835, An Act Concerning Mental Health Services**, which clarifies that the Department of Mental Health and Addiction Services is an essential member of Connecticut's Behavioral Health Partnership. DMHAS' involvement with the Department of Social Services (DSS) and the Department of Children and Families (DCF) is essential to coordinating and improving the mental health care system in Connecticut. CHA has some specific concerns, however, about the overall implementation of the Behavioral Health Partnership, as well as the specific provisions in SB 835.

We urge this Committee to mandate that as the Behavioral Health Partnership is implemented, reimbursement rates to behavioral health providers not be reduced. (Sample language that the Committee could use to accomplish this objective is attached.) The Behavioral Health Partnership is an important effort to coordinate the delivery of mental health services in Connecticut. The premise of the Partnership is that by coordinating more closely, DSS, DCF and DMHAS will be able to use their resources more efficiently and improve the delivery of behavioral healthcare services in Connecticut. One of the Partnership mandates is that any changes to the system must be budget neutral to state. It is important that the Partnership not attempt to achieve budget neutrality by reducing payments to providers such as hospitals and community mental health clinics.

No matter how the state chooses to allocate behavioral health resources, hospital emergency departments must treat all patients. Connecticut hospital emergency departments are already overwhelmed by patients in need of inpatient mental health services for whom a bed cannot be found for days or even weeks. Such backlogs are detrimental to the entire healthcare system, but they are devastating to the patients in need of treatment. If the Behavioral Health Partnership attempts to cut costs by reducing payments to mental health providers at any point in the continuum of mental health care, the patients will have nowhere to turn but their hospital emergency departments. The increased volume of patients seeking behavioral healthcare services in emergency departments will further exacerbate the existing backlog and resulting negative impact on patient care for all patients.

With respect to the specific provisions in SB 835, CHA urges the Committee to mandate that DSS cannot implement new clinical management policies and procedures without prior notice to providers. Section 1(b) of the bill modifies a statute that allows DSS to make new policies and procedures immediately effective on providers, as long as DSS publishes notice of its intention to enact regulations codifying the policies within twenty days after their implementation. Providers cannot be expected to comply with new policies and procedures before they have received notice and an opportunity to raise questions and concerns. We respectfully suggest that the Committee revise section 1(b) to indicate that DSS must adopt regulations prior to modifying policies and procedures that impact providers.

If DSS delegates clinical management services for the Medicaid population to DMHAS, it is imperative that DMHAS be given sufficient resources to effectively manage those services. In addition, no matter which agency provides clinical management services, it is important that such services do not penalize providers by retrospectively reviewing and denying necessary care. A provider who in good faith treats a patient in need of services should receive payment for those services.

Finally, the bill indicates that DSS may delegate clinical management services to DMHAS for patients seventeen or older, but existing statutes allow such delegation to DCF for children seventeen and younger. In delegating clinical management services, DSS should clearly indicate whether DCF or DMHAS has primary responsibility for seventeen year olds and also ensure that the agencies work together to effectively manage patients as they transition from DCF to DMHAS services.

CHA supports **SB 423, An Act Concerning Daily Data Collection On The Number Of Patients With Psychiatric Diagnoses Held In Hospital Emergency Departments**, which would require DSS, DCF and DMHAS to collaborate with interested parties to develop a mechanism to track on a daily basis the number of children and adults awaiting psychiatric placement in hospital emergency departments and the number of open beds in acute care and residential facilities providing mental health services. The extended stays

in hospital emergency departments of patients awaiting mental health services is a continuing problem and SB 423 is a critical first step in addressing this issue.

CHA welcomes the opportunity to work collaboratively with DSS, DCF, DMHAS and others in designing a system that will effectively identify the barriers to mental health placement and aid in the development of solutions. The tracking system should be designed in a way that minimizes the burden on already overwhelmed hospital emergency departments. One way to reduce the burden, for example, would be to exclude tracking of patients who are placed within 24 hours of arrival in the emergency department.

In addition, in order to accurately capture all patients awaiting placement, the tracking system should include not only patients waiting in hospital emergency departments, but also patients who are being held in other areas of the hospital, such as pediatric medical-surgical units, while they await inpatient psychiatric placement. The bill also should clarify that the tracking system applies to all patients, not just those patients who are already DCF or DMHAS clients, because the placement backlog is affecting all patients, including those who are privately insured.

Thank you for your consideration of our position.

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Attachment