NAMI Fairfield
National Alliance on Mental Illness

Mental Health

State of Connecticut
Legislative Recommendations 2018

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Budget Neutral Legislative Recommendations

NAMI Fairfield's mission is to build resilience and improve the lives of those affected by mental illness in our community through education, resources, support and advocacy. To that end, we are pleased to work with our state legislators to support these goals. Our affiliate backs the Legislative Priorities [Attachment #1] put forth by NAMI Connecticut and urges preservation of community services, housing supports and early intervention for children, and promotion of education, employment and wellness. We also recognize the current budget environment and wish to provide areas for legislative work that are conducive to this climate, having negligible budget impact or being budget neutral.

1. Consumer Report Card on Health Insurance Carriers

The Connecticut General Assembly mandates that the Connecticut Insurance Department (CID) publish annually a *Consumer Report Card on Health Insurance Carriers in Connecticut*. Its October 2017 report card [Reference #1] found that members' utilization of mental health services varied by provider, ranging between 3.48%-14.29% -- most less than 10% utilization. [Attachment #2] Since 20% of the population experiences a mental illness, [Reference #2] this means roughly half of Connecticut's residents who have a mental illness are not receiving needed services. Nationally SAMSHA reports that 60% of adults with a mental illness didn't receive mental health services in the previous year.

In its current form, the Report Card measures appeals for denied services following emergency department (ED) and inpatient hospitalizations. Using this lens, the Report Card overlooks the vast majority of the population who need mental health services to *prevent* a crisis. Reviewing the report's results, once someone has deteriorated enough to require an ED visit or in-patient hospitalization, payers rarely deny services; this highlights that payers recognize the need for stabilization and recovery services. For a more complete assessment, we recommend that the Report Card also include in its Care Measures a review and evaluation of how emergent/routine behavioral health services are accessed and denied. Our goal is for determination and approval of emergent/routine therapeutic services and medication management to become standard for all people in need. Determinations can be subjective and we anticipate higher denial rates – which we expect would be revealed in subsequent Report Cards. Because the CGA mandates what areas the CID measures, this is a potential area for new legislation.

2a. Mental Health Parity: Access to In-Network Providers

It has been nearly a decade since Congress passed the Mental Health Parity and Addiction Equity Act, with its promise to make mental health and substance abuse treatment just as easy to get as care for any other condition. Yet today, amid an opioid epidemic and a spike in the suicide rate, patients are still struggling to get access to treatment as many insurance companies continue to discriminate against mental health care. In November 2017 the consulting firm Millman, Inc., on behalf of a coalition of America's leading mental health and addictions advocacy organizations, published the Impact of Mental Health Parity and Addiction Equity Act. [Reference #3] Researchers found that along with payment disparities, which occur in 46 out of 50 states, "out-of-network" use of addiction and mental health treatment providers by consumers is extremely high when compared to physical health care providers.

Connecticut's Outpatient Office Visit Out-of-Network Utilization[Reference #4]
Behavioral Health: 34.2%
Primary Care: 3.3%
Specialist Care: 4.3%

Connecticut's behavioral health out-of-network utilization is 11 times more than primary care's utilization. We hypothesize that because our community is quite affluent, southwestern Connecticut's rates are even more dramatic than this report shows. To help illustrate what factors may lead to a high out-of-network utilization rate locally, we conducted an informal (and unscientific) poll of private (non-facility) mental health providers

and asked about their experiences with 3rd party payment. Attachment #3 Their responses can be put into three categories:

- Reimbursement rates are low
- The insurance company's panel is already "full," meaning insurance companies limit the number of providers who may accept their insurance
- Paperwork is cumbersome, redundant and oftentimes "lost"

2b. Mental Health Parity: Reimbursement Rates

One of the most dramatic disparities outlined in the Millman report are the low reimbursements paid to behavioral health providers when compared to physical health providers – a factor likely influencing network access and overall practitioner in-network availability.

Insurance company reimbursement rates are proprietary, and are only released to providers who are on their panel. (See attached letter from Aetna, in response to NAMI Fairfield's inquiry.) Attachment #4 Providers are forbidden from disclosing how much they are reimbursed. Furthermore, payers are willing to negotiate rates, so what one provider receives may differ from another. Despite these constraints, we were able to obtain ranges of reimbursement, and compared these to CMS rates. We also compared CMS reimbursement rates for Connecticut to the surrounding areas (Westchester/Long Island, Manhattan, Boston Metro and the rest of Massachusetts). Private payer reimbursement rates are sometimes half what CMS pays, as low as $60/45-50 minute session. Connecticut's reimbursement rates are slightly higher than (non-Metro Boston) Massachusetts, but lower than the other communities. Attachment #5

The Millman report says if the insurance companies are not in compliance with parity, "health plans should increase its payment levels to the behavioral healthcare providers to get them compliant with parity. That increase in payment rates could also lead to an increase in the desire of behavioral healthcare providers to join the plan's provider network." Attachment 6

Recommendation

Our recommendations for legislation include:

- CID to include the evaluation of routine outpatient therapeutic services in its annual Report Cards
- Require payers to implement uniform medical protocols for Connecticut providers to use, facilitating reimbursement
- Increase provider reimbursement
    - Mandate payers disclose reimbursement rates for review of parity compliance
    - Align CMS and private payer reimbursement rates for behavioral health services with other non-behavioral medical services
- Commission a state review of current parity implementation
- Petition CMS to create a separate Medicare Administrative Contractor (MAC) locality for Fairfield County, increasing its rates so equal with Westchester County
- Add mental health screening to protocol for all annual adult and pediatric health exams

The recommendations above represent critical areas of opportunity for new legislation which can drive increased awareness of the mental health crisis in our state, help close the gaps our current laws possess in protecting and serving these most vulnerable members in our community, as well as make it more attractive for our community's highest quality resources to participate as in-network providers in insurance company plans.

We are available for further discussion and look forward to working together to support the mental health needs of our community.

Attachment #1: NAMI CT Legislative Priorities

NAMI Connecticut
National Alliance on Mental Illness

2018 LEGISLATIVE PRIORITIES — *in Stories*

Mental health is an integral part of our overall health

Mental health touches US ALL:

Mothers, Fathers, Brothers, Sisters, Daughters, Sons, Aunts, Neighbors, Coworkers, Bosses

NAMI Connecticut STANDS FOR:

- Individuals with mental health conditions *living independent and meaningful lives, with their basic needs met*, such as housing and economic security;
- *Civil rights protected*; and
- *Promoting human connections* to fellow individuals, family, friends, and the larger community.

Support and Protect Community Services and Improve Quality and Equity

- Karen H. was confined to a mental health institution for over 20 years, until 2014. After many years of very expensive high-end care, legal efforts, and personal advocacy, Karen capably lives in her own apartment, located in a community where she can participate in family events whenever she wants. She works at a part-time job, volunteers, and has become an outspoken advocate for herself and others. In short, she now has her own life, a life of purpose and recovery.
- Karen's success story was only possible due to *investments in person-centered community services and legal services* that focused on Karen finding her voice again and exercising her self-determination. These *actions not only improved Karen's quality of life but also save the state money*, by avoiding continued institutional services. But this is not the reality for many other people.

Preserve Critical Housing Supports & Services to help *End* Homelessness

- Ed N. "lived outside" for 25 years dealing with his mental health issue in his own unique way, and is now living in a safe home, got himself a bike he rides around town, goes to church and is engaged in his sister's family life.
- Ed's success story is possible through the *state's investments in supportive and affordable housing, individual housing rights, and person-centered community supports and services* which extended his life. It also saves the state costs in crisis systems such as ERs.

Invest in Early Intervention Services for Children and Youth

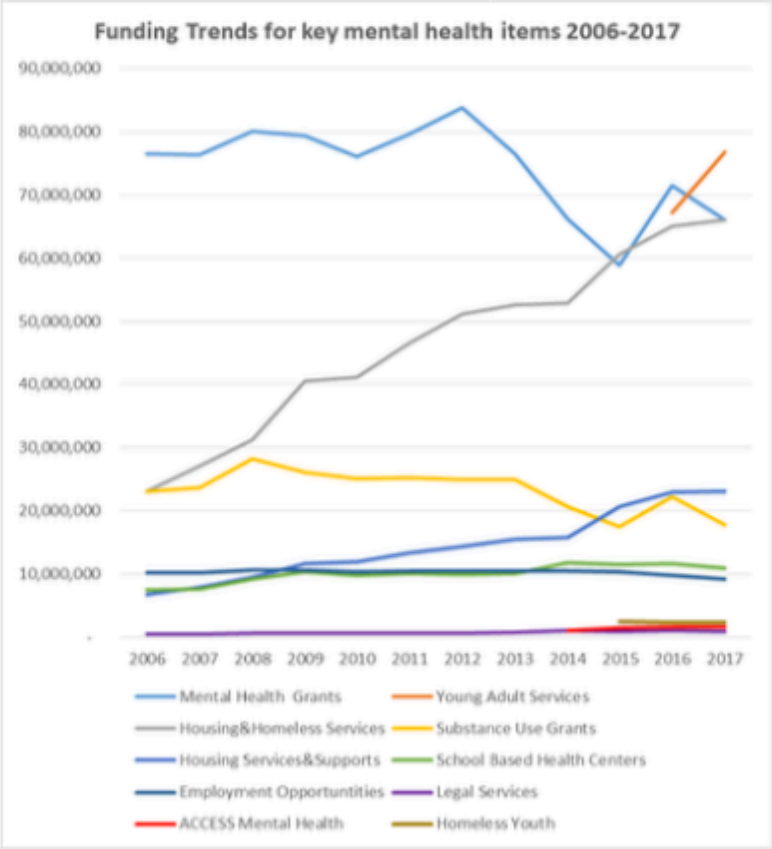
- Sam, a 4th grader, has benefited from early intervention efforts at his local elementary school. He has severe anxiety and often gets overwhelmed with class activities. School officials suggested an alternative school setting but Sam wanted to remain at the school with his friends. His mother advocated for and got an appropriate IEP (Individual Education Plan).
- Sam now goes to *weekly therapy sessions and has check-ins with his school counselor.* With support, he is learning how to recognize and respond more positively to his stress, allowing him to increase his classroom time and thrive in school activities that used to overwhelm him, such as giving an oral book report. However, not every child has access to the right interventions.

Promote Education, Employment and Wellness

- Kurt, a 26-year-old very reliable food service worker in a family-run business, lives with a mental health condition. He is able to work because he has the support of his boss who gives him time off when his condition requires him to take some extra time to care of himself, and preserves Kurt's job until he is ready to return to work. Most employees do not have this support. And most employers cannot afford this option without structural support. *Paid Family Medical Leave* would create such a support.

NAMI Connecticut

NAMI Connecticut is the state affiliate of NAMI, the nation's largest grassroots mental health organization dedicated to improving the quality of life for all those affected by mental health conditions by engaging in **support, education, and advocacy.**



Mental Health Grants:

Young Adult Services:

Housing & Homeless Services: provides adults with shelter and transitional housing services, and served slightly over 10,000 people in FY2016.

Substance Use Grants:

Housing Services & Supports:

School Based Health Centers:

Employment Opportunities:

Legal Services:

ACCESS Mental Health: program that offers free, timely consultation to primary care providers (PCPs) seeking assistance in treating youth with behavioral health concerns through age 18, regardless of insurance. In FY2017, it served almost 1,300 children and youth.

Homeless Youth: provides outreach services, crisis housing for youth, and permanent housing options for youth under age 18, and

Reference #1

Consumer Report Card on Health Insurance Carriers in Connecticut, October 2017. Mental Health Utilization Review and Care Measures, pages 32-44. Accessed January 24, 2018. http://www.ct.gov/cid/lib/cid/2017ConsumerReportCard.pdf

Attachment #2: 2017 Report Card: Mental Health Utilization

Mental Health - Care Measures

2016 DATA

HMO	Aetna Health	Anthem	Cigna	ConnectiCare	Harvard	Oxford
MENTAL HEALTH UTILIZATION						
The total number of members who received care.						
A) Any mental health service	138	24,615	297	3,000	55	2,463
B) Inpatient mental health services	2	477	6	86	1	79
C) Intensive outpatient or partial hospitalization health services	2	570	8	90	0	63
D) Outpatient or emergency department health services	137	24,538	294	2,983	55	2,450
The percentage of all enrollees with a mental health benefit who received the respective service.						
A) Any mental health service	11.23%	14.29%	3.48%	9.31%	7.45%	10.28%
B) Inpatient mental health services	0.16%	0.28%	0.07%	0.27%	0.14%	0.33%
B) Intensive outpatient or partial hospitalization health services	0.16%	0.33%	0.09%	0.28%	0.14%	0.26%
C) Outpatient or emergency department health services	11.15%	14.24%	3.44%	9.25%	7.45%	10.23%

Mental Health - Care Measures

2016 DATA

Indemnity

	Aetna Life	Anthem	Cigna H & L	ConnectiCare Benefits	ConnectiCare
MENTAL HEALTH UTILIZATION					
The total number of members who received care.					
A) Any mental health service	30,004	48,218	27,275	4,489	14,595
B) Inpatient mental health services	733	1,220	640	146	365
C) Intensive outpatient or partial hospitalization health services	765	1,155	546	121	388
D) Outpatient or emergency deptartment health services	29,845	47,998	27,127	4,460	14,515
The percentage of all enrollees with a mental health benefit who received the respective service.					
A) Any mental health service	9.17%	9.57%	9.21%	8.83%	8.88%
B) Inpatient mental health services	0.22%	0.24%	0.22%	0.29%	0.22%
B) Intensive outpatient or partial hospitalization health services	0.23%	0.23%	0.18%	0.24%	0.24%
C) Outpatient or emergency department health services	9.13%	9.53%	9.16%	8.77%	8.83%

Reference #2

National Alliance on Mental Illness, Mental Health Facts in America Infographic, Accessed 1/29/2018. https://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf

Reference #3

Imact of Mental Health Parity and Addiction Equity Act, Millman White Paper, November 2017. Accessed 1/24/2018, http://www.milliman.com/uploadedFiles/insight/2017/impact-mental-health-parity-act.pdf

Reference #4

Addiction and Mental Health vs. Physical Health: Analyzing disparities in Network Use and Provider Reimbursement Rates, December 2017. Millman Research Report. Accessed 1/24/2018. http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf

Attachment #3: Reimbursement & Payer Experiences

Anecdotal Stories from Mental Health Providers in the Fairfield area
Reimbursement and Payer Experiences
January, 2018

Limited Providers on Insurers' Panel

- Several of the large carriers like Aetna, United Healthcare and ConnectiCare have closed their panel in Fairfield County, which means they will not take on new providers as they claim there are too many in the area which is not the case. The client has to make the choice to either pay out of pocket, often having to meet very high deductibles before the insurance will cover anything, or they have to use one of the in-network providers. (LMFT in Westport; KA, LPC in Fairfield; and NS, PhD in Fairfield.)

Reimbursement Rates

- UHC and ConnectiCare's reimbursement rate is 50% lower than the standard rate, so most providers don't want to contract with them. (KA, LPC in Fairfield.)

- Insurance reimbursement is different for parent and/or family meetings vs. individual sessions. For example CPT codes used for individual sessions (90834 or 90837) are reimbursed at a higher rate than meetings without the patient or meeting as a family (90846 or 90847). The codes do not reflect the value of the services. These meetings are so critical to the treatment process and should be at least equal to or more than meeting with the patient alone. (AC, LCSW in Trumbull.)

- Here in Fairfield County having an office is more expensive (rent, insurance, etc.) than in other parts of the state. Therefore, a lot of providers choose to accept self-pay clients only: less headache and higher compensation. (KA, LPC in Fairfield.)

- The low reimbursement rates are a problem. I recently had a client tell me their employer was switching to a new insurance company so I looked into getting on that panel. The provider agreements prohibit me from sharing rates so I can't tell you what provider that is, but this is one of the largest providers of Employee Assistance Programs in the country (although I hadn't heard of them at the time), and their payment rate for 45 minute sessions for masters level licensed clinicians was $30! I called them and told them I couldn't drive to my office for that amount of money; they negotiated to $60, still the lowest rate I have seen offered by a payer. When providers are trying to pay rates as low as $30 per session, you can't possibly make a living at those rates. As an unlicensed clinician I was getting paid $25/session! Even $60 is very, very low. I don't know anyone who has worked with them but it didn't seem worth the effort. (LMFT in Westport.)

- In comparison to commercial insurance plans, Husky's reimbursement rates are comparable if not higher, and they're generous with the number of visits. I don't know why more providers don't accept state insurance. I think there is stigma associated with this population. (KA, LPC in Fairfield.)

- I am on only one insurance panel-anthem, Blue Cross Blue Shield. The reimbursement rate is so low for psychotherapy and I would have to see many more patients than I do now to make the same income. I know that this would impact the quality of care I deem essential and value highly as a professional. Being on one panel is my own contribution to try to make mental health care more available to everyone. (NS, PhD in Fairfield.)

- Reimbursement rates would have to increase for me to accept insurance. (NS, PhD in Fairfield.)

<u>Cumbersome Paperwork</u>

- There is often a huge run around working with carriers as an out-of-network provider to get paid. Claims often "get lost," meaning after not getting paid for several weeks the carriers will say that they never received the claim, or that they were missing documentation necessary to process he claim. This requires multiple phone calls, long hold times, resubmitting claims and waiting for payments. Sometimes it works right and you get paid in a few weeks. (LMFT in Westport.)

- There is not a uniform billing platform for a provider to go to one place and bill each insurance company. So for example, I have 4-5 different 3rd party billing systems for the various insurance companies that I participate in and each one has a different way to file a claim. This is a big barrier for providers to use insurance because it is very difficult and time consuming to navigate filing a claim. (AC, LCSW in Trumbull.)

- I have found HUSKY to be the easiest provider to work with, file claims with and they pay every 2 weeks by direct deposit, on time and they pay some of the highest rates. (LMFT in Westport.)

- The problem I'm noticing with Husky is that often they cut off members' benefits every month because they're missing some redetermination paper work or some other documentation. That interrupts patients' treatment. The worst part is they have to pay out of packet for their medications. (KA, LPC in Fairfield.)

- As a new private practice, I accept insurance as a way to get new clients. I also understand many people who need mental health services can't afford it without insurance and try to work with that. Some of the carriers make it very, very difficult to do that in the processing of claims and the amount of time you have to spend in the paperwork and calls to get paid. (LMFT in Westport.)

- When members change their plan and switch to a different payer they have to choose between paying me out of pocket or finding a new provider which isn't so easy. So, I often end up compromising and offering a sliding fee to patients that would suffer from interruption of treatment. (KA, LPC in Fairfield.)

- Some insurance companies only reimburse for 90834 (45 minute sessions) and request additional information and authorization should the meeting be 50-60 minutes (UBH/Optum; Oxford, Cigna). It is not worth it for me to request extra time as it would be so time consuming to do this. I just bill for a 45 minute session (90834) even when the session is 55-60 minutes. (AC, LCSW in Trumbull and AY, Westport.)

National Problems:

- Some insurances get around the Affordable Care Act's requirement to cover mental heath treatment by outsourcing the coverage to another company. For example, I had a patient who had Anthem BCBS insurance that I'm in-network with. After billing we discovered she has Anthem BCBS for medical coverage only, but for behavioral health services they subcontract to another company, Mental Health Consultants that no one heard of or is in-network with. Ultimately, the patient ended up paying out of pocket. (KA, LPC in Fairfield.)

- I think the biggest problem with access to mental health treatment is with Medicare. They only approve social workers and psychologists ("Medicare core providers") to provide mental health therapy. Many licensed providers with the same education like myself are unable to provide services for those folks (Medicare rule). Even if the member has Medicare and Medicaid but it's called Q&B combination (Medicare Qualified Beneficiary), Medicaid will only cover what Medicare approves. So, even though the provider takes Medicaid, they can't in this instance because they aren't approved by Medicare. Also, Medicare has very limited mental health benefits. They don't cover methadone, intensive-out-patient (IOP), residential or detox for mental health and/or substance abuse problems. (KA, LPC in Fairfield.)

Attachment #4: Rate Information Denied, Aetna

aetna

lorettajay@parasolservices.com Authenticated by aetna.com Valid Signature

From: aetnamemberservices@aetna.com
To: lorettajay@parasolservices.com
Sent: Jan 25, 2018 1:08:10 PM EST
Subject: Re: Website Feedback - Provider KANA 36789907

Dear Loretta Jay:

Thank you for contacting our Provider Service Department.

We do not currently have tax identification number 264157243 listed on file. We can only provide reimbursement rates for providers that are already contracted with Aetna.

Joining the network
You can find information and an application to join the Aetna network at www.aetna.com. Once on the website, follow the directions provided below:

1. Select 'Health Care Professionals'.
2. Click 'Join the Network'.
3. Then 'How to Apply'.
4. Choose the correct 'Application Request Form', by reviewing the types of doctors and/or practices.
5. Select 'Next' then:
   a. Fill in all fields marked with a red asterisk.
   b. Review your form prior to submitting.
6. Click "Submit".

Questions
If you would like to speak with someone directly, please contact our Credentialing Customer Service Support Center at:
Medical providers: 1-800-353-1232
Behavioral health providers: 1-800-999-5698

If you have questions about this information, please call us at:
1-800-624-0756 (for HMO plans)

1-888-632-3862 (for Traditional plans)
1-877-480-4161 (for Aetna Student Health plans)

Other Ways We Can Help You:
We'd also like to remind you that we offer several technology solutions designed to reduce your administrative functions and costs while delivering services to you faster. For example:

~ Call our automated voice response system, Aetna Voice Advantage(R)anytime day or night to check claim status, verify patient coverage and benefits information, request faxed copies of claim and eligibility functions, and more.

~ Visit www.aetna.com and click on "Health Care Professionals" for information on electronic data interchange and direct-connected electronic vendors at our secure website for physicians, hospitals and other health care providers.

Sincerely,
Aetna Provider Service Centers
36789907

NOTICE TO RECIPIENT(S) OF INFORMATION:
To view Aetna's privacy practices, please edit, copy and paste this website into your browser: https://www.aetna.com/legal-notices/privacy.html

*PW - Service Center - Allsites

Original Message Excluded:

This e-mail may contain confidential or privileged information. If you think you have received this e-mail in error, please advise the sender by reply e-mail and then delete this e-mail immediately. Thank you. Aetna

Attachment #5, Reimbursement Rate Comparisons

CMS Reimbursement Rates: Comparison CT v Surrounding Communities

CMS Reimbursement Rates*	CPT or HCPCS Codes	CT Non-Facility Price	NYC Suburbs/ Long Island Non-Facility Price	Manhattan Non-Facility Price	Metro Boston Non-Facility Price	MA (not Boston area) Non-Faciltiy Price
Psychotherapy 60 minutes	90837	**$138.45**	$146.10	$144.65	$140.38	$136.64
Psychotherapy 45 minutes	90834	**$92.29**	$97.28	$96.38	$93.60	$91.09
Psychiatric diagnosis with medication management	90792	**$159.86**	$169.84	$167.49	$162.24	$157.33
Family Psychotherapy 50 minutes with patient	90847	**$115.97**	$122.34	$121.15	$117.63	$114.44
Family Psychotherapy 50 minutes w/o patient	90846	**$111.49**	$117.73	$116.51	$113.06	$110.00

* https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=2&H1=90846&C=99&M=5

CT Reimbursement Rates (unofficial): Comparison between Payers

Unofficial* Reimbursement Rates from Health Insurance Providers	CPT Codes	CMS	BCBS*	Aetna*	Cigna*	UHC*	ConnectiCare*	Husky	Oxford*
Psychotherapy 60 minutes	90837	**$138.45**	$74-94	94.76	$74.00			$94.63	
Psychotherapy 45 minutes	90834	**$92.29**	$68-74		$68.00	$60.00	$60.00	$63.12	$60.00
Family Psychotherapy with patient	90847	**$115.97**	$75-80			$60.00	$60.00	$76.72	$60.00
Family Psychotherapy without patient	90846	**$111.49**	$75-80			$60.00	$60.00	$62.28	$60.00
Psychiatric diagnosis with med mngmnt - APRN	90792	**$159.86**	$90 (for APRN)						
Psychiatric diagnosis with med mngmnt - MD	90792	**$159.86**	$135 (Physician)						

*** Reimbursement rates are proprietary. These figures derived from multiple confidential sources.**

Attachment #6, Millman Report, Recommendations

Addiction and Mental Health vs. Physical Health: Analyzing disparities in Network Use and Provider Reimbursement Rates, December 2017. Millman Research Report. Accessed 1/24/2018. http://www.milliman.com/uploadedFiles/insight/2017/NQTLDisparityAnalysis.pdf

Page 8 of Millman Report:

> A health plan should evaluate its provider fee schedules to determine whether there are differences in payment levels between physical healthcare providers and behavioral healthcare providers. Plans and issuers may consider a wide array of factors in determining provider reimbursement rates for both medical/surgical services and mental health and substance use disorder services. This is the case so long as, pursuant to the NQTL rule, "as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification."
>
> Our findings of payment disparities in this data suggest that there is value in plans conducting a detailed assessment of provider payment rate methodologies to ensure compliance with MHPAEA and its NQTL regulations. Problems will not necessarily be found in every situation, but disparities appear to be common enough that close attention is warranted. If the plan finds that it is not parity-compliant in this area, the plan should increase its payment levels to the behavioral healthcare providers to get them compliant with parity. That increase in payment rates could also lead to an increase in the desire of behavioral healthcare providers to join that health plan's provider network, which could then, in turn, lead to higher use of in-network services for behavioral healthcare. This then addresses the other potential NQTL compliance issue of disparate out-of-network utilization rates between physical and behavioral healthcare. Lastly, more utilization of effective behavioral healthcare could improve the health of the plan's members with mental health and substance use disorders, thus helping the plan to achieve elements of the quadruple aim, including improving the health of insured members, improving the consumer experience, and potentially reducing healthcare costs and improving the providers' experience.