

Findings and Recommendations: Access to Mental Health and Substance Use Services

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January 2, 2013



OHA's Reports its Findings and Recommendations on Mental Health and Substance Use Services in Connecticut. The report is based on OHA's public hearing of October 17, 2012.

Key recommendations:

1. Connecticut should adopt an overall vision for health that integrates and coordinates access to effective, timely, high quality and affordable mental health and substance use prevention and treatment services into overall healthcare
2. Connecticut's mental health and substance use delivery system should be synchronized by an coordinating entity
3. Prevention, awareness and screening programs must be enhanced
4. Residents covered by self-funded and fully-insured plans should have access to community-based services
5. Mental Health Parity and Addiction Equity must be enforced
6. The recommendations of the 12/18/12 Program Review and Investigation Committee report should be adopted in full
7. State programs must be evaluated for cost effectiveness, and should be streamlined
8. Cost shifting to the state should be evaluated and minimized.



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GLOSSARY of ABBREVIATIONS

Abbreviation	Full Description
OHA	Office of the Healthcare Advocate
ACA	Patient Protection and Affordable Care Act
CID	Connecticut Insurance Department
CMS	Center for Medicare and Medicaid Services
CSSD	Court Support Services Division-Judicial Branch
CTBHP	Connecticut Behavioral Health Partnership
DCF	Department of Children and Families
DMHAS	Department of Mental Health and Addiction Services
DSS	Department of Social Services
EDT	Extended Day Treatment
EMPS	Emergency Mobile Psychiatric Services
ERISA	Employee Retirement and Income Security Act
FFT	Family Functional Therapy
HHS	U.S. Department of Health and Human Services
IICAPS	Intensive In-Home Child and Adolescent Psychiatric Services
IOP	Intensive Outpatient
JUD	State Judicial Branch
MDFT	Multi Dimensional Family Therapy
MH/SU	Mental Health/Substance Use
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
MST	Multi Systemic Therapy
OCA	Office of the Child Advocate
OHCA	Office of Health Care Access – within DPH
OSC	Office of the State Comptroller
PHP	Partial Hospitalization
PRI	Program Review and Investigations Committee
RTC	Residential Treatment Center
SDE	State Department of Education
SIM	State Innovation Model Initiative
SUD	Substance Use Disorder
USDOL	U.S. Department of Labor
VO	Value Options
VSP	DCF Voluntary Services Program

OHA Report on Findings and Recommendations from October 17, 2012 Hearing

Summary

Eight years after the Report of the Governor's Blue Ribbon Commission on Mental Health, residents of Connecticut still face significant barriers to access to preventive and treatment services for mental health and substance use disorder in Connecticut. The tragedy of the mass shootings in Newtown, CT. on December 14, 2012, brings the need for such an effort into sharp relief. Health insurance coverage is not a promise of coverage. Multiple state agencies with varying eligibility requirements provide services and/or oversight for residents struggling with mental health and substance use disorders, but these efforts are not well understood or coordinated as part of an overall vision for the state.

The State of Connecticut Office of the Healthcare Advocate is charged with establishing "a process to provide ongoing communication among mental health care providers, patients, state-wide and regional business organizations, managed care companies and other health insurers to assure: (1) Best practices in mental health treatment and recovery; (2) compliance with the provisions of sections 38a-476a, 38a-476b, 38a-488a and 38a-489; and (3) the relative costs and benefits of providing effective mental health care coverage to employees and their families.." Conn.Gen.Stat. § 38a-1041(e).

As part of meeting, its mission to analyze and monitor the development and implementation of federal, state and local laws, regulations and policies relating to healthcare coverage and recommend changes it deems necessary and facilitate public comment on laws, regulations and policies, including policies and actions of health insurers, OHA held a public hearing on October 17, 2012 to hear from consumers, providers, state agencies and others about barriers to access. The goal was to reset the current status of the delivery of mental health and substance use preventive and treatment services and to focus the state's efforts on producing optimal outcomes for residents while ensuring maximization and streamlining of existing resources and full exploitation of insurance coverage.

OHA is seeking to address the need for all Connecticut residents to have access to a mental health and substance use delivery system that is integrated with overall healthcare, addresses healthcare disparities and improves overall outcomes.

OHA was joined in its hearing panel by Mickey Kramer, Associate Child Advocate in the Office of the Child Advocate and Carol McDaid of Capitol Decisions, LLC, who provided a presentation on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

I hope that this report will shed light on the ongoing issues facing individuals attempting to access mental health and substance use treatment and provide evidence for immediate action.



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OHA PRINCIPLES FOR DETERMINING POLICY ACTION

The third prong of OHA's mission statement is to inform policymakers of problems consumers face in accessing care and propose solutions to problems. OHA develops and proposes legislative interventions and it supports or opposes legislative proposals raised by others in furtherance of its advocacy role.

Establishing a basis for deciding policy action is useful when there are many decisions to be made in a short amount of time (such as the legislative session), the decisions are complex with multiple criteria, and the decisions require comparative consistency for public and political scrutiny. A basis will ensure that OHA's position on legislative proposals is consistent, defensible, and logically integrated with other decisions.

Proposed legislation will be analyzed in relation to the principles, legislative testimony will incorporate [relevant] principles, and OHA legislative briefs and communications will reference [relevant] principles.

I. Access to quality healthcare; for our State to be competitive, our people must be healthy¹.

- A. We help healthcare consumers maximize the value of their health insurance coverage.
- B. We intervene to ensure access, parity, transparency, quality, and safety in the delivery of healthcare services.
- C. We seek redress for practices that have a chilling effect on access to quality healthcare.
- D. We influence healthcare system reforms to expand access and improve quality.

II. Reduction in healthcare system waste; innovation is essential to maximize value.

- A. We identify bureaucratic red tape and redundancies that increase spending and impair navigation of our healthcare system.
- B. We champion solutions that reduce delivery fragmentation and improve patient outcomes.
- C. We support evidence-based improvements to our healthcare system.
- D. We pursue opportunities to measure outcomes and performance through improved data reporting and analysis.

III. Healthcare industry watchdog; cost shifting practices burden the State's economy, providers, payers, and consumers.

- A. We identify deceptive, misleading, unreasonable, and unfair practices and collaborate to solve them.
- B. We take proactive and precautionary measures to prevent healthcare consumer issues.
- C. We reconcile, remediate, and return cost-shifted gains to the public economy.
- D. We facilitate ethical practice and understanding across industry stakeholders.

IV. Social Justice; OHA has a duty to represent the collective voice of 3.5 million healthcare consumers.

- A. We protect the rights of patients marginalized by the complexity, inaccessibility, and cost of our healthcare system.
- B. We guard our agency's autonomy to advocate for healthcare consumers free of industry and political pressure.
- C. We promote and protect patients' rights of autonomy, beneficence, nonmaleficence, and justice.
- D. We translate experiences of individual healthcare consumers into systemic solutions and education for all.

¹ The [World Health Organization](#) (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

FINDINGS AND RECOMMENDATIONS

Findings

- 1. Connecticut lacks an overall vision of how to recognize, evaluate and provide services for individuals with mental health and substance use delivery services**
- 2. Connecticut's current delivery system for mental health and substance use services is fragmented and inconsistent—benefits and access depend upon eligibility for healthcare coverage and whether the coverage is private or public**
- 3. Capacity for delivery of services is insufficient for the delivery of needed services- community-based services are available on a small scale only to those in public coverage, the workforce is insufficient and there are inadequate provider networks for insured individuals covered by private coverage.**
- 4. Health insurer or administrator processes for evaluation of the need for services, appeals of those decisions peer-review for insurance denials do not always reflect the need for prompt and accurate decision-making**
- 5. Mental health and substance use prevention services are largely unknown and not targeted broadly enough**
- 6. Mental health and substance use care largely is not integrated into overall healthcare models nor is it designed to improve outcomes and reduce racial and ethnic disparities**

Recommendations

- 1. Connecticut should adopt an overall vision for health that integrates and coordinates access to effective, timely, high quality and affordable mental health and substance use prevention and treatment services into overall healthcare**
- 2. Connecticut's mental health and substance use delivery system should be synchronized by an coordinating entity**
- 3. Prevention, awareness and screening programs must be enhanced**
- 4. Residents covered by self-funded and fully-insured plans should have access to community-based services**
- 5. Mental Health Parity and Addiction Equity must be enforced**
- 6. The recommendations of the 12/18/12 Program Review and Investigation Committee report should be adopted in full**
- 7. State programs must be evaluated for cost effectiveness, and should be streamlined**
- 8. Cost shifting to the state should be evaluated and minimized.**

I. INTRODUCTION

OHA Case Vignette

A.H. is now 18. He showed atypical behaviors at age 3. He first said he wanted “to be dead” at age 6, the same age he was when he received his first psychiatric diagnosis. He was diagnosed as bipolar at age 10 and by the spring of 2012 carried six more labels. A.H. entered a therapeutic residential school at age 14, after his first hospitalization. He’s been hospitalized 5 times since. Every time, A.’s parent would have to tangle with his health plan to keep him hospitalized long enough so he’d be safe when released.

A.H. was admitted to Yale Psychiatric Hospital last February for 6 days when the health plan denied continued coverage. A.H. could not function in school because he was still unstable. While waiting at home to enter a special program, A.H. declined rapidly, punching holes in the walls of his home and breaking objects. He attempted suicide by swallowing 16,000 and 19,000 mg of Tylenol, washing it down with a full bottle of Nyquil. Despite the lethality of the Tylenol dosage that A.H. took—his parent was told to be prepared that A. might die—he miraculously survived.

Yet five days after his suicide attempt while still expressing suicidal intentions, his health plan denied coverage for any additional days in the hospital. When the insurer was confronted by A.H.’s mother, the health plan stated that A.H. wasn’t actively suicidal nor expressed any suicidal ideation, despite A.H.’s continued expression of wanting to kill himself. The health plan actually stated that A.H. ‘had not harmed himself to such a degree to cause serious medical problems.’

OHA assisted A.H.’s mom to help A.H. eventually enter a program in Texas that discovered a rare frontal lobe dysfunction. Yet after voicing continued suicidal thoughts and while adjusting to new medication for his neurological disorder, the health plan again denied continued benefits. OHA intervened and secured additional time for A.H. in his program. As a result, A.H. is now stable and talking about going to college.

The example above is shocking. While sadly it is an actual case handled by OHA, it is also the reality of system that is not working as it should. If you are shocked, be shocked into action.

A. Mental Health/Substance Use- Background.

The 2012 Substance Abuse and Mental Health Administration (SAMHSA) National Survey on Drug Use and Health 2010 data estimates that 20% of Americans had the symptoms of a mental illness while 5% of Americans suffer a severe mental illness, such as bipolar disorder, schizophrenia, major depressive disorder or post-traumatic stress disorder.² However, 70-90% of those who receive appropriate treatment and support experience a reduction in symptoms.³

Six percent of the US population over the age of 12 use illicit drugs and 10% of the US population is alcohol dependent.⁴

Despite continued efforts by local, state and national agencies and advocates, substance abuse among adolescents between 12 and 17 remains an ongoing problem that has evaded adequate and equitable management by health insurers. Early and comprehensive intervention remains the standard for successful treatment of substance use and associated comorbidities, yet only 10 to 15 percent of adolescents with substance use disorder (SUD) seek intervention and treatment.⁵ Given the prevalence of drug use by Connecticut adolescents--10.9% had used an illicit drug and 20.8% had used alcohol within the past month--this is not something that we can afford to ignore any longer.⁶

Substance use disorders increase the incidences of cancer, hepatitis, cardiovascular disease, HIV, prenatal complications and premature births, domestic violence, auto accidents, homelessness, crime, absenteeism from work and decreased productivity.⁷ Substance use costs the US economy more than \$500 billion a year, more than the cost of diabetes and cancer

² Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012

³ Testimony of NAMI-CT, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

⁴ Testimony of Mark Kraus, MD, FASAM, Connecticut Chapter of the American Society of Addiction Medicine, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

⁵ Kaminer Y, Bukenstein OG. *Adolescent Substance Abuse: Psychiatric Comorbidity and High Risk Behaviors*. Haworth Press, New York, 2007.

⁶ "Adolescent Behavioral Health in Brief." N.p., Sept. 2009. Web. 21 June 2012.
<http://www.samhsa.gov/statesinbrief/2009/teens/OASTeenReportCT.pdf>

⁷ Testimony of Mark Kraus, MD, FASAM, Connecticut Chapter of the American Society of Addiction Medicine, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

combined.⁸

Complicating treatment for SUD is the increased prevalence of a psychiatric co-morbidity as an indicator of the child's risk. For example, in 2010, adolescents who had experienced a major depressive episode within the past year were more than twice as likely to use illicit drugs as those without the associated diagnosis.⁹ Those who had suffered a major depressive episode were more than three times more likely to have also experienced clinical substance dependence during that year.¹⁰ Also concerning is the national trend showing increasing substance abuse among this vulnerable population, with an increase from 9.3% of youths aged 12-17 in 2008 to 10.1% in 2010.¹¹

B. OHA's Experience

For the last five years, complaints about access to mental health and substance use services have exceeded all other types of clinical complaints. OHA's internal experience shows that mental health and substance use access to care issues under both fully insured and self-funded plans are denied at a higher rate than medical cases. OHA's experience and information reported by carriers on the Connecticut Insurance Department's managed care consumer report card show that while as a percentage of overall utilization review requests, mental health and substance use utilization review requests are only a fraction, the denials of coverage of mental health and substance use benefits in fully insured benefits vary among carriers and third party administrators.

Since the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA)¹² in 2008, at least one carrier's administration of the MH/SU benefit has become even stricter. While OHA's overall reversal rates on appeal of insurance denials is 85%, with respect to mental health and substance use conditions, our reversal rate is closer to 60%.

⁸ Ibid.

⁹ Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

¹⁰ Ibid.

¹¹ Ibid.

¹² Public Law 110-343, Division C. (2008).

Since the passage of the ACA, despite the push by advocates and providers for a 24 hour timeframe, appeal regulations that allow carriers and third party administrators 72 hours to decide expedited/urgent appeals have complicated patients' recovery efforts, as they are often unable to maintain stable mental health or substance use conditions while awaiting the health plan's decision, resulting in re-admissions into acute level care.

On January 1, 2014, when the Connecticut Health Insurance Exchange begins enrolling people into plans that must offer mental health and substance use benefits, OHA believes it necessary for CT to be prepared with an improved model for the delivery of mental health and substance use services.

OHA Cases by Highest Frequency of Clinical Category and Calendar Year						
Clinical Category (Highest Frequency)	2008	2009	2010	2011	2012	Total
Mental Health*	185	207	264	407	524	1587
Medical	123	193	155	257	261	989
Pediatrics	46	65	58	87	93	349
Geriatric	41	63	40	58	24	226
Pharmacy	68	118	120	173	141	620
Surgery	66	107	76	140	151	540
Orthopedic	33	81	79	122	113	428
Oncology	74	89	50	80	90	383
Dental	84	87	56	385	267	879
Physical Therapy	42	39	53	155	110	399
OB/GYN	33	49	39	70	33	224

* Mental Health includes Substance Use. In calendar year 2013, substance use and mental health will be tracked separately, but co-occurring conditions will be tracked by primary diagnosis

II. BACKGROUND OF EFFORTS AND ISSUES

OHA's client complaints are dominated by access to care issues for children and adults for mental health and substance use disorders. Access issues are based on both lack of capacity in our current system, denials from insurers of coverage and lack of provider participation.¹³

These issues are longstanding and were detailed in the 2001 Report of the Governor's Blue Ribbon Commission on Mental Health.¹⁴ The problems of the mental health and substance use delivery system that existed in 2000 are identical to those facing us today: "The current crisis of gridlock in state hospitals and in the emergency rooms and inpatient units of our general hospitals and the need for more community options in order that children and adults may receive appropriate services in the least restrictive environment, needs immediate attention. This issue is described in former OPM Secretary Ryan's letter of June 14, 2000. In calling for a behavioral health summit meeting on June 26, 2000, he refers to the '...myriad of issues related to the mental health crisis in the state and its impact on consumers, families, and providers.'"¹⁵

The Blue Ribbon Commission specifically recommended the development of a continuum of community based services managed locally and in tandem with systems of care to both address the gridlock of emergency departments and to offer services in the least restrictive settings possible. The Blue Ribbon Commission also suggested that state agencies involved with mental health and substance use service delivery develop aggressive plans to address ongoing needs of Connecticut residents, to maximize efficiencies and increase effectiveness. Further the Commission issued the following recommendation, "Connecticut must adopt new approaches for addressing the rich cultural diversity of persons who need mental health services."¹⁶

¹³ *Report to the Governor on Fiscal Year Activities*, August 1, 2012, available at http://ct.gov/oha/lib/oha/documents/combined_fiscal_year_12_report_with_2011_annual_report.pdf

¹⁴ Report of the Governor's Blue Ribbon Commission on Mental Health, 2001, available at <http://www.ct.gov/dmhas/lib/dmhas/publications/brcreport.pdf>.

¹⁵ Id at Chairman's Preface.

¹⁶ Id at xvi.

In 2010, a broad group of advocates and providers, including the Office of the Child Advocate, proposed the “Mental Health Blueprint for Connecticut’s Children”.¹⁷ That recommendation essentially offered a new proposal to address the needs of the 20% of Connecticut’s children and adolescents with psychiatric needs. It builds on the Connecticut Behavioral Health Partnership (CTBHP), ensuring the partnership of schools and child guidance clinics and others to provide enhanced community based services. To do so, it would use the portion of the current premium dollars paid to private carriers for mental health and substance use services and dedicate it to a statewide administrative services organization, the CTBHP, to deliver services to all children, whether publicly or privately insured. The Blueprint has not been acted upon since its release.

Twelve years after the Blue Ribbon Commission’s report, progress has been made on some areas of recommendation for children in public programs, but a significant number of the recommendations of the Blue Ribbon Commission have not been addressed. For instance, denial of coverage by managed care plans and the limited number of providers accepting certain kinds of private plans have hindered access to care for those with private insurance coverage. Consumers testified that carriers denied care even in cases when children were actively suicidal or otherwise in need of ongoing care.

Private insurance carriers and third party administrators do not extend coverage to evidence-based community based services to their members or deny care outright at higher levels of care than our public programs do, which exacerbates the need for inpatient, partial hospitalization and intensive outpatient levels of care for all residents, further creating an inefficient delivery system and a backlog of needed capacity at all levels of care for all age ranges. Further, such denials often increase the cost of care through repeat emergency room visits, inpatient hospitalizations or other treatments. OHA’s October hearing on barriers to access to preventive and treatment mental health and substance use services, substantiated these problems.

¹⁷ See Testimony of Andrew Lustbader, MD, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

III. CONNECTICUT'S CURRENT DELIVERY SYSTEM

At present, Connecticut has a two or three tiered delivery system for individuals with behavioral health and substance use disorders. Individuals covered under public programs in Connecticut access the CT Behavioral Health Partnership (CTBHP) which contracts with a wide range of community based providers to deliver care. Uninsured individuals can access programs through clinics, hospitals and non-profit community-based programs. Privately insured individuals access services through their carriers or third party administrators or carve out companies. Under private health plans, a substantial number of services are provided by community providers. Still others access care through special programs of the Judicial Department (JUD), the Department of Corrections (DOC) and their local schools.

Individuals with mental health and/or substance use disorders may need one or more of alternative levels of care to access appropriate treatment: outpatient therapy or intensive outpatient (IOP), partial hospitalization (PHP), transitional living arrangements, residential (RTC) or inpatient/hospital levels of care. These levels of care exclude the support services, such as housing and other psychosocial supports that people need to achieve successful outcomes.

In CT, approximately 2.4 million residents are covered by private managed care plans.¹⁸ This enrollment represents 69% of the state's population. The enrollment represents individuals enrolled in plans that are regulated by the state, fully-insured plans, or by the federal government, self-funded plans. Approximately 59% of state residents are enrolled in self-funded plans.^{19, 20} Whether in fully or self-funded plans, decisions about whether coverage for mental health and substance use treatment services are made most often by insurers themselves or insurers or other entities acting as third party administrators. In either role, insurers use the same criteria to make determinations about medical necessity. In a self-

¹⁸ Consumer Report Card on Health Insurance Carriers in Connecticut, October 2012, a p.8-9, Connecticut Insurance Department, available at http://ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf.

¹⁹See "Health Insurance Coverage of Nonelderly 0-64, states (2009-2010), U.S. (2010)," The Henry J. Kaiser Family Foundation. at: <http://statehealthfacts.org>. See also <http://www.ct.gov/oha/cwp/view.asp?a=2261&q=299792>

²⁰ See "Health Insurance Coverage of Nonelderly 0-64, states (2009-2010), U.S. (2010)," The Henry J. Kaiser Family Foundation. at: <http://statehealthfacts.org>. See also <http://www.ct.gov/oha/cwp/view.asp?a=2261&q=299792>.

funded plan, the package of benefits is dictated by the employer. In fully insured plan, the minimum package of benefits is dictated by state law.

The Connecticut Behavioral Health Partnership (CTBHP) administers mental health and substance use benefits for individuals in the Charter Oak, HUSKY A and B, C and D plans²¹ and DCF Voluntary Services. DSS, DCF and DMHAS are all parties to the contract with Value Options to administer the CTBHP, which covers services similar to those offered in private plans, as well as community-based services.²² (For HUSKY D enrollees seeking residential treatment, DMHAS handles those services, through its administrative services organization, Advanced Behavioral Health (ABH).) The CTBHP also coordinates local systems of care. The CTBHP serves over 611,000 individuals.²³ The Partnership was designed to implement an integrated behavioral health service system for HUSKY Part A child/parent/caregiver members, HUSKY Part B members (children) and children enrolled in the DCF voluntary services. The CTBHP operates as an Administrative Services Organization or ASO; it does not assume the risk for decisions it makes concerning the medical necessity or appropriateness of approving or denying care. A governing council of stakeholders is vested with extraordinary authority governing the CTBHP's operation, including rate setting methodology approval.²⁴

The MED-Connect program is a Medicaid program that allows individuals with disabilities to earn up to \$75,000 per year and still qualify for medical assistance. Coverage is the same as that provided to those under the HUSKY C program, Medicaid for the aged, blind or disabled. Individuals may pay premiums for coverage if their income is above 200% of the federal poverty level.²⁵ MED-Connect provides individuals with disabilities an opportunity to obtain or continue employment without the loss of medical assistance.

Whether covered by private insurance, Medicaid or CHIP, the CTBHP's, ABH's or insurers' decisions about whether coverage is medically necessary is governed by state and/or

²¹ The plans represent the Medicaid programs in Connecticut and the Children's Health Insurance Program in Connecticut. A brief description can be found at <http://ct.gov/dss/cwp/view.asp?a=2353&q=490478>.

²² See Conn.Gen.Stat. §§ 17a-22h et seq.

²³ DSS presentation to the Council on Medical Assistance Program Oversight, December 14, 2012, states over 611,000 individuals are enrolled in Medicaid. Presentation available at <http://cga.ct.gov/ph/medicaid/default.htm>, at "Minutes".

²⁴ Conn.Gen.Stat. § 17a-22o.

²⁵ See <http://ct.gov/dss/cwp/view.asp?a=2353&q=305220>, accessed December 30, 2012. SSDI or SSI eligibility qualifies an individual for MED-Connect. An individual may also prove his or her disability to DSS.

federal law (self-funded plans, HUSKY A, B, C and D and Charter Oak. Insurers in Connecticut that deliver fully-insured plans are bound to adhere to a statutory definition of medical necessity in making determinations. Conn.Gen.Stat. §§ 38a-482a (individual policies), 38a-513c (group policies), and 17b-259b (all medical assistance programs administered by DSS).

A. Services Covered

Connecticut insurance law requires that all fully-insured plans—individual and group plans—cover services provided by licensed and certified health care providers for covered conditions included in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders or the “DSM.”²⁶ Accepted provider types include: psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional counselors, advanced practice registered nurses, licensed alcohol and drug counselors, and a behavior analyst certified by a behavior analyst certification board for certain autism spectrum behavioral therapies. The following services are not required to be covered under Connecticut insurance statutes: “(1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders".”²⁷ Coverage for residential treatment is explicitly authorized under group policies.

As a matter for federal law, self-funded plans are not required to cover mental health services. Larger group plans, as a matter of practice do cover mental health services to varying degrees. The self-funded Connecticut state employee plan, however, complies with the provisions of Connecticut’s benefit provisions described above.

Medicaid and CHIP offer comprehensive mental health and substance use benefits. Under federal law, the Medicaid program is required to follow the requirements of Early,

²⁶ See Conn.Gen.Stat. §§ 38a-514, 38a-514a and 38a-514b. Substance use disorder is listed in the DSM at the stages of abuse and dependence. The DSM is currently under revision, with a new, fifth edition expected in 2013. The most recent draft version (as of November 2012) would expand the definition of a substance use problem, with the aim of making earlier intervention covered by insurance plans. The DSM revisions are also expected to narrow the range of autism spectrum disorders.

²⁷ Conn.Gen.Stat. § 38a-514.

Periodic, Screening, Diagnostic and Treatment or EPSDT, which requires that the state cover any medically necessary service for an individual under the age of twenty one, even if the service is not one included under Connecticut's Medicaid state plan, filed with the Center for Medicare and Medicaid Services, as long as the service is coverable under Medicaid.

Connecticut's Medicaid program does not cover autism behavioral therapies.

Various state agencies, most notably, DMHAS, DCF and DSS provide hundreds of millions of dollars worth of treatment services and other services such as housing supports, rehabilitative services, and educational supports. For instance, "DMHAS provides and funds prevention, treatment and recovery services to more than 110,000 people in Connecticut needing care for psychiatric disabilities and substance use disorders. From inpatient psychiatric and substance use treatment to community support programs, jail diversion, peer supports, employment readiness and housing; we are available to individuals and their families who have significant symptoms and are medically indigent. **Our major role is to be the safety net for those who do not have insurance coverage and the resources to meet their significant behavioral health needs.**"²⁸ (emphasis added)

According to its website, DCF "protects children who are being abused or neglected, strengthens families through support and advocacy, and builds on existing family and community strengths to help children who are facing emotional and behavioral challenges, including those committed to the Department by the juvenile justice system."²⁹ DCF offers behavioral services to children through in home and community based services, residential placement and hospital services. It also operates the Voluntary Services Program (VSP), which provides behavioral health services to children who are not committed to DCF and who otherwise do to have access to the services they need.

Agencies such as the State Department of Education, Judicial Department and the Department of Corrections are involved in behavioral health evaluation and treatment. The State Department of Education (SDE) estimates that 120,000 students in Connecticut are likely

²⁸ Testimony of DMHAS Commissioner, Pat Rehmer, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

²⁹ See <http://www.ct.gov/dcf/cwp/view.asp?a=2565&Q=314326#Agency>, accessed on December 30, 2012.

affected by mental health or substance use issues.³⁰ While schools are often the frontline of identifying mental health issues for children, schools have limited capacity to address mental health and substance use needs and rely heavily, therefore, on the safety net of school based health centers, child guidance clinics and the like.³¹

The array of services available from state agencies is vast, yet not well understood, catalogued or readily transparent. Navigating the offerings of the various state agencies is a difficult process, given the number of agencies involved and the varying eligibility for various state programs. Policy decisions affecting the continued offering of proven programs in a difficult budget climate are critical to future access to services.

The bulk of services provided through the various state agencies are provided by the non-profit community-based service sector and safety net providers such as community health centers, school based health centers, child guidance clinics and community programs. All depend heavily on state assistance to provide vital services.

For the uninsured, the main avenues to treatment are through safety net providers such as community health centers and hospitals.³² The uninsured made up 12% of Emergency Department admissions in Fiscal Year 2012, yet only 2% of inpatient discharges,³³ which suggests the possibility of lack of acute treatment options for those without a payment source.

B. Mental Health Parity and Equity Addiction Act

According to the U.S. Department of Labor:

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. MHPAEA supplements prior provisions under the Mental Health

³⁰ Testimony of Scott Newgass, State Department of Education, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

³¹ Ibid.

³² According to the Community Health Center Association of Connecticut, approximately 290,000 individuals access the services of an FQHC every year and approximately one-third of those individuals are uninsured. See https://www.chcact.org/Content/Who_We_Serve.asp, accessed December 30, 2012.

³³ See testimony of Carl Scheissl, Director of Regulatory Advocacy, Connecticut Hospital Association. http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

Parity Act of 1996 (MHPA), which required parity with respect to aggregate lifetime and annual dollar limits for mental health benefits.³⁴

The MHPAEA went into effect for plan years starting on or after July 1, 2010. Interim Final Regulations were issued in 2010. The regulations provided substantial protections to consumers by, in addition to clarifying financial prohibitions, prohibiting disparities in quantitative and non-quantitative treatment limitations, such as application of, medical necessity criteria, prior authorization, rate-setting, prescription drug formulary design, visit limits, etc.

Large self-funded plans that offer mental health and/or substance use coverage must comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008,³⁵ unless they have more than 100 employees AND opt out of the Act. The state employee plan is subject to the MHPAEA.

Studies have shown that some large employers have enhanced their coverage of mental health and substance use disorders, while some have excluded certain diagnoses or levels of care from their coverage options since passage of the MHPAEA.³⁶

By including mental health and substance use disorder benefits, including behavioral health treatment, as one of the essential health benefit categories to be offered in new individual and small group coverage under the Connecticut Health Insurance Exchange plans in January 1, 2014, the federal government has extended the standards and requirements of the MHPAEA to these plans in its guidance and regulation.³⁷

C. Medical Necessity

For individuals covered by individual insurance and group health plans governed by state law, the following definition governs a determination by an insurer whether a service is

³⁴ Overview of MHPAEA, United States Department of Labor, Employee Benefits Security Administration, available at <http://www.dol.gov/ebsa/mentalhealthparity/index.html>, accessed December 28, 2012.

³⁵ P.L. 110-343, Division C.

³⁶ See *Employers' Insurance Coverage Enhanced or Maintained Since Parity Act, but Effect on Coverage of Enrollees Varied*, Government Accountability Office, GAO 12-63, November 2011, available at <http://gao.gov/assets/590/586550.pdf>.

³⁷ See <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf> at p.9 and 45 CFR § 156.115 to meet the essential health benefits proposed regulation of 45 CFR § 156.110(a)(5) of the essential health benefits benchmark plan standards for a plan to be offered in the Exchange. See also <http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf>.

medically necessary—the group policy provision is similar, substituting the word “group” for “individual” in describing the type of health insurance policy:

- (a) No insurer, health care center, hospital service corporation, medical service corporation or other entity delivering, issuing for delivery, renewing, continuing or amending any individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (6), (10), (11) and (12) of section 38a-469 in this state shall deliver or issue for delivery in this state any such policy unless such policy contains a definition of "medically necessary" or "medical necessity" as follows: "Medically necessary" or "medical necessity" means health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (1) In accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and (3) not primarily for the convenience of the patient, physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For the purposes of this subsection, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Conn.Gen.Stat. §§ 38a-482a and 38a-513c.

The definition applied to medical assistance programs offered by DSS, and consequently the CTBHP’s decisions, follows:

- (a) For purposes of the administration of the medical assistance programs by the Department of Social Services, "medically necessary" and "medical necessity" mean those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B) recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

- (b) Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.

- (c) Upon denial of a request for authorization of services based on medical necessity, the individual shall be notified that, upon request, the Department of Social Services shall provide a copy of the specific guideline or criteria, or portion thereof, other than the medical necessity definition provided in subsection (a) of this section, that was considered by the department or an entity acting on behalf of the department in making the determination of medical necessity.

Conn.Gen.Stat. § 17b-259b.

DMHAS uses Advanced Behavioral Health to conduct its medical necessity reviews for HUSKY D members seeking residential treatment. The Medicaid statutory medical necessity definition applies to these reviews.

For most plans, including the Medicaid program, prior authorization is required prior to receiving most behavioral health services. The exception is usually outpatient therapy, which is usually exempt from prior authorization for a certain number of visits. When determining whether a service should be prior authorized, a review of the service is done to determine its medical necessity. The definition used by DSS medical assistance programs is explicit in prohibiting decision makers from equating the guidelines or criteria to the actual definition of medical necessity. The same is not true for fully-insured plans or self-funded plans, which use their criteria as the articulation of medical necessity.

IV. OHA HEARING TESTIMONY AND RESEARCH

Several themes emerged at OHA's hearing on October 17, 2012. For purposes of discussion, we have categorized the general areas of concern addressed by those who testified into the following: Capacity, Insurance Procedures, Cost Shifting, Lack of Integration and Coordination of Care and Medicaid. Within each category, we include sub-categories where applicable and summarize the testimony relating to those categories or sub-categories. We also point to research and OHA's experience that supports or clarifies the concerns raised at the hearing.

A. CAPACITY

1. WORKFORCE AND FACILITIES

The DPH Office of Health Care Access (OHCA) Statewide Facilities and Services Plan³⁸ was published in October 2012. Connecticut currently has a shortage of 38 FTE mental health professionals and 27 mental Health Professional Shortage Areas per Health Resources Administration guidelines.³⁹ Individuals with mental disorders are defined as persons at-risk or

³⁸ Connecticut Statewide Health Care Facilities and Services Plan, October 2012, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf.

³⁹ Ibid @19-20.

a vulnerable population for purposes of DPH's work to identify and improve health status to cure health disparities.

The Connecticut Council on Child and Adolescent Psychiatry agrees, stating that there is a lack of availability of mental health professionals, specifically for those needing specialized services. Specifically, there is a lack of Child and Adolescent Psychiatrists. The Council recommends recruitment and retention policies to ensure development of this needed work force.⁴⁰

Another witness expressed concern that there are not enough trauma specialists.⁴¹

Mary Denise Moller, a psychiatric-mental health APRN, surveyed and provided testimony on behalf of the psychiatric-mental health APRN community. She raised the following issues related to capacity:

- Lack of available physicians willing to enter into the legislatively mandated collaborative relationship-the collaborative requirement is outdated
- A two tiered reimbursement system (public and private) with no reimbursement for uninsured patients, thus impeding access to care
- Lack of planning for community-based care for thousands of patients who have been deinstitutionalized as well as lack of provision for acute-care services when these individuals experience a relapse of their chronic psychiatric condition, specifically citing the low number of acute care beds in CT and criminalization of individuals with mental illness
- Dramatic decreases in state budget funding for community based care, e.g., the Connecticut Mental Health Center clinicians are facing increasing caseloads and lessening the ability to take additional patients, the loss of the STEP program and IOP services for uninsured patients, forcing them to go to the ED for services
- Lack of providers trained in children's psychiatric care – six month waits are not uncommon⁴²

According to the OHCA report, emergency department (ED) use, approximately 18%, for behavioral health issues, exceeds that of the average ED use of the United States.⁴³

Recent data from the Connecticut Hospital Association (CHA), provided at the OHA hearing, verify that ED use is up dramatically since 2008. The rate of increase in the last four

⁴⁰ Testimony of CT Council on Child and Adolescent Psychiatry, available at

http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁴¹ Testimony of Barbara Sloan, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁴² Testimony of Mary Denise Moller, APRN, available at

http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf

http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁴³ Connecticut Statewide Health Care Facilities and Services Plan, October 2012, available at

http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

years of the percentage (42.9%) of senior ED non-admissions for mental health and substance use services is nearly equal to the increase in the percentage of children and adults (47.9% and 41.0%, respectively).⁴⁴ While the overall rate of inpatient behavioral health discharges increased by 13% overall, the rate for children increased by 25% and for adolescents by 26%. During the same period, ED non-admissions increased by 40%, with 48% of those non-admissions representing children. These statistics should sound the alarm for Connecticut, both for the rate of increase on non-ED admissions, but also for the sheer number of individuals seeking services at hospitals for mental health and/or substance use care.

Further, the number of children in inpatient care appears to exceed that of adults. The payer mix of the CHA provided data reflects the fact that many who are admitted inpatient have Medicare, while smaller number have private coverage or Medicaid. The highest percentage of people of ED non-admissions are those covered by Medicaid.

There is widespread belief that there is a lack of beds available for inpatient admission. Whether the lack of beds is an overall lack of beds or a lack of beds for patients with certain diagnoses or a lack of beds because of unavailable community resources, is a subject that OHA is currently exploring with the OCHA and the hospitals themselves. DMHAS has a publicly available bed vacancy list that it puts out every week, available on its home page for adults.⁴⁵ Although the contract with Value Options and DCF, DSS and DMHAS requires the development of a bed census tracking system, no formal system has been put in place. According to Value Options representative, Value Options keeps an informal tracking system through phone calls to all hospitals.

Sabina Lim, MD, Executive Director of the Yale-New Haven Psychiatric Hospital testified that in FY 2012 Yale-New Haven and St. Raphael's had a combined 4,300 inpatient hospitalizations and over 40,000 outpatient visits. The two hospitals also had a combined 8,000 ED visits in the same time period. The available beds at Yale-New Haven and St. Raphael's are at 100% occupancy nearly every day.⁴⁶

⁴⁴ Testimony of Carl Scheissl, Director of Regulatory Advocacy, Connecticut Hospital Association, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁴⁵ Ct.gov/dmhas, "What's New".

⁴⁶ Testimony of Sabina Lim, MD, Executive Director of Yale-New Haven Psychiatric Hospital, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

Kieran Delamere, LCSW, of the Western Connecticut Health Network, consisting of Danbury and New Milford Hospitals, testified that, “There is a significant lack of intermediate and long-term in-patient care facilities in [DMHAS] region 5. Region 5 is the only region in the state that does not have an in-patient psychiatric hospital for the chronic adult and pediatric populations, dating back to the closure of Fairfield Hills in 1995.”⁴⁷ WCHN also noted that lack of supportive housing contributes to the inability of patients to be discharged.

Consistent with the testimony of participants at OHA’s hearing, a group discussion of ED facilities’ staff as part of the Statewide Facilities report stated the following themes related to ED use, which contribute to overall lack of bed availability:

- Behavioral health patients presenting at EDs, although other treatment settings would be more appropriate
- Limited access to behavioral health services (especially inpatient adult or residential youth services)
- Lack of coordination of care between EDs and community based services⁴⁸

According to the OHCA Statewide Health Care Facilities and Services Report:

ED staff participants believed that many behavioral health patients presenting do not need emergency room treatment and could be more effectively and less expensively managed in outpatient settings. Focus group members were concerned that inappropriate referrals will continue as long as EDs are the only facilities available around-the-clock. In addition, limitations on the length of stay for patients in general hospital inpatient psychiatric beds, by private insurance companies, has added to the problem of patients relapsing and returning to the ED. Participants noted that the decline in State-operated beds for adults and community residential beds for children places an extreme burden on EDs. For “new” patients with behavioral health needs, it can be difficult to schedule appointments in the community for initial assessments to obtain outpatient treatment or medication management. Obtaining preauthorization for behavioral health services can be very time consuming. The group believes that communication between EDs and community programs needs to be improved to help behavioral health patients receive more appropriate care in settings outside the ED.⁴⁹

As Dr. Paul Rao, child psychiatrist for DCF, staff psychiatrist at Clifford Beers Child Guidance Clinic, former chief resident of the Yale-New Haven Psychiatric Hospital's adult treatment unit and a teaching faculty member of the Yale School of Medicine in the Departments of Psychiatry and Yale Child Study Center, testified: “Discharging patients prematurely leads to an increase in emergency room visits, which in addition to driving up costs, burdens emergency rooms, which in turn transforms them into brief treatment units,

⁴⁷ Testimony of Kieran Delamere, Western Connecticut Health Network, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁴⁸ Ibid @ 33.

⁴⁹ Ibid @ 34.

something they are not prepared for. Emergency rooms anyway are not appropriate settings for treating those in severe mental pain.”⁵⁰

While most acute hospitals have accommodated at least short-term hospital stays, the status of available outpatient services across the state is less clear. As DPH states:

There is currently not a single, verifiable source of information on the types or levels of behavioral health outpatient services provided by Connecticut’s short-term general hospitals, but information from various sources indicates that the vast majority of the state’s short-term general hospitals provide some level of behavioral health outpatient services, either as a hospital service or through an affiliated or contractual arrangement. These other sources include Value Options, the Connecticut Clearinghouse, (<https://www.ctclearinghouse.org/Default.asp>), OHCA’s service line survey of hospitals (Inventory Table 3), the SAMHSA facility locator (<http://store.samhsa.gov/mhlocator>), the United Way of Connecticut’s 2-1-1 search engine (www.211ct.org/referweb/landing.aspx), and Network of Care (<http://connecticut.networkofcare.org/mh/home/index.cfm>).⁵¹

Sabina Lim, MD, testified that for many patients with co-morbid psychiatric and substance use diagnoses, access to community based services and/or lower levels of care such as residential treatment, there are often very long waits for services. In a study of adult Yale-New Haven Psychiatric Hospital patients that were hospitalized for more than 6 weeks, the patients stayed in the hospital a collective 260 days or over 7 months longer than needed to provide acute care treatment. Yale-New Haven is actually working with a community partner to arrange for temporary housing to allow patients to move back into their community.⁵²

A witness noted that individuals often receive acute care for substance use and are released because of the lack of other treatment options. He recommended that hospitals expand their programs to include direct channels of treatment outside the emergency room and into the community. Such short treatment does not “sufficiently interrupt or break the habit.”⁵³

⁵⁰ Testimony of Dr. Paul Rao, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁵¹ Connecticut Statewide Health Care Facilities and Services Plan, October 2012, at p. 95, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf. (internal citations omitted)

⁵¹ Ibid @19-20.

⁵² Testimony of Sabina Lim, MD, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁵³ Testimony of Raymond Currytto, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

In terms of available residential placement options, DMHAS has group homes, supervised apartments and mental health residential living centers, but in order to access those options, one must be eligible for DMHAS. DCF licenses 132 congregate living locations for children—some of which are therapeutic group homes or residential treatment centers. Some of these are PRTFs.⁵⁴

DPH reports 205 licensed psychiatric outpatient clinics for adults and 199 facilities licensed as facilities for the care or treatment of substance abusive or dependent persons. Many hold mental health licenses, too, and can treat people co-occurring disorders.⁵⁵

DCF licenses 63 outpatient psychiatric clinics for children, and 23 Extended Day Treatment (EDT) facilities.

Although state law requires insurers to contract with school-based health centers (SBHCs)⁵⁶ and the state's federally qualified health centers contract with the state's insurers, there is no requirement that insurers and the DPH and DCF licensed hospitals, and residential treatment facilities or outpatient clinics contract with each other. While insurers are required to have adequate networks, this does not translate into insurers contracting with all licensed facilities or clinics. This is also true for Medicare Advantage plans. In fact, contract disputes between hospitals/hospital systems and insurers have become common in the last few years.

There may be other barriers as well. An insurer may require that a facility meet certain criteria before the insurer contracts with it, and in the case of residential facilities, the definition may be narrower than DCF's own definition of its residential facilities. In addition, the definition under an insurance policy often requires accreditation by a national body, which may further limit access.

Residential treatment may not be the treatment of choice in many circumstances, but there is a lack of step down or community-based services that offer significant wrap around supports. PRI determined that residential level of treatment is denied more frequently by fully-

⁵⁴ Connecticut Statewide Health Care Facilities and Services Plan, October 2012, See Chapter 8 generally, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

⁵⁵ Ibid.

⁵⁶ Conn.Gen.Stat. § 38a-472e.

insured plans than any other level of care.⁵⁷ DCF has made great progress bringing children home from out of state settings, but even its commissioner has determined that more needs to be done to ensure that adequate community resources are available to children to allow them to remain in their communities.

Recently, Commissioner Joette Katz said in an OpEd piece:

In the next month, the Department of Children and Families expects to launch a new RFP, entitled The Community Bridge. It is intended to provide intensive community based treatment for youth who are experiencing mental health or behavioral challenges that are of sufficient severity that a residential placement would have historically been the treatment of choice. The Bridge is envisioned as a flexible array of family-based, community, residential and aftercare programs that are closely linked and integrated.

Most services will be oriented to an in-home venue and will be rooted in evidenced based practice. Youth referred to community based services will be 11-18 years of age and have complex behavioral, emotional, and physical needs that would likely necessitate out-of-home care if a successful intervention were not implemented.⁵⁸

The safety net, including acute care hospitals, community and school based health centers and non-profit community providers in Connecticut have absorbed a substantial volume of insured individuals needing care. Of the 330,000 individuals who access the services of any one of the 14 federally qualified health centers or FQHC lookalikes in 2011, most, approximately 77%, were insured.⁵⁹ The Community Health Center Association of Connecticut expects the number of insured individuals, who access its 13 community health centers at 80 sites in Connecticut at the rate of over one million visits per year, to rise as the cost of health insurance continues to rise.⁶⁰

The Connecticut Community Providers Association (CCPA) testified in 2012 that its members provide services and supports for people with disabilities and significant challenges including children and adults with substance use disorders, mental illness, and intellectual and physical disabilities. Community providers deliver quality health and human services to 500,000

⁵⁷ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Approved December 18, 2012, <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf> at p.20, and <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Appendices-12-18-12.pdf> at Appendix F.

⁵⁸ Katz, J., "A commissioner Outlines DCF Reforms After Newtown," *The Ct Mirror*, December 25, 2012, available at <http://ctmirror.org/story/18557/dcf-looks-mental-health-post-newtown>.

⁵⁹ https://www.chcact.org/Content/What_is_a_Community_Health_Center_.asp, accessed December 30, 2012.

⁶⁰ Ibid and https://www.chcact.org/Content/What_We_Do.asp, accessed December 30, 2012.

Connecticut residents each year.⁶¹

There are 75 school based health centers (SBHCs) licensed as outpatient clinics by DPH in Connecticut, located in 18 communities, serving approximately 20,000 students per year.⁶² According to the Connecticut Association of School Based Health Centers, its member SBHCs provided more than 40,000 mental health visits annually for a range of mental health and substance use disorders.⁶³

In terms of Medicaid access, Stephen Karp, MSW, Executive Director of the National Association of Social Workers-CT Chapter, testified in favor of DSS reimbursing licensed clinical social workers (LCSWs) for the provision of services to HUSKY C and D clients. LCSWs are already part of the HUSKY A and B programs. Because of the unique challenges of the HUSKY C and D populations, the training of LCSWs can offer enrollees case management to the adults in these HUSKY coverage groups. The NASW-CT identified at least ten other states in which LCSWs provide services to adults enrolled in Medicaid. Mr. Karp provided convincing evidence that LCSWs engage in collaborative relationships with prescribing practitioners. These factors, combined with the geographic accessibility of LCSWs across the state and their willingness to accept patients, raise serious concerns as to why DSS has not exercised the option of allowing LCSWs to be participating providers for HUSKY C and D enrollees.⁶⁴

Scott Newgass, Educational Consultant with the State Department of Education, testified that the capacity of schools to provide needed services is compromised by the following:

Scheduling

- The need to provide uninterrupted and regularly scheduled appointments for students;
- Accommodating parents' schedules within the school day or
- Collaboration with community service providers;

⁶¹ Connecticut Community Providers Association (CCPA), Testimony of Hillary Teed before the Appropriations and Human Services Committees, July 24, 2012, available at <http://www.ccpa-inc.org/documents/CCPA%20Comments-%20Joint%20Approps%20and%20Human%20Services%20Public%20Hearing%207-24-12.pdf>, accessed January 3, 2012.

⁶² <http://www.ctschoolhealth.org/AboutCASBHC/WhatYouNeedToKnow.asp>, accessed December 30, 2012.

⁶³ <http://www.ctschoolhealth.org/Resources/BriefReports/MentalHealthBriefReport2011.pdf>, accessed on December 30, 2012.

⁶⁴ Testimony of Stephen Karp, Executive Director of the NASW-CT, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

Funding as

- Special education services can be funded through Title XIX but general education services cannot
- No federal funding to provide mental health services in schools outside of competitive and short term grants or school based health centers; and
- Schools are often faced with the choice of funding a teaching position or the position of a school mental health professional⁶⁵

To prove the point, Michela Fissel testified that she never received “information on mental health and/or substance related disorders through the Windsor Public School curriculum and therefore I was never informed about the possible underlying reason that could explain why I was having such difficulty controlling my emotional states and behaviors.”⁶⁶

The OHCA Statewide Health Care Facilities and Services Plan makes the following recommendations to improve behavioral health capacity in Connecticut:

- Explore ways that Connecticut’s behavioral health service system can measure or determine capacity as it relates to need and access to care.
- Inventory and discuss behavioral health care services provided by private practitioners and include how the provision of services in private practice contributes to the overall provision of behavioral health care in the state.
- Further advance the discussion of additional types of providers (e.g., private practitioners, Veterans Administration) and the availability of clinical level services in the state and seek and provide more information on recovery supports available to residents in the state.
- Inventory distinct service levels.
- Enhance OHCA’s Hospital Reporting System (HRS) reporting mechanisms to capture accurate, usable data from short term general and children’s general hospitals on hospital-based or hospital-affiliated behavioral health care services (such as a revamped Report 450218 or a new schedule).
- Provide more focus on the provision and interrelation or co-location of mental health, primary care and/or oral health services within the various settings and provide further discussion as to the concept of “no wrong door” to accessing these services at any location.
- Further consider how health care reform and a possible blended behavioral health license might change the landscape for both behavioral health finance and delivery of care in the future.⁶⁷

Finally, the PRI committee is studying the Connecticut’s capacity to provider substance use treatment services to adolescents in Connecticut. A report is expected in early 2013.

⁶⁵ Testimony of Scott Newgass, SDE, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

⁶⁶ Testimony of Michaela Fissel, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

⁶⁷ Statewide Health Care Facilities and Services Plan, Office of Health Care Access, at p. 134, October 2012, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf, accessed December 31, 2012.

2. LACK OF INSURANCE COVERAGE FOR EVIDENCE-BASED PRACTICES

DMHAS has implemented statewide, the evidence-based practice, Integrated Dual Disorder Treatment (IDDT), for people who have co-occurring mental health and substance use disorders in mental health treatment settings. Several witnesses testified that the lack of services such as Intensive In-Home Child and Adolescent Psychiatric Services (IICAPs) and other community based services resulted in emergency admissions to hospitals or psychiatric hospitals that might have been prevented. Lack of coverage for evidence based therapies such as Extended Day Treatment (EDT), Multi Systemic Therapy (MST), Functional Family Therapy (FFT), and Multi Dimensional Family Therapy (MDFT) for the commercially insured population.

Extended Day Treatment (EDT)

Three provider witnesses testified that Extended Day Treatment (EDT) is an evidence-based community based service that provides six months of five day per week, three hours per day of intensive group, parent, and family, psychiatric and individual therapy as needed. Witnesses stated that EDT prevents hospitalizations, sub-acute placements and partial hospitalization program placements. These witnesses attest to the value of EDT as a transitional service as a component of discharge planning.⁶⁸ Yet EDT is not covered by insurance or self-funded plans.

Multidimensional Family Therapy (MDFT)

According to the Yale Child Study Center:

Multidimensional Family Therapy (MDFT) is a family-based, comprehensive treatment program focused on adolescent and young adult substance abuse and related behavioral and emotional difficulties. The model is widely recognized as an effective evidence-based treatment for adolescent substance use disorders and delinquency (e.g., Liddle et al 2008; Liddle et al 2009; Rigter et al, 2005; Vaughn & Howard, 2004; Waldron & Turner, 2008). MDFT is theory driven, combining aspects of several theoretical frameworks such as, family systems theory, developmental psychology, and the risk and protective model of adolescent substance abuse. It incorporates key elements of effective adolescent drug treatment, including comprehensive assessment; an integrated treatment approach; family involvement; developmentally appropriate interventions; specialized engagement and retention protocols; attention to qualifications of staff and their ongoing training; gender and cultural competence. MDFT is flexible treatment delivery structure, tailoring treatment to the needs of the youth and family.⁶⁹

⁶⁸ Testimony of Stephanie Ehrman, Testimony of Eric Arzubi, MD, Testimony of Andy Lustbader, MD, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁶⁹ Description of MDFT from Yale Child Study Center, available at <http://childstudycenter.yale.edu/family/MDFT.aspx>, accessed on December 30, 2012.

MDFT is not routinely covered under fully- or self-funded plans.

Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS)

Developed by the Yale Child Study Center, IICAPS is a service that:

addresses the comprehensive needs of children with psychiatric disorders whose families need assistance in managing their behaviors to keep them safe in the home and community. Children appropriate for IICAPS are those who are discharged from psychiatric hospitals or residential treatment facilities with additional in-home support; children in acute psychiatric crisis for whom hospitalization is being considered; or children for whom traditional outpatient treatment is insufficient to maintain them in the community.⁷⁰

IICAPS is an evidence-based practice funded by DCF and widely used to prevent children from needing out of home placement. IICAPS is supervised by a clinical supervisor and a child and adolescent psychiatrist. Services usually last six months, and coverage is available around the clock for emergencies or crises. While IICAPS is not covered by health insurance plans, it can be accessed by children with private insurance.

Multisystemic Therapy (MST)

Multisystemic therapy (MST), according to DCF, “offers intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to problems of delinquency, disruptive behavior and/or substance abuse. Eligibility for MST services does not require DCF-involvement. Referrals to MST are typically made by the DCF Area Offices, System-of-Care Collaboratives, Juvenile Justice staff, and community providers.”⁷¹

Family Functional Therapy (FFT)

Family Functional Therapy Teams “offer intensive clinical services and support to children and youth returning from out-of-home care or who are at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Eligibility for

⁷⁰ Description of IICAPS from Yale Child Study Center, <http://childstudycenter.yale.edu/family/iicaps.aspx>.

⁷¹ DCF Intensive In-Home Services Description, <http://www.ct.gov/dcf/cwp/view.asp?a=2558&Q=314366>, accessed December 30, 2012.

services does not require DCF-involvement. Referrals to FFT are typically made by the DCF Area Offices, System-of-Care Collaboratives, and community providers.”⁷²

Emergency Mobile Psychiatric Services (EMPS)

EMPS is a DCF funded service targeted to any child or youth in crisis in the state. The service includes:

mobile response; psychiatric assessment; medication consultation, assessment, and short-term medication management; behavioral management services; substance abuse screening and referral to traditional and non-traditional services for any family with a child in crisis.

Emergency mobile psychiatric services (EMPS) deliver a range of crisis response and crisis stabilization services to children, youth, their families and caregivers including children residing in relative, adoptive and foster care homes. For children currently involved in clinical treatment, the EMPS first assesses the capability of that clinical service to handle the intervention. The EMPS provider is responsible for assuring that the client receives appropriate care during the crisis period.⁷³

EMPS is a partnership of DCF and the United Way. 2-1-1 is the main access point for EMPS. EMPS is not covered by fully-insured or self-funded plans. Like the other community-based services described above, the state funds these evidence based services, to prevent unnecessary use of hospital based services or juvenile justice involvement, to focus on family involvement, to ensure successful outcomes. In FY 2012, 13,814 calls were handled by EMPS; 10,560 resulted in EMPS care. Thirty-three percent of the calls to EMPS were for privately insured youth.⁷⁴ None of these interventions is reimbursed by private healthcare coverage for those children and youth covered by fully insured or self-funded policies.

Dr. Paul Rao testified:

Aftercare options such as intensive in-home child and adolescent psychiatric services (IICAPS), partial hospital programs (PHP) or intensive outpatient programs (IOP) are often required following hospitalization and even periodically between times of stabilization. The paucity of full insurance coverage for these essential treatment modalities that prevent re-hospitalization means frequent cycles of emergency room visits and brief inpatient admissions for many with severe and persistent mental illness.⁷⁵

⁷³ DCF description of Emergency Mobile Services, available at <http://www.ct.gov/dcf/cwp/view.asp?a=2558&Q=314354>, accessed December 30, 2012.

⁷⁴ EMPS Crisis Prevention Services, FY 2012 Annual Report, available at <http://www.empst.org/download/AnnualFY12.pdf>, accessed December 30, 2012.

⁷⁵ Testimony of Dr. Paul Rao, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

Greg Williams, co-founder of Connecticut Turning to Youth and Families testified that “for individuals with substance use disorders, benefit design and services offered are not relevant to evidence-based practices of treatment for a chronic health disorder (i.e. limited prevention, early intervention, recovery support services, or family inclusion benefits offered).”⁷⁶

Robert Davidson, PhD, Director of the Eastern Regional Mental Health Board and President of NAMI-CT, testified of the importance of psychosocial rehabilitative services, such as residential supports and vocational services, to recovery. He acknowledged that this is an area in which “the public system is more enlightened and cost effective than private insurance.” He urged that private insurance cover these cost-effective services so that individuals who need such services would not have to impoverish themselves to be eligible for such programs through the public system.⁷⁷

One witness testified how if it weren’t for the fact that she was eligible for DMHAS services, she doesn’t know what she would do, because private insurance doesn’t cover the breadth of services that the DMHAS Young Adult Services program does. The witness started experimenting with substance use in high school and started spiraling out of control, eventually attempting suicide five years ago. She was diagnosed with bipolar disorder and represents a large group of individuals with co-occurring mental health and substance use disorders.

These issues are also discussed in the section on cost shifting.

3. INADEQUATE NETWORKS

Adequacy of providers for public and private networks has been a longstanding issue in Connecticut. In late 2006, OHA commissioned a study of the adequacy of the mental health and substance use provider HMO networks for privately insured residents in Connecticut. Of the 337 providers who completed the telephonic survey, 33% treated adults only, 5 % treated only children and adolescents, and 62% treated both. The survey found that 17 percent of

⁷⁶ Testimony of Greg Williams, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

⁷⁷ Testimony of Robert E. Davidson, PhD, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

HMO network listings were inaccurate and 30 percent of participating network providers was not accepting new patients. Of those not accepting new patients, the majority cite the lack of available appointments as an important explanation.⁷⁸ The report confirmed a substantial barrier to obtaining access to services.

A 2007 report by the Office of the Child Advocate and the Office of the Attorney General made the following findings from surveys of child and adolescent psychiatrists in Connecticut with respect to children access to mental health care:

- Nearly half of all responding child and adolescent psychiatrists do not participate in any managed care plan;
- Most of the responding doctors who have advanced certification in child and adolescent psychiatry do not participate in managed care;
- Responding psychiatrists reporting that they have been forced out of managed care have created a parallel care delivery system financed by enrollees' out-of-pocket payments.⁷⁹

The report also found “managed care plan participation lists are inaccurate; all seven managed care plans have misstated the [child and adolescent psychiatrists] on their participation lists. Aetna and Cigna have radically overstated the number of doctors participating in their networks.”⁸⁰

These findings, though five years old, are supported by those who testified at the OHA hearing. The Connecticut Council on Child and Adolescent Psychiatry specifically testified that in addition to the lack of availability of mental health professionals, including child and adolescent psychiatrists, the provider lists maintained by health plans are often inaccurate.⁸¹

Currently, there is no requirement in the state’s insurance statutes or federal law that requires independent monitoring of the adequacy of insurers’ provider networks. Current law provides:

Each insurer, health care center, managed care organization or other entity that delivers, issues for delivery, renews, amends or continues an individual or group health insurance policy or

⁷⁸ Barry, C., et al., *HMO Enrollee Access to Specialty Mental Health Care in Connecticut*, Yale University School of Public Health, February 28, 2007. A description of the study, commissioned by OHA, can be found at http://www.ct.gov/oha/lib/oha/Annual_Report_2006_OHA.pdf.

⁷⁹ *Connecticut Children Losing Access to Psychiatric Care*, at p.23, Office of the Attorney General and Office of the Child Advocate, April 2007, available at http://ct.gov/oca/lib/oca/CCH-MENTAL_HEALTHCARE_AVAILABLE_TO_CT_CHILDREN.pdf.

⁸⁰ Ibid @ 27.

⁸¹ Testimony of Council on Child and Adolescent Psychiatry at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

medical benefits plan, and each preferred provider network, as defined in section 38a-479aa, that contracts with a health care provider, as defined in section 38a-478, for the purposes of providing covered health care services to its enrollees, shall maintain a network of such providers that is consistent with the National Committee for Quality Assurance's network adequacy requirements or URAC's provider network access and availability standards.⁸²

The standards used by insurers in their accreditations include the number and type of providers, the geographic distance to participating providers and timeliness of appointment scheduling. Each insurer has its own standards. The standards are not publicly available. CID does not independently evaluate the accuracy of the insurer's provider networks. As a result, to ensure transparency of network standards to consumers and providers and to ensure that networks are independently monitored for their accuracy, the Health Insurance Exchange Board adopted the following requirements for health plans in the Health Insurance Exchange:

The Exchange will require each Issuer to provide the Exchange the criteria used to define the adequacy of its network, including but not limited to, geographic distance standards to providers and timeliness of appointment scheduling. Such standards shall include information on variation of standards by provider specialty. All such standards shall be made readily available to the public and consumers on the Exchange.

The Exchange will actively monitor, through whatever means are most appropriate, an Issuer's provider networks to ensure it maintains a network adequacy standard equivalent to the standard agreed upon as a condition of certification.⁸³

Provider reimbursement was another area that came up repeatedly in the discussion about the lack of adequate networks for both private and public coverage.

A masters level clinician with twenty years of participation as an in-network provider for several insurance companies in Connecticut noted, "The current rate structure has remained constant in spite of the cost of living increases over the past 10+ years. While the rate of copayments for clients has increased, the reimbursement rate for Providers has remained the same."⁸⁴ She also stated that it is difficult to negotiate with the insurers, who often do not respond to phone calls and who will say, "you can drop out of the network." She had to drop out of several networks to make ends meet, knowing that it means more difficulty for members

⁸² Conn.Gen.Stat. § 38a-472f.

⁸³ Initial Solicitation to Health Plan Issuers for Participation in the Individual and Small Business Health Options Program (SHOP) Exchanges, p. 26-27, released December 13, 2012, available at http://ct.gov/hix/lib/hix/Connecticut_QHP_Solicitation_%28Final_12132012%29.pdf.

⁸⁴ Testimony of Mary Lombardo, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

to access care other than on an out-of-network basis, which substantially increases costs for them.⁸⁵

Paul Gionfriddo, a former Connecticut state legislator, submitted testimony that documented licensed clinical psychologists under certain Blue Cross Blue Shield plans are being paid \$46 per hour, less than the \$52 they were paid previously and still below the hourly rates for electricians, carpenters and plumbers.

Mary Denise Moller, APRN, testified that poor reimbursement “has created an inefficient form of psychiatric care called split therapy in which a prescriber is forced to see a patient for only 15 minutes, to generate a modicum of revenue, while the therapy is provided by a social worker that may not even be in the same office as the psychiatric provider.”⁸⁶

B. INSURANCE PROCEDURES

Consumers and providers often view all types of healthcare coverage as “insurance” that is regulated by CID. As stated earlier, while many issues that OHA handles are identical across fully-insured and self-funded plans, CID does not regulate self-funded plans. Therefore, while some of the issues highlighted in this section fall under CID’s jurisdiction, some fall instead under the jurisdiction of the federal government. Accordingly, OHA has raised most of the issues herein with the U.S. Department of Labor and the Department of Health and Human Services. In any event, the issues highlighted here affect nearly all Connecticut residents and, therefore, should be of concern to all.

1. CRITERIA

Consistent with OHA’s findings, in some cases, the criteria used by the insurers and third party administrators to determine medical necessity does not match up with the practice guidelines cited by the plan as the basis for its criteria.

In accounting for individuals with co-occurring psychiatric and substance use disorders, insurers or insurers acting as third party administrators assert that the criteria that they apply to these cases are based on current psychiatric literature in addition to criteria promulgated by the American Psychiatry Association (APA), American Academy of Child and Adolescent

⁸⁵ Ibid.

⁸⁶ Testimony of Mary Denise Moller, APRN, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

Psychiatry(AACAP), the American Society of Addiction Medicine(ASAM), as well as other relevant sources.

However, “the American Academy of Child and Adolescent Psychiatry’s Practice Parameters for the Assessment and Treatment of Children and Adolescents with Substance Use Disorders concluded that it is essential to treat psychiatric disorders that are co-morbid with substance use disorders among adolescents, and that integration of psychotherapy and medication therapy is currently thought to be the best treatment of that population [and that]...treatment of dually diagnosed adolescents should include interventions for both disorders because lack of adequate treatment of one of the disorders might interfere with recovery.”⁸⁷ Additionally, commonalities among various treatments indicates that retention in treatment results in improved outcomes.^{88,89}

The legislature’s Program Review Investigations (PRI) Committee recently conducted an investigation into alleged problems with fully-insured and public coverage⁹⁰ of substance use services for adolescents. PRI staff also found the private carriers use varying criteria to decide whether services are medically necessary. Because of the variation in insurers’ criteria, the failure of the criteria to reflect the most current standards for treatment decisions, and PRI committee’s finding that in 7 of the 21 cases provided by OHA to the committee, insurers used restrictive criteria in denying coverage of substance use services, PRI staff recommended that current insurance statutes be changed to require that insurers use the ASAM medical necessity criteria for substance use disorders or the its equivalent, provided the equivalent is proven sufficient.⁹¹

⁸⁷ Psychiatry (Edgemont) 2007;4(12):32-43

⁸⁸ Gerstein, DR. *Outcome research: Drug Abuse*, in The American Psychiatric Publishing Textbook of Substance Abuse Treatment, 3rd Ed., Washington DC, American Psychiatric Publishing, 2004, pp 137-147.

⁸⁹ De Leon G, Wexler HK, Jainchill N. *The Therapeutic Community: success and improvement rates 5 years after treatment*, Int J Addiction 1982, 17; pp 703-747.

⁹⁰ The PRI study was limited to fully-insured plans—those that are regulated by the state of Connecticut. More than half of those covered by health coverage in CT are covered by self-funded plans, which are regulated by the federal government.

⁹¹ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Approved December 18, 2012, <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf> at p.20, and <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Appendices-12-18-12.pdf> at Appendix G.

The variations in criteria also extend to mental health criteria. OHA's experience is that residential level of care, even more so than other levels of care, when needed for certain types of disorders or individuals, is difficult to obtain. Residential criteria for eating disorder, substance use and psychiatric treatment are varied among Connecticut insurers, and in at least one case, are inconsistent with practice guidelines of the associations upon which the insurer's criteria are purportedly based.

Dr. Margo Maine testified that many individuals with eating disorders need anywhere from 3 – 6 months of inpatient care. "[E]ating disorders require prompt, comprehensive and specialized care, at the intensity and duration determined by the individual's condition. When I talk to insurance reviewers to pre-certify care or refer to a higher level of care, they talk like we are 'making a deal,' instead of dealing with life and death issues of seriously ill patients."⁹²

A witness who waged a four year battle with her health plan to get her daughter the treatment she needed for her eating disorder notes that the criteria the plan uses to evaluate whether ongoing mental health treatment is needed for the condition.⁹³

Insurers' and plan administrators' criteria for inpatient hospitalization is also controversial.

According to calculations made by the PRI committee based on the CID Consumer Report Card on Health Insurance Carriers in Connecticut, inpatient hospitalizations were denied 19% and 36% of the time, and at least two carriers denied extensions of stay 13% of the time.⁹⁴ Statistics for self-funded plans are not available.

Dr. Paul Rao, child psychiatrist, testified:

Though these [high risk] patients may indeed not be voicing suicidal thinking or refraining from self-injury, the family work and care coordination that need to be strongly in place prior to discharge are often still in process. And using absence of active self-injury or suicidal thinking as the primary markers for continuing care means discounting other signs or symptoms that signify

⁹² Testimony of Margo Maine, PhD, FAED, CAPS, available at

http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

⁹³ Testimony of Diana Leyden, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

⁹⁴ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Approved December 18, 2012, at Appendix G, <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Appendices-12-18-12.pdf>.

continued high risk: high levels of anxiety, insomnia, continued presence of lethal means for suicide or self-harm in the home, or continued environmental turmoil.⁹⁵

OHA heard testimony from Maureen Sullivan Dinnan, Executive Director of HAVEN, that assistance program created under Conn.Gen.Stat.§ 19a-12a for healthcare professionals facing the challenges of physical illness, mental illness, chemical dependence, or emotional disorder. Ms. Sullivan Dinnan testified to the difficulties of accessing the appropriate treatment because insurers deny treatment unless someone has failed at a lower level of care. These access issues are a result of the criteria used by insurers and third party administrators.

For medical professionals, failing at the lower level of care does not mean that they will then be allowed to advance to the more aggressive treatment; it may mean that they lose the opportunity for confidential treatment. Failure at the lower level of care is required to be reported to the licensing bodies in accordance with state law. The licensing bodies may impose disciplinary action for failure to respond to treatment. The facts underlying the medical issue will then become available on the internet. This becomes a tremendous barrier discouraging professionals to seek treatment.⁹⁶

Rista Luna, Director of Admissions and Utilization Review at Silver Hills Hospital testified that, “It is our experience that patients that meet commitment criteria, dual diagnosis patients that require acute psychiatric services, and patients that are failing at a lower level of care are often denied access to their benefits based on the managed care company subjective application of their own medical necessity criteria.”⁹⁷

Greg Williams, co-founder of Connecticut Turning to Youth and Families, testified, “Medical necessity criteria used by healthcare payers to manage and authorize [substance use] treatment is not transparent, public, or consistent.... As a result we have “fail first” stipulations of lower levels of care that promote young people to continue to use and they end up dying, getting locked up, bankrupting families who need to pay cash for treatment, and cost-shifting to the public sector.”⁹⁸

⁹⁵ Testimony of Dr. Paul Rao, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

⁹⁶ Testimony of Maureen Sullivan Dinnan, Executive Director of HAVEN, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

⁹⁷ Testimony of Rista Luna, Director of Admissions and Utilization Review, Silver Hill Hospital, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

⁹⁸ Testimony of Greg Williams, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

The Connecticut Council on Child and Adolescent Psychiatry recommended at the hearing that treatment be authorized that is consistent with current professionally recognized practice parameters and current standards of care.⁹⁹

OHA agrees with the Connecticut Council on Adolescent Psychiatry. OHA also endorses the recommendations of PRI to revise Connecticut statute to require health plans to adhere to consistent and appropriate medical criteria. Because of variations in mental health and substance use criteria, OHA has sought the assistance of the U.S. Department of Labor to determine whether the criteria of at least one Connecticut insurer, used by that insurer in fully-insured and self-funded plans (as a third party administrator), violates the Mental Health Parity and Addiction Equity Act or general ERISA provisions. In early 2012, OHA requested of CID that those criteria be evaluated for sufficiency under state and federal law. The criteria were sent to the UConn School of Medicine for review by CID.

2. GRIEVANCE PROCESS ISSUES

According to child psychiatrist, Andrew Lustbader, MD, “[T]he upper and lower classes are, to varying degrees, able to receive adequate mental health care for their children. However, the vast majority of children who are in the middle class -- those who are insurance dependent -- have far greater difficulty receiving reimbursement for much-needed services; Services that are therefore ultimately often denied to them.”¹⁰⁰

PRI staff found that certain plans are outliers with respect to denials of services. The self-reported data provided to the Connecticut Insurance Department for its annual report card substantiate this conclusion. The behavioral health statistics are broken out separately in the report card.¹⁰¹

PRI performed a statistical analysis of the report card data. According to the PRI Report Appendix:

“The resulting analysis, presented in the table below, shows that particular plans are clear outliers for percentages of initial denials and ultimate request success rates by levels of care.

⁹⁹ Testimony of CT Council on Child and Adolescent Psychiatry, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁰⁰ Testimony of Andrew Lustbader, MD, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁰¹ See http://ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf at 36-37.

- Inpatient requests were denied 19 and 36 percent of the time for two carriers, but 0 to 3 percent of the time for the other four carriers;
- Outpatient initiation requests were denied 13 percent of the time for one carrier, but 2 to 8 percent for the other five carriers; and
- Extensions of stay were denied 13 percent of the time for two carriers, but 1 to 4 percent of the time for other four carriers.

Each of these differences reached the level of statistical significance ($p < 0.01$), meaning it is highly unlikely a difference that large is due to chance¹⁰²

Essentially, PRI's conclusions mean that one's likelihood of accessing medically necessary mental health or substance use treatment depends on which insurer one is enrolled in and which level of service one is seeking.

Data reported separately by the carriers to PRI showed a fairly high rate of approval of non-residential treatment substance use services, but the data reported to PRI included partial denials as "approvals" of services. The reporting of partial denials as approvals is inconsistent with the reporting made to the Insurance Department for behavioral health data in the report card, which separates approvals from partial denials. In any event, however, the rate of approved services as reported to PRI is inflated. It is unclear why the data reported to PRI did not correctly code partial denials as such, since when a request is denied as requested, it is considered to be a denial for purposes of the right to grievances and appeals under both state and federal law.

Conn.Gen.Stat. § 38a-591 states—emphasis added:

(1) "Adverse determination" means:

(A) **The denial, reduction, termination or failure to provide or make payment, in whole or in part**, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional, based on a determination by a health carrier or its designee utilization review company:

(i) That, based upon the information provided, (I) upon application of any utilization review technique, such benefit does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or (II) is determined to be experimental or investigational;

(ii) Of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(B) Any prospective review, concurrent review or retrospective review determination **that denies, reduces or terminates or fails to provide or make payment, in whole or in part**, for a benefit under the health carrier's health benefit plan requested by a covered person or a covered person's treating health care professional.

¹⁰² Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Appendix p. 100-101, available at <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Appendices-12-18-12.pdf>.

Federal law defines an adverse determination similarly. Appeal processes adopted by federal regulation defer to the description of adverse determinations under regulations for the Employee Retirement and Income Security Act (ERISA) at 29 CFR 2560.503(1)(f):

Except as provided in paragraphs (f)(2) and (f)(3) of this section, if a claim is wholly **or partially denied**, the plan administrator shall notify the claimant, in accordance with paragraph (g) of this section, of the plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim by the plan, unless the plan administrator determines that special circumstances require an extension of time for processing the claim....

The PRI staff also reviewed data supplied by the Connecticut Behavioral Health Partnership (CTBHP). The PRI staff found that the CTBHP process of reviewing cases through reliance on up to date criteria and a robust peer review process resulted in significantly fewer denials than the private insurance coverage system in Connecticut.¹⁰³ The difference in approvals from private plans is likely even larger than PRI concluded because, as stated earlier, in supplying data to PRI on approvals for substance use treatment, carriers in Connecticut counted partial denials—where less than a full request is granted, e.g., five days are requested, but three days are granted—as approvals.

A hospital ED staff focus group, convened as part of the Statewide Health Care Facilities and Services Plan, stated that, “limitations on the length of stay for patients in general hospital inpatient psychiatric beds, by private insurance companies, has added to the problem of patients relapsing and returning to the ED.”¹⁰⁴

The Connecticut Hospital Association (CHA) testified at the OHA public hearing about the high number of denials of services for individuals who are currently hospitalized and need additional days in the acute care setting or whose admissions from EDs into a hospital are denied as not medically necessary by private insurers.

¹⁰³ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Appendices p. 77, Approved December 18, 2012, available at <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Appendices-12-18-12.pdf>.

¹⁰⁴ Connecticut Statewide Health Care Facilities and Services Plan, October 2012, at p. 34, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

Eric Arzubi, MD stated that it is not uncommon for private insurers to deny inpatient hospitalization or partial hospitalization, even when a patient is at imminent risk for committing suicide.¹⁰⁵

A witness testified that his son was diagnosed with a “drug addiction/alcohol/depression problem” documented by four attending physicians’ statements, but still was denied inpatient treatment because his insurer thought the treatment was not medically necessary.¹⁰⁶

Another witness testified about the 13 denials her self-funded plan, administered by a health insurer acting as a third party administrator, issued in a 5 month period, including repeated denials for coverage for hospitalization while her daughter was actively suicidal and also struggling with an eating disorder. The witness took note of the plan administrator’s inaccurate denial letters, something OHA has brought to the attention of the health plan and CID in the context of fully-insured cases.

Dr. Paul Rao, child psychiatrist, testified:

The major barrier to care that I've encountered is this: Insurance companies routinely denying appropriate coverage for inpatient hospitalization.

Countless times have I worked with children and adults who suffered from severe mental illness and had recently made suicide attempts or injured themselves, requiring stabilization in an inpatient setting.. After a few days - sometimes as little as 2-3 days, rarely more than week - the insurer denies coverage of further inpatient treatment. Appealing their decisions requires numerous calls up an administrative phone chain whose sole purpose seems to be to deny any rational or even compassionate argument for keeping a high-risk patient in the hospital. I've spoken to administrators - and sorry to say, physicians representing the insurance companies! - who say that if the patient, after 5 days, has not demonstrated self-harm behaviors or voiced suicidal thinking (to be expected, because they are in a contained setting!), they no longer meet criteria for hospital level of care.¹⁰⁷

¹⁰⁵ Testimony of Eric Arzubi, MD, available at http://ct.gov/oha/lib/oha/documents/pdf testimony/portfolio_-_created_1-2-13.pdf.

¹⁰⁶ Testimony of Vincent Mitchell, available at http://ct.gov/oha/lib/oha/documents/pdf testimony/portfolio_-_created_1-2-13.pdf http://ct.gov/oha/lib/oha/documents/pdf testimony/portfolio_-_created_1-2-13.pdf.

¹⁰⁷ Testimony of Dr. Paul Rao, available at http://ct.gov/oha/lib/oha/documents/pdf testimony/portfolio_-_created_1-2-13.pdf.

Rista Luna of Silver Hills Hospital provided multiple examples of denials of inpatient hospital stays for actively suicidal patients. The denial letters accompanying the determinations were grossly inaccurate in their portrayals of the facts of the cases.¹⁰⁸

The National Alliance for Mental Illness, Connecticut Chapter (NAMI-CT), also testified that it is not uncommon for health plans to deny inpatient hospitalizations for patients with ongoing and persistent urges to commit suicide.¹⁰⁹

Mirela Loftus, a child and adolescent psychiatrist at the Institute of Living relayed the experience of a 13 year old girl with schizoaffective disorder, who was found walking on the side of I84 in Chesire to find her imaginary in-laws that had allegedly kidnapped her imaginary triplets. The young girl was hospitalized –her third hospitalization--for 12 days at IOL, but her insurer paid for only four of those days. In denying the continued stay despite the girl’s continued false beliefs about alleged in-laws kidnapping her imagined triplets and her inability to process the safety concerns about walking along a highway, the medical director of the insurer told IOL that “walking on the side of the highway may be illegal but not dangerous.”¹¹⁰

Another witness testified to her seven year battle with her health plan to get her self-mutilating, suicidal daughter the treatment she needed.¹¹¹

One of the barriers to coverage for MH/SU treatment is the ability to have the request for coverage evaluated by an appropriate clinical peer. The Connecticut Council on Child and Adolescent Psychiatry recommends matching peer reviewers.¹¹² The Connecticut State Medical Society(CSMS) offered testimony that peer reviewers are often inadequate. CSMS expressed concern that those making decisions should be trained in the area of care being recommended for the patient, yet non-practicing providers and those without training in psychiatry or a sub-

¹⁰⁸ Testimony of Rista Luna, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

¹⁰⁹ Testimony of Sara Frankel, NAMI-CT, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

¹¹⁰ Testimony of Mirela Loftus, MD, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

¹¹¹ Testimony of Deborah Strong, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

¹¹² Testimony of CT Council on Child and Adolescent Psychiatry, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

specialty of psychiatry are often making these decisions. CSMS also expressed concern with insurers not authorizing continued treatment unless a traumatic event occurs.¹¹³

OHA informed PRI staff that the clinical peer requirements under state insurance law for internal appeal are looser than those for external appeal and that inappropriate peers were used by plans to review services. PRI staff proposed statutory changes to curb plan variations by requiring that requests for services be reviewed by appropriate clinical peers prior to rendering a coverage decision.¹¹⁴

Timeframes for decision making under the CTBHP are tighter than those in fully-insured and self-funded plans.¹¹⁵ PRI issued recommendations included statutory revisions on appeal turnaround times for urgent cases from 72 hours to no more than 24 hours—the standard Connecticut used to follow. Those recommendations should be adopted in full.

Among fully-insured plans, approximately 5% of all denials are appealed, despite major marketing efforts by OHA and provisions in state legislation and the Affordable Care Act requiring OHA's contact information be including on every denial notice.¹¹⁶ In calendar years 2009, 2010 and 2011, behavioral health appeals were 34%, 43% and 36% of all external appeals accepted by CID—appeals of fully-insured plan denials and the state employee plan, suggesting the high level of interest in appeals for those who are aware of the process.¹¹⁷

PRI issued recommendations that promote awareness of appeal rights, including more visible notation of the availability of OHA to assist in appeals, the use of appropriate clinical peers in the initial review and appeal of cases, more oversight by the Insurance Department,

¹¹³ Testimony of Connecticut State Medical Society, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹¹⁴ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Approved December 18, 2012, <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf>

¹¹⁵ *Ibid* at p.27, and <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Appendices-12-18-12.pdf> at Appendices I and J.

¹¹⁶ Conn.Gen.Stat. §38a-591d and amendments to the Public Health Service Act adding §2719, via the Affordable Care Act, Pub.L 110-148, § 1002. OHA has been Connecticut's consumer assistance program under the ACA since 2010.

¹¹⁷ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, Approved December 18, 2012, at Appendix F., <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf>

and modifications to the external review processing of applications.¹¹⁸ These recommendations should also be covered in full.

OHA also heard testimony from the Connecticut Psychiatric Society that plans requiring 90 day supplies of psychiatric medications for their members were creating serious risks for those members. Exception processes to change the fill to a thirty day supply are often denied, leaving some patients at risk for suicide with a large supply of medication that could in fact cause death if not used as directed.¹¹⁹

OHA estimates that of the cases related to substance abuse and co-morbidities that OHA takes to appeal, 60% are overturned at external appeal. This trend casts grave doubt on the efficacy of the insurer's internal mechanisms to adequately review and determine appropriate treatment protocols for their members. It's important to remember that by the time an appeal reaches external review, the claim has already been reviewed at least twice by the insurer, sometimes three times counting the initial claim review and up to two levels of internal appeal, a process that typically takes several months.

OHA believes that aggressive enforcement of the MHPAEA will improve access to care. Enforcement of the MHPAEA has been delayed, although based on information referred by OHA to USDOL for alleged MHPAEA violations, USDOL is ramping up its enforcement efforts. . Complicating MHPAEA enforcement is the failure of the federal oversight agencies to issue final regulations.

The Partnership for Workplace Mental Health recently worked with Milliman, Inc., to develop a guide designed to help employers assure compliance by their health plan vendors with the requirements of the MHPAEA, estimated to affect 113 million people, including 82 million nationally who are enrolled in self-funded plans. The guide provides a concrete and thorough analysis of the interim federal MHPAEA regulations how they apply to level of care parity requirements.¹²⁰ The guide should allow for better enforcement of the MHPAEA.

¹¹⁸ Program Review and Investigations Committee, *Access to Substance Use Treatment for Privately Insured Youth Phase 1*, <http://www.cga.ct.gov/pri/docs/2012/ASUT-Committee%20Report-12-18-12.pdf>

¹¹⁹ Testimony of Sherrie Sharp, MD, Connecticut Psychiatric Society, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹²⁰ *Employer Guide for Compliance with the Mental Health Parity and Addiction Equity Act*, Partnership for Workplace Mental Health, December 2012, available at <http://www.workplacementalhealth.org/erguide>.

Senator Richard Blumenthal testified at OHA's hearing the he wrote to both USDOL and to the Center for Consumer Information and Oversight, an office within HHS, to request that the agencies imminently issue final regulations so that the promise of the MHPAEA can be fulfilled.¹²¹

One witness articulated the promise of parity when he wondered whether if substance use and mental health were treated similarly to a medical condition such as diabetes, insurers would still deny coverage.¹²²

3. COSTS

According to CID's report card, insurance companies in Connecticut spend between \$7.88-11.56 per enrollee per month on mental health and substance use coverage under fully insured plans.¹²³ With most individual insurance plan premiums ranging between \$400 and \$999 per month,¹²⁴ the self-reported amount spent by insurers in calendar year 2011 on mental health and substance use services is 2-2.9 % of the monthly premium at the low end of the monthly premium range (\$400) and 0.8-1.2% of the high end of the premium range (\$ 999). Mental health and substance use claims by Connecticut insurers ranged from 6.25 to 14.14% of claims submitted to insurers during calendar year 2011.¹²⁵

By far, the most affordable policies in Connecticut are associated with high deductibles and significant cost sharing. In fact, the vast majority of individual policies (90%) and small group policies (55%) sold in Connecticut over the last year are at or well below the 60% actuarial value of policies that will be required to be offered in Connecticut's Health Insurance Exchange beginning in 2014.¹²⁶ (Actuarial value is a measure of the percentage of costs

¹²¹ See letters from Sen. Richard Blumenthal to HHS and to USDOL, available at

<http://ct.gov/oha/lib/oha/documents/pdf testimony/portfolio - created 1-2-13.pdf>.

¹²² Testimony of Vincent Mitchell, available at <http://ct.gov/oha/lib/oha/documents/pdf testimony/portfolio - created 1-2-13.pdf>.

¹²³ CID, Consumer Report Card on Health Insurance Carriers in Connecticut, at 38, October 2012, available at

http://ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf.

¹²⁴ Mercer Government Human Resources Consulting, *Health Insurance Exchange Planning Report*, Appendix 2A, January 19, 2012, available at http://www.ct.gov/hix/lib/hix/mercer_final_report_ct_hix1.20.12.pdf, accessed December 31, 2012.

¹²⁵ CID, Consumer Report Card on Health Insurance Carriers in Connecticut, at 38, October 2012, available at http://ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf

¹²⁶ Mercer Government Human Resources Consulting, *Health Insurance Exchange Planning Report*, January 19, 2012.

covered by a health plan. Sixty percent actuarial value means that a consumer is responsible for approximately 40% of the costs of the plan and care received.)

While Medicaid eligibility will expand to 133% of the federal poverty level (FPL) on January 1, 2014, giving approximately an additional 50,000 residents access to low or no cost healthcare coverage, the cost of insurance may remain a barrier for many individuals in Connecticut. One third of those children eligible for Exchange coverage are above 400% FPL, and therefore, ineligible for subsidies.¹²⁷

As a practical matter, however, this means that young adults who are at high risk for substance use and/or mental health issues, will have to purchase a policy on the individual market, if their parents cannot or will not provide coverage for them, they are ineligible for Medicaid or otherwise do not have access to coverage or subsidies for coverage on the Exchange. And they will face policies high out of pocket costs. Annual out-of-pocket expenditures for 90% individual policies exceed \$2000.¹²⁸ Adding a dependent to an individual policy in Connecticut, raises the premium for that policy anywhere from \$300-\$1100 per month. Adding a dependent to a small group policy will increase a family's premium by similar margins.¹²⁹

An anonymous witness at the OHA hearing testified that the "shift to high deductible plans is not a cost sharing program but a cost shifting program that has likely caused barriers for some people to receive needed care and is likely to increase the numbers of individuals who are foreclosed from services."¹³⁰ OHA has advocated for individuals with deductibles of up to \$10,000. Even with the assistance of a Health Savings Account, individuals with high deductible plans often find themselves not obtaining needed healthcare. The Affordable Care Act restricts the maximum deductible, in general, to \$2000 for an individual and \$4000 for a family, though the maximums may be indexed based on premium changes.¹³¹

¹²⁷ See http://www.ct.gov/hix/lib/hix/Exhibit_E_Review_of_Thompson_Reuters_Data.pdf at p.6, accessed December 30, 2012 and http://www.ct.gov/hix/lib/hix/Exhibit_E.3_CT-Exchange-Medicaid-Demographic-Summary.pdf.

¹²⁸ Ibid.

¹²⁹ Ibid.

¹³⁰ Anonymous testimony, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹³¹ Patient Protection and Affordable Care Act, P.L. 111-148, §1302(c)(2). (March 23, 2010)

The Connecticut Health Insurance Exchange Board recently formed a strategy committee to address issues affecting the affordability of health insurance in Connecticut.¹³²

Based on the PRI report, OHA's data, OHA's hearing and the CID report card, one can make a direct connection to private insurance or self-funded status contributing to barriers to access to care. The variations between plans mean that one's access to needed mental health and substance use services depends upon which plan one is enrolled. Such uneven coverage for the residents of Connecticut is unacceptable.

c. COST SHIFTING

As stated in the section on capacity, despite substantial evidence for the effectiveness of multiple in-home services, such as IICAPS, EDT, MFDT, FFT, MST and EMPS, insurers and self insured employers refuse to cover these effective services. Despite lack of coverage, children and youth covered by such plans can still access these services. The failure of insurers and self-funded plans to cover these services, results in a substantial cost-shift to the state.

According to the EMPS FY2012 Annual Report, although the majority of youth served by EMPS were covered by public programs, 33.2% of children served by EMPS had some type of private insurance coverage.¹³³

Eric Arzubi, MD, cites insurance denials as a reason for cost shifting to the state for use of CTBHP services, while Andrew Lustbader, MD, testified that insurers' and health plans' failure to cover services such as EDT that prevent hospitalizations or other more intensive service use result in cost shifting to the state because the non-profit sector has to step in and provide the needed services. Reforms in the state's relationship with this important sector are necessary to maintain the safety net for this vulnerable population. The October 2012 Cabinet on Nonprofit Health and Human Services report to the Governor noted that significant modifications to this relationship were essential to securing the sustainability of these non-

¹³² Minutes from the first meeting are available at http://www.ct.gov/hix/lib/hix/DRAFT_Minutes_HIX_Strategy_Committee_Mtg_111512.pdf. The state also submitted an application for a State Innovation Model grant from CMS to tackle head on healthcare costs and payment reform.

¹³³ EMPS Fiscal Year 2012 Annual Report, at p. 6, available at <http://www.empsect.org/download/AnnualFY12.pdf>, accessed December 30, 2012.

profits.¹³⁴ He also stated that commercial carriers are paying for shortened stays and denying further days even when a hospital level of care is warranted shifts costs of treatment onto the public sector.¹³⁵

Additionally, continued denials of coverage by the private system results in cost-shifting to the state because of lack of access to care under private insurance arrangements. At OHA's public hearing on October 17, 2012, DMHAS Commissioner Pat Rehmer testified:

Our public system is strong. All of this work however, does not easily transfer to the privately insured population. We do hear from many parents of adult children with psychiatric disabilities and substance use disorders who have private insurance, that they cannot access the same services we offer and we have worked with many families where appropriate to help them access additional levels of care and recovery services, but it is a difficult task, can be resource intensive and not always successful. One recent study of individuals with schizophrenia who are just entering the mental health system showed that they do not hold on to their private insurance for very long and that private insurance is often not adequate to meet the needs of someone with this serious illness.¹³⁶

Further, individuals can be enrolled in Medicaid and private insurance coverage. Currently approximately 11% of the state's Medicaid population is enrolled in other healthcare coverage.¹³⁷ Unwarranted denials by fully-insured or self-funded plans for mental health or substance use services can expose the state to unnecessary costs.

One witness testified that after repeatedly fighting her insurance company to cover needed hospitalization and outpatient services, she turned to DCF Voluntary Services, and her daughter received intensive in-home behavioral management and therapeutic mentoring, while the family received respite care and parent training. All of these services were community-based, evidence-based services that were not covered by her insurance plan and were paid by the state of Connecticut. The witness developed a cost comparison sheet, which showed that

¹³⁴ Governor's Cabinet on Nonprofit Health and Human Services Report to Governor Dannel P. Malloy, October 1, 2012 http://www.ct.gov/opm/lib/opm/assets/temp/governors_np_cabinet_annual_report_final_2012-10-01.pdf

¹³⁵ Testimony of Erci Arzubi, MD and Testimony of Andrew Lustbader, MD, available at, http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

¹³⁶ Testimony of Commissioner Pat Rehmer, DMHAS, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_created_1-2-13.pdf.

¹³⁷ Levin-Becker, A., "State's Failure to Appeal Health Insurance Denials Costs Millions," The CT Mirror, available at <http://ctmirror.org/story/15037/state-covering-children-health-insurance-remedy-action-one-agency-others-lag>, accessed December 31, 2012.

the cost of the DCF provided services, though borne by the state, were substantially lower than the costs of the services originally advocated for with the insurer.¹³⁸

Laura M.I. Saunders, Psy.D., ABPP, a clinician at the Institute of Living, testified that the failure of any commercial insurers in Connecticut to cover in-home clinical services such as IICAPS discriminates against families with commercial insurance and “puts an undue burden on the Department of Children and Families to allocate resources for families that don’t necessarily need DCF to partner with them in other ways.”¹³⁹

A year ago, DCF Voluntary Services Program spent approximately \$16.4 million on necessary mental health and substance use services for children who were also covered by private insurance.¹⁴⁰ DCF and OHA have partnered to exhaust private healthcare coverage prior to providing state funded services. The project is in early days, but has already yielded savings to the state. Because individuals can be enrolled in private coverage and Medicaid, the state is also expending significant funds under the Medicaid program to cover mental health and substance use services that are denied by private carriers.

Currently, the state does not appear to have a clear handle of the overall level of cost shifting it is absorbing with respect to mental health and substance use services. A detailed study is in order to ensure that the state is not inappropriately incurring costs and that its own resources are used as efficiently as possible.

D. LACK OF INTEGRATION AND COORDINATION OF CARE

One of the clear messages at the OHA hearing was the lack of integration of mental health and substance use prevention and treatment into primary and overall healthcare settings and other systems of care.

OHCA’s Statewide Health Care Facilities and Services Plan details the options available and ongoing efforts to integrate mental health and substance use issues into primary care

¹³⁸ Testimony of Ann Nelson, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

¹³⁹ Testimony of Laura M.I. Saunders, Psy.D., ABPP, available at http://ct.gov/oha/lib/oha/documents/pdftestimony/portfolio_-_created_1-2-13.pdf.

¹⁴⁰ Levin-Becker, A., “State’s Failure to Appeal Health Insurance Denials Costs Millions,” The CT Mirror, available at <http://ctmirror.org/story/15037/state-covering-children-health-insurance-remedy-action-one-agency-others-lag>, accessed December 31, 2012.

settings. FQHCs in some practice groups and outpatient clinics have already incorporated the concept into their practices.¹⁴¹

The Connecticut Council on Child and Adolescent Psychiatry recommended that there be funding and collaboration between mental health providers and other caregivers—a seamless transition of care must be available when multiple systems of care are involved, e.g., school, juvenile justice, DCF. CT Council on Child and Adolescent Psychiatry recommends family participation in treatment and assessment and reimbursement for family treatment.

The private insurance model has not historically integrated mental health and substance use care into overall healthcare. However, there is evidence that through the use of payment reform models that reward outcomes and care coordination, there will be more concerted effort to integrate care for privately insured individuals. Hampering this effort is the traditional failure of insurers to track access to care issues for mental health and substance use treatment through reported demographic or outcome data. Nor do insurers track mental health and substance use issues as part of overall system of care issues related to social determinants such as housing, employment and the overall economy, or population health and other health factors that contribute to mental health or substance use treatment needs.

The state is shifting direction to care coordination and integration for publicly funded programs. There are models in the state employee health program administered by the Office of the State Comptroller, DSS, DMHAS and DCF.

From the state's Innovation Model Initiative grant application filed with CMS:

In October of 2011, The State Employee and Retiree Health Plan embarked on a new value based plan design -- the Health Enhancement Program -- to complement the payment reform initiatives mentioned above. Building a sustainable health care future depends on engaging State employees in their health and wellness, emphasizing primary care services, and improving care coordination. Connecticut believes that traditional methods to manage and monitor health care are no longer sufficient to deliver a meaningful impact on medical cost trend or overall health and wellness of populations. Therefore, a new, evolutionary care model is required to achieve the triple aim of improving quality, reducing total cost and enhancing the participant experience.

The State Health Plan has adopted an overarching strategy for health and wellness known as Total Health Management. The goal is to improve or maintain the health of

¹⁴¹ Statewide Health Care Facilities and Services Plan, Office of Health Care Access, at p. 110, October 2012, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf, accessed December 31, 2012

participants by working with their doctors, engaging participants in their own health and health care decisions, and improving their experience related to wellness activities. The state's strategy achieves results because we focus on specific initiatives that are clinically important to the provider community, and are tailored to the culture and practice of physicians. We believe that this strategy should be incorporated into our vision for the state.¹⁴²

DSS has also shifted the Medicaid program as part of an overall shift toward more coordinated care through its person centered medical home model and its integrated care for dual eligibles demonstration project. In addition to other utilization management strategies, the Medicaid medical ASO, CHNCT, began enrolling members into Intensive Care Management (ICM) as of January 1, 2012.

In support of its ICM activity, CHN-CT has fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs, culturally attuned conversation scripts as well as chronic disease management scripts. Additionally, CHN-CT now has in place geographically grouped teams of nurse care managers. An important feature of ICM is coordination with a co-located unit of Value Options (the behavioral health ASO). Care managers from CHNCT, DSS and the Behavioral Health Partnership meet twice weekly to review hospitalizations and planned admissions to identify the appropriate care manager to take responsibility for the member's care. In cases where neither the physical or behavioral diagnosis is primary, both the CHN and the BHP care manager remain involved. At any given time, approximately 500 members are receiving ICM because they are diagnosed with a Serious and Persistent Mental Illness (SPMI) in addition to physical health conditions.¹⁴³

The Court Support Services Division (CSSD) of the Judicial Branch has piloted or used a couple of models designed to ensure the individuals on probation are less likely to be rearrested. CSSD engaged in a Mental Health Case Management Project which established 10 mental health officers over 35 probation offices in an attempt to reduce re-arrest rates. The MHO officers were specially trained in communication and problem solving techniques. The project was successful, yielding a 25% lower rate among probationers enrolled in the program versus a comparison group. The evaluators suggested that the major predictors of success in the program were motivation and drug use; those who were compliant with and motivated for treatment, fared better than those who were not.¹⁴⁴ Evaluators recommended expansion of

¹⁴² State Model Innovation Initiative Grant Application, December 7, 2012, available at <http://healthreform.ct.gov/ohri/cwp/view.asp?a=2742&q=334428>.

¹⁴³ Ibid.

¹⁴⁴ Cos, S., et al. *The Final Report of the Evaluation of the Court Support Services Division's Mental Health Case Management Pilot Project*, Division of Criminology and Criminal Justice, Central Connecticut State University, June 2010, available at http://www.jud.ct.gov/cssd/research/Ev_CSSD_MentalHealth_CMPP.pdf.

the program with clinical supports and coordination with DMHAS because of the prevalence of substance use in the pilot population.

In 2011, Judicial CSSD issued a report on a three-year project of employing the Women Offender Case Management Model, a model initiated by the National Institute of Corrections that employed a gender-based model to assist women on probation, many of whom were high-risk from being rearrested. The typical participants in the program were at high risk for recidivism with substance use involvement. Women who participated had more contacts with providers, including substance use and mental health providers, and resources in the community than those who did not participate. On a one year follow-up, those who participated had a 25% lower recidivism rate than those who did not. The impact on high risk participants was even greater, with the rate of new arrests among high risk participants 13% lower than the high risk control group. The researchers conclude that the gender-specific model works to improve outcomes for those who are at risk for negative outcomes.¹⁴⁵

DMHAS' Recovery Initiative is the model the agency uses in addressing the needs of residents who use its services. The Commissioner has issued several policy statements on recovery.¹⁴⁶ The recovery model emphasizes the broad –based involvement of stakeholders. According to a DMHAS policy statement:

Recovery is a process rather than an event. Thus, the service system shall address the needs of people over time and across different levels of disability. Recovery principles shall be applied to the full range of engagement, intervention, treatment, rehabilitative and supportive services that a person may need. Recovery principles shall also be applied to health promotion and prevention services for those at risk of mental illness or of substance use disorders, especially those for whom selected or indicated prevention strategies are appropriate. ...

The recovery-oriented service system shall be notable for its quality. It will be marked by a high degree of accessibility, effectiveness in engaging and retaining persons in care such that they can achieve the highest degree of stability and recovery, and its effects shall be sustained rather than solely crisis-oriented or short-lived. To attain this level of quality, the recovery-oriented service system shall be age and gender appropriate, culturally competent, and attend to trauma and other factors known to impact on one's recovery. Whenever possible, services shall be provided within the person's own community setting, using the person's natural supports. The service system shall help the person to achieve an improved sense of mastery over his or her condition

¹⁴⁵ Millson, B., et al., *Women Offender Case Management Model Outcome Evaluation*, November 29, 2010, available at http://www.jud.ct.gov/cssd/research/WOCMM_outcome_eval_0111.pdf, accessed December 31, 2012.

¹⁴⁶ <http://ct.gov/dmhas/cwp/view.asp?a=2901&q=335084>.

and assist the person to regain a meaningful, constructive sense of membership in the community

“Recovery” is a process of restoring or developing a positive and meaningful sense of identity apart from one’s condition and then rebuilding one’s life despite, or within the limitations imposed by that condition. Recovery is a person-centered approach and thus may vary from person to person and within the mental health and addiction communities. Just a few examples of recovery include:

- Returning to a healthy state evidenced by improving one’s mood and outlook on life following an episode of depression;
- Continuing education in support of career development;
- Managing one’s illness such that the person can live independently and have meaningful employment and healthy social relationships;
- Reducing the painful effects of trauma through a process of healing;
- Attaining or restoring a desired state such as achieving sustained sobriety;
- Building on personal strengths to offset the adverse effects of a disability;
- Connecting and re-connecting with family and friends;
- Pursuit of spiritual activities to the extent of interest;¹⁴⁷

DMHAS’ focus beyond strict notions of treatment to core supports including family and community supports is a model that should be more broadly adopted by the state, although components of recovery have been incorporated into other state programs.

DCF uses its Strengthening Family Practices model—uses SAMHSA support of Systems of Care, a community-based service delivery model that promotes positive mental health outcomes for children and youth from birth through 21 years of age and their families. The focus is on providing family-driven, culturally and linguistically competent, and evidence-based services and supports.

As stated in the DPH Statewide Health Care Facilities and Services Report:

An individual’s recovery plan or care plan depends on needs and circumstances. For adults, a plan might include transportation, vocational services, life skills training, housing, employment, social or recreational opportunities, faith organizations and community support. These are not health care services, but are related and, in many instances, may be necessary for full and lasting recovery within a community. These recovery support systems may be facilitated through or referred by a person’s mental health or substance use treatment provider or the mental health or substance use treatment provider may have some recovery supports built directly into their program of care. The efforts of providers to focus on both the direct treatment services and needed support systems to serve the person in recovery is aimed at keeping persons in recovery in the community and creating opportunities for them to participate and thrive as a member of the community. The goal of these initiatives is to create

¹⁴⁷ DMHAS Commissioner’s Policy Statement, Chapter 6.14, Promoting a Recovery Oriented Service System, available at <http://www.ct.gov/dmhas/lib/dmhas/policies/chapter6.14.pdf>.

a supportive system where persons don't relapse back into the treatment system or decompensate due to lack of recovery supports.¹⁴⁸ (emphasis added)

Despite its success, the recovery model has not been widely adopted by employers and private health insurance plans.

As to illustrate the importance of the recovery model—and perhaps its limitations with respect to receipt of certain benefits-- one of OHA's hearing witnesses testified that she chose to participate in the North Central Regional Mental Health Board's Day in the Life Team as a "financial, emotional and psychological opportunity" to assist in her recovery.¹⁴⁹

Another witness supports the recovery model, but testified that there is no recovery model available for adolescents:

DCF, DHMAS, JJ, and CSSD professionals, parents, and schools have been on the front lines witnessing use problems growing among young people. Unfortunately they have lacked the community based recovery models that research suggests are the best way to support long-term recovery. Due to the bi-furcated CT system for children/adults, no single state agency has championed a "good and modern" approach to treatment for adolescents as our adult system has done for more than ten years.¹⁵⁰

One witness, who served 12 years in prison, testified that he has made a brand new start through his recovery program at the Connecticut Community for Addiction Recovery. He has stayed off the streets for 17 months.¹⁵¹

Programs such as MED-Connect, which allow individuals who are disabled to obtain or maintain employment without the loss of medical assistance benefits are vital to the adoption of overall recovery model for Connecticut.

The key is to integrate mental health and substance use preventive and treatment services into our overall decisions about policy in Connecticut. Some of our public funded models

¹⁴⁸ Connecticut Statewide Health Care Facilities and Services Plan, October 2012, at p. 95, available at http://www.ct.gov/dph/lib/dph/ohca/publications/2012/ohcastatewide_facilities_and_services.pdf

¹⁴⁹ Testimony of Catherine Kriss, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf. She was penalized because the income she received from her participation disqualified her from receiving Supplemental Security Income. She might have benefited from Med-Connect.

¹⁵⁰ Testimony of Greg Williams, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁵¹ Testimony of Tony Mack, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

stress care coordination and support services as the successful route to prevention of and treatment for mental health and substance disorders.

Our insurance delivery system is not designed to promote the community based treatment and support services that our public models do. If our goal is to address the needs of ALL residents, whether children, adults or seniors, we must improve access to evidenced based community services and supports. We must recognize that enhancing recovery is not only about healthcare.

E. MEDICAID

Those who testified about Medicaid were pleased with the CTBHP.

One witness pointed out that delay in eligibility determinations for public programs delays much needed treatment, particularly for someone who is actively using substances. The witness stated that delays in treatment once someone decides he or she is ready for it can lead to incarceration, death from overdose or reconsideration of the decision to get treatment; he suggested that funding be made available to cover treatment cost while eligibility is pending.¹⁵²

Another witness suffering from a serious mental illness testified about receiving a rejection letter from DSS despite having sent in her redetermination form in a timely manner.¹⁵³

Alijah Cafro, Attorney Sheldon Toubman the Connecticut Association of Behavior Analysis, and Melissa Olive, PhD., all testified that the lack of coverage for ABA services in Medicaid despite coverage in private group insurance plans and the requirements of EPSDT and three federal court cases requiring coverage in other state programs, is illegal or inconsistent with Connecticut's public policy.¹⁵⁴ Ms. Cafro and Mr. Toubman raised several legal issues about the Medicaid program's current failure to cover ABA that warrant DSS' careful attention and

¹⁵² Testimony of Raymond Currytto, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁵³ Testimony of Catherine Kriss, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁵⁴ Testimony of Alijah Cafro, Testimony of Sheldon Toubman, Testimony of Connecticut Association of Behavior Analysis, Testimony of Melissa Olive, PhD, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

consideration. Ms. Cafro described the success of ABA in helping her son. Dr. Olive described similarly successful results for five of her child clients.¹⁵⁵

Surprisingly, there was little discussion at the OHA hearing about the availability of MED-Connect to assist disabled individuals in maintaining or obtaining employment. As detailed earlier, the MED-Connect program allows individuals who are disabled to earn up to \$75,000 per year without the threat of the loss of their medical assistance through Medicaid.

V. DISCUSSION

Mental health and substance use disorders affect people of all ages, all incomes, and all racial and ethnic groups, in all geographic areas in Connecticut. The obvious conclusion that can be drawn from the OHA hearing is the lack of a cohesive mental health and substance use strategy for the state. Our current “system” is premised upon factors such as income, geographic location, age, employment and insurance status. The publicly funded system in Connecticut is one that involves all stakeholders, is person-centered and recovery oriented. The insurance system is designed merely as a funding mechanism. It does not incorporate the principles of prevention and recovery that our publicly funded system does. In that sense, insurance coverage falls far behind the comprehensive view of mental health and substance use treatment adopted by DMHAS, DCF and DSS.

Recently, the state submitted a grant application to CMS under the State Innovation Model initiative to transform Connecticut’s healthcare system, including mental health and substance use. The state’s vision as stated in our application is:

To create a health system that promotes individual and community wellness, prevention and detection, and intervention; works to reduce health disparities; assures access broadly; rewards beneficiaries for acting as good health care consumers and providers for providing value (health outcomes, care experience); grounds itself in data, evidence and quality improvement; enables transparency; optimizes use of public and private funds; and yields population-based improvements in health status.

Our approach to integrating mental health and substance use services must align with this broader vision toward health. Such a vision is consistent with a recovery oriented model as articulated by DMHAS and the integrated models of care pursued by DSS, DCF and OSC. IN order to exercise this vision, OHA recommends a coordinating entity lead an overall health reform transformation in the state.

¹⁵⁵ Ibid.

As part of our implementing our vision, we should coordinate and build on prevention efforts that DMHAS and DCF promote. Such efforts should be targeted toward the entire state. DMHAS has a series of prevention initiatives¹⁵⁶ Prevention should be part of school, work, wherever people live, play and learn.

Although the subject of stigma did not come up much at the hearing, stigma continues to be an obstacle to individuals' willingness to get treatment. One witness testified that the biggest barrier to treatment is in the recognition and willingness of the individual to accept that there is a problem and to seek treatment. She suggested a continuing public campaign aimed at the individual's awareness of the problem and options for treatment would help.¹⁵⁷

The witness also said, "Perhaps, a trained staff could do outreach through the clinics on the street, encouraging individuals, especially homeless individuals, to seek various treatments, whether substance abuse, mental health, or usually both. Perhaps a public campaign including, print, radio and television could provide easy channels, such as the 211 information service, to make seeking and identifying treatment options a smooth and rapid process."¹⁵⁸

In another statement in support of public awareness, Mark Kraus, MD, FASAM, testified about the importance of Screening Brief Intervention and Referral to Therapy (SBIRT) in the context of substance use. He also warned of the importance of educating parents to talk to their children about the dangers of drugs and alcohol and to keep their prescription drugs stored under lock and key.¹⁵⁹ Dr. Kraus also suggested a social marketing campaign targeting drug and alcohol use and the proper use of prescription pain medications.¹⁶⁰

While we focus on prevention, the state should consider taking the best of its models within each of its agencies and exporting them to all residents. For instance, the recovery model at DMHAS could be exported to all residents, including those with private insurance coverage, through some type of wrap-around services. Such efforts require coordination, perhaps through a coordinating entity, and study of the cost-effectiveness of such efforts in

¹⁵⁶ <http://ct.gov/dmhas/cwp/view.asp?a=2912&q=335148>.

¹⁵⁷ Testimony of Raymond Currytto, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁵⁸ Ibid.

¹⁵⁹ Testimony of Mark Kraus, MS, FASAM, available at http://ct.gov/oha/lib/oha/documents/pdf/testimony/portfolio_-_created_1-2-13.pdf.

¹⁶⁰ Ibid.

their current iterations and the practical implementation and fiscal impact of making discrete, evidence-based successful services available more widely in the state.

OHA could not locate a statewide overall cost-effectiveness study of current state programs designed to prevent or treat mental health and substance use disorders. Such a study would examine the success of programs offered by state entities and insurance delivery through a series of measures aimed at determining whether the state is promoting health by: increasing access for all residents to appropriate levels of treatment for appropriate durations; achieving measurable outcomes, including measures designed to reduce racial and ethnic health disparities in access to treatment; addressing work force issues; averting interactions with the criminal justice system, lowering the rate of homelessness, increasing job retention, etc.

Though some studies of discrete programs exist, the state should examine each of its programs in the context of overall healthcare delivery in Connecticut. Finding programs offered to Connecticut residents, whether private insurance-based or publicly available programs that address mental health and substance use, is difficult to find among the many state agencies that touch this area. Further, it is difficult to find concrete information on the amount of state and/or federal or grant funding dedicated to each of our programs, the eligibility for each program, how many people each program serves, whether the programs are duplicative and whether individuals are being served by multiple programs. A centralized accounting of all programs, both financial and outcome-based, is overdue. An overall vision and implementation of that vision through a coordinating entity are the keys to substantive and meaningful improvement to Connecticut's mental health and substance use delivery system.

OHA has taken a step toward possible transformation of our system. There is widespread belief that the CT BHP offers a model of care delivery that includes community based services shown to be effective and is focused on integrating behavioral health into overall healthcare in a manner that reduces racial and ethnic disparities in access and outcomes and prevents unnecessary utilization of higher cost and less effective treatment models and that allows for tracking indicators such as housing and other health factors as an indicator for mental health or substance use treatment. The CTBHP incorporates recommendations from

the Blue Ribbon Commission Report by supporting local systems of care and community-based services. Publicly available reports attest to the CTBHP's purported success at its first mission: "expansion of individualized, family-centered, community-based services."¹⁶¹

At the same time, based on the information gathered in the hearing, anecdotal evidence and experience of clients accessing both the CTBHP and insurance, there is widespread belief that the private insurance delivery system, operated directly by insurers or through carve-out companies and third party administrators, does not operate in a manner designed to promote overall health and often denies care when necessary. The insurance system is a funding mechanism. That private insurance or coverage system also creates cost-shifting to the state through denials of coverage.

OHA has submitted an application for a grant to conduct the first independent, complete evaluation of the CTBHP since its inception in 2006 to determine whether the CTBHP might be a model for coordinated delivery of mental health and substance use services for all residents in Connecticut.

Most of the state's residents cannot avail themselves of the services available to our publicly covered residents. The reason for this is simple. Most of Connecticut's population is insured and/or does not meet the eligibility requirements of public programs. The assumption has been that those who are insured through their employer or individually will have access to the mental health and substance use services they need. This is not the case, as described earlier in this report.

Connecticut needs to develop one mental health and substance use service delivery system for all of its residents based on an overarching vision of health. Unfortunately, we have developed a patchwork, three tiered system in Connecticut to fill in the gaps of insurance and even Medicaid covered services, but we may just have discovered how much we value the programs offered by our state agencies in implementing that vision.

¹⁶¹ Ibid.

VI. RECOMMENDATIONS

Based on the testimony heard at OHA's hearing, OHA's experience and the research conducted since the hearing, OHA makes the following recommendations to achieve overall transformation of access to and delivery of mental health and substance use services in Connecticut. Some of these recommendations are short-term measures that should be seen as steps toward transformation.

- 1. Connecticut should adopt an overall vision for health that integrates and coordinates access to effective, timely, high quality and affordable mental health and substance use prevention and treatment services into overall healthcare**
- 2. Connecticut's mental health and substance use delivery system should be synchronized by an coordinating entity**
- 3. Prevention, awareness and screening programs must be enhanced**
- 4. Residents covered by self-funded and fully-insured plans should have access to community-based services**
- 5. Mental Health Parity and Addiction Equity must be enforced**
- 6. The recommendations of the 12/18/12 Program Review and Investigation Committee report should be adopted in full**
- 7. State programs must be evaluated for cost effectiveness, and should be streamlined**
- 8. Cost shifting to the state should be evaluated and minimized.**

VII. CONCLUSION

It is not too late for Connecticut to design a delivery system to achieve a bold vision and design the funding mechanisms, including insurance, to achieve the vision, rather than what we have done until now, designing our system around the funding mechanisms. We should have a system that treats all residents equally and with dignity. Access and services should not depend on income, employment, geographic location, gender, age, etc. We must design one outstanding system for all of our residents.