



Disability Rights Connecticut
"Connecticut's protection and advocacy system"

**846 Wethersfield Avenue
Hartford, CT 06114**

March 16, 2023

**Re: Testimony of Sheldon Toubman before the Human Services Committee
Regarding HB 1173, 1205, 6885**

Good afternoon, Senator Lesser, Representative Gilchrest and other distinguished members of the Human Services Committee:

My name is Sheldon Toubman and I am the Litigation Attorney at Disability Rights CT. We are the Protection and Advocacy System for CT, serving individuals with a full range of physical, behavioral, intellectual and developmental disabilities. I am here to testify about the impact of three bills on people with disabilities.

SB 1173

This bill would require a study and report by DSS regarding (1) How responsive department programs are to recipients of services; (2) what problems, if any, exist within such programs; and (3) whether staff is *allocated* in a manner to meet the need for services within such programs.

This study is important to people with disabilities who are routinely identifying access issues at DSS, through all means offered -- the physical offices, the phone system and through the limited on-line service system.

While DSS has, to the credit of former Commissioner Roderick Bremby, transformed the platforms for processing applications and communicating with clients with the implementation of the "ImpaCT" system, unfortunately those platforms have never been adequately staffed. At the time of the transformation, individual case workers were ended for most kinds of cases and the push was for on-line servicing wherever possible, but mostly through creation of a Call Center, where any random worker could pull up documents uploaded

through the scanning system and respond to any questions an applicant or beneficiary caller might have.

But the Call Center has never been adequately staffed and right now it is terribly understaffed. People are taken off of the backed-up Call Center to process applications and redeterminations, and people are taken off of backed-up processing to try to help out the overburdened Call Center. The situation is so bad that the Call Center (as well as the physical offices) are closed all day every Wednesday and, increasingly, on **other days of the week** it closes down as well, because of volume and lack of staff to accept the calls. Sometimes, this even occurs before noon. This means no phone access for the rest of the day.

While we understand that the agency may be hiring about a hundred new people, it will take months to get them fully trained. Further, this will not be enough even then. The agency is estimated to be down by **hundreds** of frontline employees to staff the Call Center and the walk-in offices- the latter of which are particularly important for people with disabilities who need in-person interaction. And the need is increasing because of the “unwinding” of the continuous enrollment provisions which have prevented most terminations of Medicaid during the public health emergency, resulting in tens of thousands newly being cut off Medicaid each month starting in May.

But the long-term problem is that the executive branch has never adequately staffed this agency to do the job which the new platforms required. It is time to change that. This study bill is important, but the study will be much more beneficial to the people we represent if it expressly includes looking at the “*sufficiency* of current and planned staffing levels”—“allocation” of staff, as provided in the current draft, is a relatively minor problem compared with the more basic problem of lack of bodies to do all the tasks needed- ie, there are just way too few people to allocate, and it is time to quantify how many staff really are needed. All of this must be looked at with a fresh, wide-angle lens.

SB 1205

This bill would require a state plan amendment under Medicaid to reimburse for peer support specialists. Peer support, through individuals with lived experience with mental health conditions or substance use disorders, is recognized by the

Centers for Medicare and Medicaid Advocacy as an evidence-based model of care, as outlined in an [August 15th, 2007 State Medicaid Director Letter from the Centers for Medicare and Medicaid Services.](#)

This is an important value-added service for Medicaid programs seeking to provide comprehensive care to people with mental health conditions, and some 39 states already cover peers in their Medicaid programs to some degree. People with mental health disabilities will benefit from having these kinds of providers available when appropriate.

There are some concerns that have been raised with the specific language in the bill, particularly in the limited specification of kinds of peers covered. The testimony by the Keep the Promise Coalition suggests some modest revisions which would address these deficiencies, particularly a broader definition to include “peer support services for mental health, substance use, and behavioral health conditions.” This definition would assure coverage for the broadest range of people with mental health disabilities.

The testimony from the DSS Commissioner includes the usual refrain that money is not in the Governor’s budget to cover peer support services and she references some very limited coverage for peers under certain waivers. First, there is a reason we have a second branch of the government, such that the Governor’s proposed budget is not the final word. Particularly as we address the mental health crises coming out of, and exacerbated by, the pandemic, we need to broadly cover appropriate behavioral health services now, not later. And the waivers referenced have very limited eligibility—e.g., the Mental Health Waiver has an eligibility standard requiring a specific finding of institutionalization without the provision of waived services, in order to receive any services under it. Covering peer support through a state plan amendment will provide for far broader coverage for people with mental health conditions.

Finally, covering peer support services through a state plan amendment, as a majority of those 39 states do, will assure coverage for these services without risking under-service, as would be incentivized by paying for the services through any kind of “value-based payment” which places financial risk on providers, such as capitation of primary care providers (as has effectively been proposed for Community Health Workers in SB 10). A state plan amendment is the tried and

true way of paying for new services under Medicaid that are valued and which we want to see delivered to individuals in need. This applies to peer support.

HB 6885

The bill would, among other things, require Medicaid payment rates to slowly increase to at least come close to Medicare rates for the same services, to 100% by June of 2028. Such increases, while slow, should eventually result in substantially improved access to specialists. And, sooner, it would require rates at 70% of Medicare by June of 2024. Since we are currently at a shockingly low 57% of Medicare payment level for most specialist rates, this is clearly a benefit to people with disabilities on Medicaid needing specialist services who routinely complain about the access to those services (versus access to primary care, whose providers are paid over 95% of Medicare rates by CT Medicaid).

However, this will not address the needs of people, particularly children, who need services not covered by Medicare at all. I am particularly thinking of children with autism who need access to in-home services. Other advocates and I have been talking to legislative committees about this for over a year and, frankly, nothing has been done, such that our Medicaid provider rates for ASD services remain pitifully below the rates of all our neighboring states, resulting in months-long waiting lists for kids to get access to critically needed services.

Without these services, children often develop or experience further exacerbation of their mental health symptoms and/or behavioral problems, resulting in a loss of stability, psychological deterioration, and crisis. In turn, the inability to stay in their homes with their families and in their local communities is compromised. Children's deterioration places them at risk of institutionalization and even unnecessary involvement with child protective services as families struggle to meet their children's needs and lose confidence in the system to help them.

The most significant bottleneck in accessing services comes after a child diagnosed with ASD seeks to connect with a provider who can perform a functional behavioral assessment, develop a treatment plan and deliver the services under that plan. Providers will generally not even see a child with ASD if they do not have the capacity to actually provide prescribed services. The delays

are severe. Beacon Health now warns parents in their official brochure about ASD services that it “may take several months” after the diagnosis to “connect your child with a provider in the community.”

The extreme waits are largely due to an extreme shortage of providers (particularly board-certified behavioral analysts (“BCBAs”) or behavioral technicians (“techs”)), explained by the fact that the CT Medicaid payment rates for these kinds of providers are extremely low compared both with rates from private insurers and under Medicaid in neighboring states, as shown below, based on our own research and a recent article in the *CT Mirror*: [Advocates: Medicaid rates leave CT kids without autism services \(ctmirror.org\)](https://ctmirror.org/advocates-medicaid-rates-leave-ct-kids-without-autism-services).

Comparison of CT Medicaid Rates with CT Commercial Rates (Blended Averages) for Key ASD Services (per 15 minutes) from Private Providers

			<u>CT Medicaid</u>	<u>CT Commercial Provider Rates</u>		
				Provider #1	Provider #2 ¹	Provider #3
97153	RBT/BCaBA	Direct treatment by technician	\$12.17	\$16.73	\$18.05	\$21.50
97155	BCBA	Direct treatment by QHP	\$21.20	\$22.61		\$29.30

Comparison of State Medicaid Payment Rates for Key ASD Services (per 15 minutes)

<u>CPT Code</u>	<u>License Type</u>	<u>Description</u>	<u>CT</u>	<u>NY</u>	<u>MA</u>	<u>RI</u>
97153	RBT/BCaBA	Direct treatment by technician	\$12.17	\$19.07	\$16.37	\$16
97155	BCBA	Direct treatment by	\$21.20	\$19.07	\$30.73	\$28

Last year, the legislature took a major step forward in addressing this extreme disparity in rates by passing legislation requiring the Office of Health Strategy, in consultation with DSS and the Department of Insurance, to conduct a study comparing CT Medicaid rates for behavioral health services for children with commercial rates in CT for the same services. PA 22-47. The report was due to be submitted to the legislature by January 1, 2023. But OHS decided to hire an expensive consultant to do the study rather than do it in house, and then made the argument that contracting out was too difficult so they could not get the

¹ We do not have an average commercial rate for BCBAs for this provider.

study done by January 1st. OHS asked for and obtained dispensation to ignore the deadline in the statute and came up with a new deadline -- July 1st, too late for this legislative session. In the above article, OHS's then-acting director was quoted justifying the delay by saying that "it is ultimately up to our vendor as to when this work begins"- that is, with some 500,000 in taxpayer dollars.

At least for ASD services, we really don't need yet another study, as the DSS Commissioner urges in her testimony on this bill, because we can see in stark comparison now how very little we pay compared with neighboring states – to which providers, especially those on the borders, can readily choose to commute so as to obtain much higher wages. Children needing these services who can't access them can't wait yet *another* year for our state to just *begin* to tackle the problem.

If the CT Medicaid rates for ASD services were substantially higher, such as to be equivalent to the *lower* of MA/RI Medicaid's rates, or \$16/\$28 per 15 minutes for BCaBA Techs/BCBAs, disabled children in CT with autism would have their access to timely health care significantly improved. You can mandate that right now without waiting yet another year -- and imposing another year of harm on these at-risk children.