Tow Youth Justice Institute
Making connections. Informing solutions.

Draft TCB Legislative Recommendations

This document outlines the draft TCB Legislative Recommendations, which are still under review and subject to modification. We are currently soliciting feedback from stakeholders to ensure these recommendations reflect the needs and priorities of our community. The finalized legislative proposals will be presented at the TCB meeting in December.

If you are interested in contributing to the Services or System Infrastructure Workgroups, please contact imendietamartinez@newhaven.edu for more information on participation.

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Co-Chairs: Alice Forester (aforrester@cliffordbeers.org) and Jason Lang (jlang@chdi.org)¶
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TCB Infrastructure Group
Co-Chairs: Alice Forester (aforrester@cliffordbeers.org) and Jason Lang (jlang@chdi.org)

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1. **Strengthening the Workforce/Reimbursement Rates**: The workgroup identified inadequate reimbursement rates for children's behavioral health services as a top concern for legislative action so that providers can attract and retain an experienced workforce. The recent Medicaid rate study showed Connecticut's Medicaid rates for behavioral health were on average 62% of those in comparable states[i], and a recent report showed that inflation has outpaced Connecticut's Medicaid rate for a common type of therapy session by approximately 25% over the past decade.[ii] The rate study estimates this would cost an additional $42.4M (presumably in 2023 dollars), which is the equivalent of approximately $45.5M in 2025. Medicaid and private insurance fee for service reimbursement rates do not come close to covering the actual cost of delivering behavioral health services. While alternative payment models (e.g. CCBHC) are promising, it is unclear when or how they will be implemented, and in the meantime the system continues to struggle.

   Without meaningful increases in reimbursement rates, disparities in access to and quality of care for the state's most vulnerable families will worsen. Medicaid providers are increasingly unable to secure the necessary skilled workforce to serve Connecticut's most vulnerable populations. Youth covered by Medicaid often have more complex and acute conditions, fewer resources, yet when they are able to access services they often receive treatment that is woefully inadequate to address the full needs of the child and families. Providers are forced to hire less experienced clinicians due to providers' inability to offer competitive wages and a viable career path. In addition, providing behavioral health services to children and youth requires additional time and resources (e.g. care management, communicating with caregivers, addressing family needs) than adult behavioral health, and reimbursement rates should reflect these added costs.

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The top priority of the infrastructure workgroup is that reimbursement rates cover the actual costs of providing care, and we make the following recommendations:

a. The legislature and DSS should immediately provide funding and policy changes needed to increase all Medicaid behavioral health reimbursement rates to the average rates of the comparison states in the recent Medicaid rate study, inflation adjusted for the year implemented. The rate study

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estimates this would cost an additional $42.4M (presumably in 2023 dollars), which is the equivalent of approximately $45.5M in 2025.

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b. The legislature and DSS should provide a billing code or modifier for an enhanced reimbursement rate of 25% for services that are evidence-based as recognized by national standards and delivered by a provider who is certified or credentialed in the evidence-based practice. These practices require additional time for training, consultation, and service delivery, but result in improved outcomes for children, compared to usual care services, and data from Connecticut indicate they reduce disparities in treatment outcomes by race/ethnicity.[iii]

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c. The legislature and DSS should require Medicaid behavioral health reimbursement rates to be adjusted annually based on inflation, cost of living adjustments (COLA) or a similar benchmark.
d. The legislature and/or state agencies (e.g. Department of Insurance) should require or incentivize commercial insurers to similarly increase rates immediately and annually based on inflation or similar benchmark, to the extent of what is permitted under federal law.
e. The legislature and/or Department of Insurance should prohibit insurers from not allowing providers to share negotiated reimbursement rates.
f. The legislature should provide funding to conduct an independent study of the anticipated cost of children's behavioral health care incorporating input from a wide range of providers, family members, and other stakeholders (See additional detail about this in the Medicaid rate study, p. 47). Rates should incorporate all aspects of high quality care, including professional development, supervision, outreach/community engagement, data reporting, quality improvement, evidence-based treatments, care coordination/case management, administrative requirements, etc.). The study should also identify ways to reduce the regulatory burden on providers to make services more efficient. The study should provide recommendations for alternative payment models (e.g. bundled rate, per-person per-month rate) that cover the actual costs of care.

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g. The legislature should require DSS within the next three years to implement one of the study's recommended payment models for children's behavioral health services.

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2. **Data/QI**: The workgroup identified a need to have better publicly available data about how the children's behavioral health system is functioning. This includes not just identifying new data elements, but taking a critical look at existing data requirements to minimize the burden on providers currently entering data and to ensure that data are available from all providers. Data collected by state agencies should be made available to the public whenever possible while protecting family privacy and confidentiality (e.g. with consent, in aggregate, de-identified). Improved data about the system would increase transparency and accountability by providing the public and those referring children for services with better information about 1) what services are available, where, and when; 2) how effective services are and how satisfied families are with services; 3) whether there are disparities in service access or outcomes for certain populations; 4) what gaps and needs there are in the service array. Better data about the system, if paired with adequate reimbursement, also allows ongoing quality improvement to ensure that services are working as intended and benefiting all youth and families. The workgroup feels strongly that implementing this recommendation is contingent upon a substantive increase in reimbursement rates or other funding in order to be feasible for providers, as described in the previous recommendation. ***An initial review of some of this data is currently being conducted through the TCB by the Innovations Institute. The workgroup makes the following recommendations, which will vary depending upon the findings from the current data review, which due by the end of 2024:***
   a. The legislature should provide funding to [Who? CBHPIAB? DCF? TCB?] to map the existing data (including demographics, staffing, services, and outcomes data) of all services including children's behavioral health providers across all levels of care, including what data are required by legislation, federal requirement, or other mandate, and how such data are used, reported (including to whom), and shared. Because there are several existing state committees or agencies that have or are doing similar work (Children's Behavioral Health Plan Implementation Advisory Board, Behavioral Health Partnership Oversight Council, Emergency Department Crowding Working Group, DMHAS Evaluation, Quality Management, and Improvement Division), this process should be done by or in close collaboration with these entities.

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1. Include providers, services, and levels of care where no data are currently collected or reported (e.g. private practices, providers that don't receive state grant funding)
2. Include multiple data sources related to children's behavioral health including social determinants of health, education, and sources from related organizations.

b. Based on the results of (a), Identify currently collected data elements that could be eliminated (e.g. not required, not used or reported, redundant).
c. Based on the results of (a), identify any needs for new data elements not currently available that are needed to monitor the system and/or for public use.
d. Conduct a review of best practices in children's behavioral health data and quality improvement from other states and research
e. Develop recommendations for a set of standardized and limited data collection and reporting across services, providers, and levels of care including for public reporting about service availability, capacity, quality, and outcomes. Ensure that family privacy is protected in data collection and reporting.
f. Use an existing, or convene a new, working group to review A through E (could be the CBHPIAB or the TCB infrastructure workgroup) to finalize detailed recommendations for system-wide data collection, analysis, reporting, and quality improvement, including a publicly available data dashboard about services.

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[i] https://www.documentcloud.org/documents/24421604-ct-medicaid-rate-study-phase-1-final-report-february-2024

[ii] https://www.chdi.org/index.php/publications/policy-briefs/policy-brief-who-will-do-work-strengthening-childrens-behavioral-health-workforce-meet-families-increasing-behavioral-health-nee

[iii] Lang, J. M., Lee, P., Connell, C. M., Marshall, T., & Vanderploeg, J. J. (2021). Outcomes, evidence-based treatments, and disparities in a statewide outpatient children's behavioral health system. *Children and Youth Services Review, 120,* Article 105729. https://doi.org/10.1016/j.childyouth.2020.105729

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TCB Services Workgroup
Co-Chairs: Edith Boyle (eboyle@lifebridgect.org) and Yann Poncin (yann.poncin@yale.edu)

WORKING DRAFT Recommendations to TCB:

Vision Statement for Services:

- Children and families of Connecticut will have access to quality behavioral health care when they need it, and where they need it across the continuum of care, ensuring equity of access, treatments, and outcomes.

1. **Strengthening the Workforce/Reimbursement Rates**: In alignment with the infrastructure workgroup, the services workgroup identified inadequate reimbursement rates for children's behavioral health services as a top concern for legislative action so that providers can attract and retain the skilled workforce needed to bolster the system. The recent Medicaid rate study showed Connecticut's Medicaid rates for behavioral health were on average 62% of those in comparable states[ii], and a recent report showed that inflation has outpaced Connecticut's Medicaid rate for a common type of therapy session by approximately 25% over the past decade.[iii] Medicaid and private insurance fee for service reimbursement rates do not come close to covering the actual cost of delivering behavioral health services. While alternative payment models (e.g. CCBHC) are promising, it is unclear when or how they will be implemented, and in the meantime the system continues to struggle.

   Without meaningful increases in reimbursement rates, disparities in access to and quality of care for the state's most vulnerable families will worsen. Medicaid providers are increasingly unable to secure the necessary skilled workforce to serve Connecticut's most vulnerable populations. Youth covered by Medicaid often have more complex and acute conditions, fewer resources, yet when they are able to access services they often receive treatment from less experienced or skilled clinicians due to providers' inability to offer competitive wages and a viable career path. In addition, providing behavioral health services to children and youth requires additional time and resources (e.g. care management, communicating with caregivers, addressing family needs) than adult behavioral health, and reimbursement rates should reflect these added costs.

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b. The legislature and DSS should provide a billing code or modifier for an enhanced reimbursement rate of 25% for services that are evidence-based as recognized by national standards and delivered by a provider who is certified or credentialed in the evidence-based practice. These practices require additional time for training, consultation, and service delivery, but result in improved outcomes for children, compared to usual care services, and data from Connecticut indicate they reduce disparities in treatment outcomes by race/ethnicity.
c. The legislature and DSS should require Medicaid behavioral health reimbursement rates to be adjusted annually based on inflation, cost of living adjustments (COLA) or a similar benchmark.
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f. The legislature should provide funding to conduct an independent study of the anticipated cost of children's behavioral health care incorporating input from a wide range of providers, family members, and other stakeholders (See additional detail about this in the Medicaid rate study, p. 47). Rates should incorporate all aspects of high quality care, including professional development, supervision, outreach/community engagement, data reporting, quality improvement, evidence-based treatments, care coordination/case management, administrative requirements, etc.). The study should also identify ways to reduce the regulatory burden on providers to make services more efficient.

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g. The legislature should require DSS within the next three years to implement one of the study's recommended payment models for children's behavioral health services.

2. **A landscape analysis:**
   a. To determine:
      1. What services are currently offered in the State (array, continuum)
      2. Where the services are provided:
         1. Traditional community, pediatric offices, schools
         2. Geography
      3. When are services available (hours of operation, off hours)
      4. Waitlists
      5. Seasonality of need
   b. This analysis should clarify what gaps or barriers are present according to:
      1. The continuum of care
      2. Service delivery
      3. Geography
      4. Social determinants of health, equity
      5. Population demographics
   c. The analysis should clarify what services are available, unavailable, and under-available.
      1. The analysis should help clarify how each of the above is affected by reimbursement, workforce shortages, or other factors that impede the availability of services on the continuum.
   d. Consider non-traditional services in the continuum
      1. **Care coordination**
      2. Respite
      3. Transportation needs

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