RICHARD BLUMENTHAL
CONNECTICUT

UNITED STATES SENATE
WASHINGTON, D.C. 20510

October 17, 2012

Mr. Gary Martin Cohen
Director
Center for Consumer Information
and Insurance Oversight
United States Department of Health
and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Cohen,

I am writing to you regarding an enforcement issue concerning the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA" or the "Parity Law") and the law's Interim Final Rules (the "IFR" or the "Rules"). This issue pertains to which entities have enforcement authority under MHPAEA and the IFR and the role of the states in the enforcement of MHPAEA and the IFR.

Specifically, I understand that there is substantive variability in states' understanding of their role in implementation and enforcement of MHPAEA and the IFR. Many states are declaring that they do not have the authority to enforce MHPAEA or the IFR and cannot act on any complaints regarding potential violations of the Parity Law or Rules. At least one state appears to be confused as to which federal authorities have the ability to enforce MHPAEA and the IFR; this confusion has resulted in plan participants being directed to the Department of Labor regarding fully insured, and not self-funded, health plans.

Clarification of this issue with the states is essential to ensure proper enforcement of the Parity Law and the Rules within their authority. Clarification is also necessary in the instance where a state has declared that it cannot enforce the Parity Law and the Rules. It is essential that states know their obligation in implementing and enforcing the Parity Law on fully insured plans.

In the absence of guidance, states' confusion is limiting patient access to the benefits promised to them under the Parity Law. Right now, in certain states, patients in fully insured plans have no ability to seek enforcement of MHPAEA and the IFR.

I ask that you formally communicate this information through directives, sub-regulatory guidance, or other means to each state to educate them about their role in the enforcement of MHPAEA and the IFR over fully insured plans in their state.

Thank you in advance for your time and consideration. Please contact Rachel Pryor with my staff at (202) 224-2823 with any questions.

Sincerely,

Richard Blumenthal
United States Senate

RICHARD BLUMENTHAL
CONNECTICUT

UNITED STATES SENATE
WASHINGTON, D.C. 20510

October 17, 2012

The Honorable Hilda Solis
The Secretary of Labor
Washington, D.C. 20210

Dear Madam Secretary,

I am writing to urge you to issue final regulations or sub-regulatory guidance on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Because the law has been implemented without guidance on scope of services, health plans continue to provide disparate benefits to individuals with mental health and substance use disorders than those patients with other medical conditions. As a result, plan participants in Connecticut are being denied essential services, treatments, and benefits.

The Congressional intent of this law was to ensure patients' access to the full scope of mental health and substance use disorder benefits that are medically appropriate for their condition. The basic framework of the law is to equalize mental health and substance use disorder benefits and medical benefits, and end the discrimination that has for so long limited access to mental health and substance use disorder benefits as compared to medical benefits covered by plans.

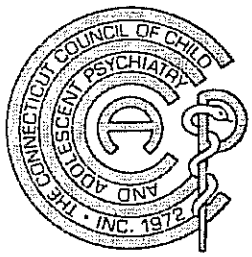
Unfortunately, patients in Connecticut today continue to have limited access to intermediate levels of care – partial hospitalization and intensive outpatient and residential treatment services – even though a full continuum of care is provided under their plan for medical benefits. In the absence of regulations that make Congressional intent clear, plans have increasingly excluded coverage for residential life-saving eating disorder and addiction treatment.

I look forward to continuing to work with you on the implementation and enforcement of these important protections for the tens of millions of Americans affected by mental health and substance use disorders. Please contact Rachel Pryor with my staff at (202) 224-2823 with any questions.

Sincerely,

Richard Blumenthal
United States Senate

Connecticut Council of Child and Adolescent Psychiatry, Inc.



Connecticut Chapter of the American Academy of Pediatrics

The CT Council of Child and Adolescent Psychiatry (CCCAP) is a membership organization representing 260 child and adolescent psychiatrists in CT. We are very pleased that the Office of Healthcare Advocate is exploring the issue of barriers to access for those needing mental health and substance abuse treatment. It is an enormously difficult issue and it can be almost insurmountable for families who are trying to find help for an ill child.

Despite the dramatic advances in scientific knowledge regarding childhood and adolescent mental illnesses and their treatment over the past 20 years, only a small fraction of children and youth suffering from mental illnesses and substance use problems receive treatment. Our health care system often fails to provide the most basic mental health services to those children in need. The Surgeon General declared this a public health crisis. The CT Council supports the principle that needed mental health treatment services must be available to all children, youth and families. The CT Council is committed to the elimination of all barriers that prevent children and youth from having access to these services.

The lack of availability of mental health professionals for children and adolescents with psychiatric illnesses and substance use disorders is a major barrier. Often parents are given a list of network clinicians attached to their Managed Care Organization (MCO). Specialized professionals and services listed for youth are too often not available, outdated or not covered by MCO's. There are currently about 7,000 child and adolescent psychiatrists practicing in the U.S. (AMA, 2010). In 1990 it was reported that the nation would need more than 30,000 child and adolescent psychiatrists by 2000, based on increasing rates of child mental illnesses and managed care staffing models.

We call for a real end to discriminatory insurance policies regarding mental illness and substance use disorders particularly as compared with physical illness; these limit access, impede treatment and perpetuate stigma.

The CT Council supported CT's parity legislation that provides patients and families with access to the full range of appropriate evaluation and treatment services. However, it must be legitimate. It cannot be in name only.

Treatment must be obtained without financial penalties, hardship, limitations or stigma. We recommend:

- offering and authorizing adequate assessment and treatment consistent with professionally recognized practice parameters and current standards of care for psychiatric illnesses and substance use disorders
- maintaining a network of qualified, truly available and licensed children's mental health professionals, including sufficient child and adolescent psychiatrists; with strategies to ensure that there are both recruitment and retention of these professionals
- supporting the participation of families in the assessment and treatment process, by covering family treatment
- ensuring that funding for communication and collaboration between mental health providers and other caregivers is provided. When treatment involves multiple systems of care, a typical occurrence, a seamless transition of care and funding must occur, (school, juvenile justice, child welfare agency, etc)
- prohibiting procedures that arbitrarily reduce the time and reimbursement for assessment and treatment for children's mental illness and substance use disorders. If care is denied, appeals must be handled by a board certified child and adolescent psychiatrist (please refer to attached AACAP policy statement on utilization management) and must occur in a timely manner
- providing real parity for all psychiatric and substance use disorders of children and adolescents.

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

Policy Statements

Issues in Utilization Management

Approved by Council, June 1990
To be reviewed

External utilization management, an organized process of managing medical services provided by others, is a rapidly growing method of quality assurance and cost containment. Managed care is an important issue for the members of the American Academy of Child and Adolescent Psychiatry because it directly affects the quality and availability of medically necessary treatment.

Definitions

Utilization management organizations: organizations that monitor care provided by others.

Utilization review: a review of the use of medical diagnostic and/or treatment services (resources) based upon established criteria.

Psychiatric peer review: the evaluation by a practicing psychiatrist of the quality and efficiency of services ordered or performed by other practicing psychiatrists.

Quality assurance: care of high quality such as that which consistently contributes to the maintenance or improvement of health and well-being.

Medically necessary: the evaluation of the severity off illness and degree of impairment so as to determine issues of the frequency, intensity, complexity and location of treatment.

The National Utilization Review Committee states that a utilization management organization conducts a review of the proposed site of service, and a review of the health care resources required or the proposed procedure or treatment. In addition, utilization management organizations assist in discharge planning, catastrophic case management and other health care review or benefit coordination services. Based on the information provided at the time of the review, the utilization management organization advises the claim administrator by issuing a certification that the proposed site and/or service appears to meet the applicable health benefit plan's health care review requirement.

From the clinician's point of view, many utilization management reviewers are intruding into clinical practice in a way that has a negative effect on quality of care by disturbing the potentially fragile treatment alliance, by compromising confidentiality, and by inappropriately mixing fiscal and medical treatment concerns. This appears to be particularly true for the child or adolescent who needs treatment for a serious psychiatric illness or drug or alcohol problem. Improperly managed utilization review may grossly compromise the ongoing treatment process so that significant psychiatric or physical harm may result

treatment process so that significant psychiatric or physical harm may result.

Measure to manage the cost of health care are necessary. Appropriately implemented, utilization management may be able to balance the clinical needs of the patients with cost-containment objectives. Some of the better designed plans are able to redistribute resources devoted to inpatient treatment and facilitate appropriate utilization of residential, outpatient or day hospital treatment. There is a larger number of utilization management organizations, and they vary widely in terms of organizational structure and quality. Considering concerns expressed by a number of child and adolescent psychiatrists, there are at least fifteen areas where there are issues that need to be addressed. The following statements, if adopted by these organizations, would resolve problem areas:

- Utilization review procedures should be designed so they do not inhibit or intimidate patients from seeking or continuing to use medically necessary and appropriate psychiatric services.
- Review criteria for the initiation of services, continuation of services, and changes in levels of care should be made available to clinicians who are being reviewed. This should be consistent with the standards of national professional organizations, such as those outlined by the American Academy of child and Adolescent Psychiatry in their publication Guidelines for Treatment Resources, Quality Assurance, Peer Review and Reimbursement (Washington, D.C.: AACAP, March 1989).
- Utilization management organizations should formally introduce themselves to clinicians and institutions. Prior to initiating any review procedures, the utilization management organization should provide in writing its name, address, telephone number, organizational structure, contact person, Medical director, review procedure, nature of their informed consent procedures and appeal process.
- A utilization management organization should provide a program of educating providers and beneficiaries about the organization and its procedures, particularly its appeal procedures.
- Parents of minors and when appropriate, patients, must be informed fully of the utilization review process. This is a shared responsibility of the utilization management company to provide necessary general information and the hospital and/or physician in obtaining informed consent for their participation in providing the information.
- The utilization management organization should have policies in force to ensure that no more information is obtained than is necessary to make appropriate reviews, that the information is held confidential, and that it is used only for the purpose of making a determination on the medical necessity and level of care for a particular episode of illness.
- The individual conducting the review will accept information about the patient provided by a designated member of the hospital staff. When the utilization management organization requires the direct input of the attending psychiatrist, the reviewer will be a board certified child and adolescent psychiatrist.
- The utilization management professional staff should have training, continuing education and ongoing experience in the specialty field under review and with the treatment setting being reviewed. Specifically, child and adolescent patients in psychiatric inpatient treatment should be reviewed by board certified child and adolescent psychiatrists with psychiatric hospital experience.
- Utilization management organizations and the payer that contracts them (usually the employer) must accept the fact that communication with managed care organizations is a separate, billable medical service (American Medical Association's current Procedural terminology code 99080 or 90889) provided by the psychiatrist and therefore may result in an extra fee paid by the insurance company or the patient.
- Utilization management organizations are not to be involved in the process of a patient's treatment. Prescribing a particular course of treatment for a patient is the practice of medicine--the responsibility of the patient's physician. The prescribing of treatment by a physician who has not personally evaluated that patient and who does not have an agreement with the patient to be the treating physician, is unethical.
- Interviewing patients and family members, or discussing or recommending a specific

course of treatment, is an unacceptable intrusion into the physician authorized by the attending physician, the patient and the family and done in accordance with medical staff policy.

- It is unethical for a reviewer to encourage the patient to enter into treatment with the reviewer or the reviewer's affiliated professionals or organization.
- The final appeal process regarding medical necessity must utilize a mechanism that has sufficient independence that one can be confident that there is an objective assessment regarding issues of medical necessity and level of care. The reasons for denial should be specific and communicated in writing.
- Managed care organizations should have a formal process of contact and feedback with major provider groups, professional organizations and beneficiary groups. There should be a specific process to deal with feedback and criticism offered by these groups.
- Each state should have a readily available and well-publicized mechanism to resolve situations where patients, providers or their advocacy groups disagree with the utilization management organization.

To maintain the patient's accessibility to high-quality effective health care and also to control costs requires a careful balancing of interests. Utilization management companies must be effectively regulated so as not to unduly disrupt that balance. Since these are generally multistate companies, the regulation process will be complicated and will have to be done on a state-by-state- basis. The Academy should accept the challenge to advocate for such regulations. To do otherwise would jeopardize the care of our patients and the professional autonomy of our members.

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October 17, 2012

BEFORE THE OFFICE OF THE HEALTHCARE ADVOCATE

Testimony of Alijah Cafro concerning the Denial of ABA Services to Children with Autism by Medicaid in Violation of Federal Medicaid Law

Good afternoon . My name is Alijah Cafro. My son, Judaea, is autistic. He is diagnosed with sensory integration disorder, PDD-NOS and has OCD tendency. He is three years old. I am writing to you today to ask for your assistance in correcting a systemic breakdown between current legislation, insurance companies and the state agencies that are responsible to provide services and protection for all citizens, including low-income children with autism on Medicaid.

Judaea was receiving treatment for his medical diagnoses from Beacon Services of Connecticut under the Birth to Three Program. He was receiving 15 hours of applied behavioral analysis (ABA) as well as speech and occupational therapy (OT) as prescribed by his neuro-developmental specialist.

While Judaea was receiving these services the advancements that he made were incredible. In the past, he could not effectively communicate his needs, fears, or emotions. Within just a short time after the services began, he was able to really communicate for the first time. This was amazing to see as a parent. He continued to progress day after day. Then he reached his third birthday and the services stopped.

On his third birthday July 22, 2012, he "aged out of the Birth to Three program". I was told that the only way he could continue to receive these services was if I paid Beacon or another agency like them, out of my own pocket. Even though Jude is on Medicaid, and I have been told by various advocates that, as a matter of federal law, Medicaid must cover for low-income kids any treatment "to correct or ameliorate defects and physical or mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the [Medicaid] State plan" (42 U.S.C. § 1396d(r)(5)), I was told by state representatives that the Husky A/Medicaid program would not cover these services under any circumstances.

While trying to navigate my way through the many denials, I applied for SSI for Jude and he was approved. This only provides $700.00 dollars per month, and while that might sound like a lot, 6 hours of ABA services a week for a period of one month costs nearly $2,000.00 dollars. Six hours is less than half of the hours he was receiving under the Birth to Three program. The only way I was able to pay for a month of therapy was because I had saved his SSI money for the three months leading up to his third birthday.

That money has since run out. Even while I was self paying, the significantly reduced hours proved to be inadequate and his regression began. Judaea stopped progressing. He stopped answering questions. He stopped making as much eye contact. He began to show less affection towards others and he started using inappropriate behavior instead of language to communicate. It has become almost unbearable at times. He was doing so well before and now his regression is heart-wrenching to watch as a parent.

Because of this blocked access, I decided to try and get an individual healthcare policy with help from my family, even though Jude is on Medicaid. Even this has proven impossible. As a matter of state law, since 2009, commercial insurers in Connecticut have been required to provide ABA services to kids with autism when medically necessary. Conn. Gen. Stat. § 38a-514b. The legislature made the determination that it is critical that these services be provided because the failure to provide them in a timely manner has lasting negative consequences not just for the individual child and his or her family, but the broader society. Unfortunately, however, §38a-514b only mandates that insurance companies provide ABA services for **group** policy plans of 50 or more through an employer.

A simple amendment to the wording of this law should suffice to rectify the issue here for families able to buy individual policies. It should state that **all** insurance plans, individual and group, not restricted to larger companies, must provide ABA and the autism therapies recommended by each affected person's treatment team, where medically necessary. It should also say that the insurance company must pay a reasonable, competitive and fair rate to the providers of such treatment so that the children of lesser fortune will not be compromised by sub-level treatment.

However, for many families, including my own, whose incomes are so low that they qualify for Medicaid, this legislative change would not help: the only place they can get health insurance is through the Medicaid program. The Department of Social Services (DSS) persists in denying ABA services to Jude and other kids with his illness, claiming that ABA services will not "restore" him to a level of functioning he already had, that these services are "habilitative" not "rehabilitative," and that the former do not need to be provided to children under Medicaid, despite the broad federal law protections for these vulnerable kids. DSS is just plain wrong in its interpretation of the rehabilitation provision of federal Medicaid law. Children born with Autism Spectrum Disorder (ASD) are born with a genetic defect and lack some of the innate abilities that are inherent to the general population. They are born with a disorder that requires rehabilitative therapy to improve functioning and put them on track with their peers. If a child was born with a broken hip, that child would require rehabilitation even though that child never knew the world without the pain of that ailment. ASD children are born with a broken gene of sorts, and they will not know the world as we do without intensive therapies.

It has been scientifically proven that ABA, along with other methodologies, can improve functioning of ASD children to the point (in many cases) that they could even lose their autism diagnosis. They can function in the neuro-typical world with little or no support if they are given intensive intervention at an early age. This intensive therapy will not only "rehabilitate" a genetic disorder, but also save the individual, the insurance companies, the school systems and the tax payers from providing greater support to these children in the future. Therefore, whether ABA services are classified as "rehabilitative" or "habilitative" treatment is beside the point. The erroneous DSS interpretation of federal Medicaid law renders services needed to improve functioning, and thus avoid a lifetime of costly dysfunction, completely unavailable to Jude and thousands of others like him, and needs to be legislatively reversed.

The physicians and supervisors from the Behavioral Health Partnership have not returned my calls to them about this issue. It has been two months since I requested ABA, speech therapy and OT for Judaea, and, though I have called, filed complaints and begged for Jude's therapies to be approved, I haven't even received a call back. I believe that this is all because they are acting under the direction of DSS, which does not want

to pay for these services in defiance of federal law.

You should also know that other states which have been challenged for applying a similar erroneous interpretation of Medicaid law have righted this wrong. Two federal courts, in Ohio and Florida, have struck down the very same "habilitation"/"rehabilitation" dichotomy being erroneously used by DSS here to deny ABA services, and ordered these services to all children with autism for who have a medical need for them. See *Parents League for Effective Autism Services v. Jones-Kelley*, 565 F. Supp. 2d 905, 916-17 (S.D Ohio 2008), *affirmed*, 339 Fed. Appx. 542 (6th Cir. 2009); *K.G. v. Dudek*, Case No. 11-20684-CIV-LENARD/O'SULLIVAN, slip opinion at 9-11 (S.D.Fla. March 26, 2012)(Amended Permanent Injunction Order). No court which has heard the argument being put forth by DSS has accepted it; all have rejected it.

ABA services have been recognized for decades to be an effective treatment for many children on the autism spectrum, but DSS resists the great weight of authority by persisting in categorically denying these services. In Connecticut, there have been many attempts to correct this. In September 2011, the Office of the Healthcare Advocate wrote to Commissioner Bremby at DSS. In January, 2012, the Office of the Child Advocate wrote to Commissioner Bremby in a joint letter with other organizations asking for action. And the Office of Protection and Advocacy for Persons with Disabilities, which is responsible for protecting vulnerable Connecticut residents with disabilities from discrimination, also wrote to the Commissioner on March 5th. All of these efforts have been to no avail, with DSS exhibiting a remarkable insensitivity to the needs of the low-income children it is responsible for serving, even as Governor Dannel Malloy asserts that he is committed to preserving the safety net and says he himself greatly benefited from receiving special services to address his own disability as a child.

To a mother of a child suffering it seems so simple that an amendment to a law that was specifically written to help these children when enrolled in commercial insurance must be made, and, similarly, that DSS must be instructed to provide ABA therapy and other therapies needed by the lowest income kids with autism, those on Medicaid, just as other states' Medicaid agencies have been instructed to do. In urging this legislation, I am not unmindful of the costs of providing ABA services. But if these services are not provided now, at the critical developmental stage, the taxpayers will ultimately end up paying a much higher price, for special education services, social work services, and, sadly, in some cases, even the child welfare agency and criminal justice services.

I have exhausted every resource available to help my son. My plight is far too lengthy to explain. Truly every state agency and even private programs have been unable to assist Jude. However, since we are on Medicaid, DSS is the ultimate obstacle blocking Jude's access to these services, and the legislature can override this obstructiveness. Any help that you could provide would be appreciated beyond measure. Time is the enemy for my son. The longer he goes without his prescribed services the greater the risk to his development and the less likely it is that he will be able to function in the neuro-typical world. Connecticut was the leader in this battle at one time. Please help to make Connecticut a leader in combating autism spectrum disorders again.

Thank you.

Sincerely,

Alijah B. Cafro

cc: David Cafro
Healthcare Advocate Victoria Veltri
Acting Child Advocate Mickey Kramer
James McGaughey, Office of Protection and Advocacy for Persons with Disabilities
Rep. Catherine Abercrombie

Connecticut State Medical Society
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Hearing on Mental Health Parity
Office of Health Care Advocate
October 17, 2012

On behalf of our more that 6,500 physician and physician-in-training members, thank you for the opportunity to present this testimony to you today in support of efforts to increase parity in coverage for mental health services in Connecticut. Most importantly, we must continue to state that insurance coverage for services does not guarantee access to care, and the focus today should be on access to mental and behavioral health services. In addition, we increasingly see situations in which services may be covered, but not to an adequate extent, and often insurers are using unqualified health care providers to make coverage decisions for medical care services they were never trained to provide.

In 1996, the Mental Health Parity Act (MHPA) was enacted, requiring parity in aggregate lifetime and annual dollar limits for mental health benefits and medical/surgical benefits. The MHPA, however, did not apply to substance abuse disorder and did not prevent some other types of limitations on mental health benefits. In 2008, the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was signed into law. The MHPAEA expanded on the MHPA by broadening the parity rules as they apply to mental health benefits as well as extending these rules to substance abuse disorder benefits.

Under the MHPAEA, any group health plan that includes mental health and substance abuse disorder benefits along with standard medical and surgical coverage must treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review. For example, a plan may not apply separate deductibles for treatment related to mental health or substance abuse disorders and medical or surgical benefits – they must be calculated as one limit. MHPAEA applies to employers with 50 or more workers whose group health plan chooses to offer mental health or substance abuse disorder benefits. MHPAEA was effective for plan years beginning on or after July 1, 2010.

In February of 2010, the Obama Administration issued regulations implementing the MHPAEA providing greater clarity on how MHPAEA should be applied. For the first time, these rules help assure that those diagnosed with debilitating and sometimes life-threatening disorders will not suffer needless or arbitrary limits on medical care. The rules bring needed relief to families faced with meeting the cost of obtaining mental health and substance abuse services.

Unfortunately, in Connecticut, MHPAEA law and regulations do not apply to everyone – especially those receiving insurance through small employer groups and in the individual market. The same federal safeguards outlined above must be applied to anyone who receives health insurance coverage in Connecticut, regardless of the size of the group or whether insurance is obtained in the individual market. CSMS urges the adoption of parity in health insurance and access to health care services in Connecticut, regardless of whether individuals are seeking health insurance or medical care for mental or behavioral health matters, substance abuse disorders or any other medical condition.

Absent a state law that further strengthens federal protections, CSMS continues to believe that mental health parity is a good concept, but its implementation is lacking in Connecticut. Although a patient may have "coverage" on paper, health-insurer delays and denials in authorization too often curtail critical access to these services. More needs to be done to guarantee that insurers not only identify that mental and behavioral health services are covered benefits, but that they are establishing adequate networks that will guarantee access to mental health services provided by well-qualified and trained physicians to actually provide this care. As previously mentioned, coverage does not necessarily mean access -- and access requires that networks are sufficiently robust and that patients have choices in the physicians and other providers who have the training and experience to provide these services. Furthermore, care cannot be denied by someone not trained in the area of care being recommended for the patient. We have come too far already to go back to the days when medically necessary care was denied by bureaucrats looking at a computer screens and not at the needs of the patient.

We are familiar with situations in which non-practicing clinicians, or even worse, those without training in psychiatry or sub-specializations in psychiatry are denying or limiting care that they have never provided and may not understand. We are continually provided with examples by our members of situations in which it appears the underlying mental health status or condition of the patient is completely ignored by the individual assessing the medical care plan modality for the insurer. In fact, we are constantly told of instances where insurers will not authorize continuation of treatment of Connecticut patients unless a traumatic event occurs (because improvement means discharge from inpatient programs). This contradicts all efforts being made to improve the health and well-being of every resident of the state of Connecticut, regardless of medical status or condition.

Thank you for the opportunity to present this testimony to you today.

HAVEN

Health **A**ssistance Inter**V**ention **E**ducation **N**etwork

Testimony
Office of the Healthcare Advocate
Public Hearing October 17, 2012
Mental Health of Substance Use: Access to Prevention, Treatment, and Coverage

Healthcare Advocate Victoria Veltri and Special Guest Speaker Carol McDaid, my name is Maureen Sullivan Dinnan. I am the executive director of the Health Assistance InterVention Education Network (HAVEN) for Connecticut healthcare professionals. HAVEN was created in 2007 following the passage of Conn. Gen. Stat. Sec. 19a-12a and is the assistance program for healthcare professionals facing the challenges of physical illness, mental illness, chemical dependence, or emotional disorder. I thank you for the opportunity to present this written testimony on the critical issue of access to prevention, treatment, and coverage for mental health and substance use disorders.

Since 2007, HAVEN has assisted more than five hundred medical professionals suffering from chronic physical illnesses, mental health illnesses, and substance use disorders. Currently, HAVEN is monitoring approximately two hundred sixty medical professionals. Mental health conditions, including substance use disorders, do not discriminate based on race, education, or socio-economic status. HAVEN does not provide care and treatment. HAVEN's role is to provide the structure and accountability that enables professionals to be responsible patients as well as to obtain the care and treatment necessary for them to have sufficient well-being to be able to provide quality patient care to others. Our nurses, doctors, dentists, veterinarians, and allied health professionals in Connecticut face the same barriers to mental health and substance use treatment as the general population.

A key barrier that we face daily at HAVEN is that insurance companies will not provide coverage for the level of care necessary to treat the identified illness. Too often, we hear that the patient will not be allowed a residential treatment, partial hospitalization program or even an intensive outpatient program, as the patient has not failed at a lower level of care. Mental health and substance use must be considered as dangerous a brain disease as other chronic physical illnesses. Despite attempts to achieve parity, there is no such parity. Due to insurance coverage determinations, patients go to an inappropriate level of care because they cannot afford to pay out of pocket for the treatment that is desperately needed. While the insurance companies offer appeals, such appeals are not timely and most patients cannot risk losing an appeal. Unless the patient has the resources to put forth $20,000 to $40,000, the individual is not able to access the needed care.

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 from seeking treatment. How we define success and failure in treatment is also

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problematic. Insurance companies appear to consider treatment effective if the individual does not use while in outpatient treatment, and so, if they lapse, they may be required to repeat outpatient treatment. Success is establishing sustained remission for a chronic illness. Arbitrarily allowing a defined number of sessions to treat depression, obsessive compulsive disorder, or relapse prevention therapy limits access to needed care. Care for chronic illness should be lifelong care.

The determination of medical necessity is abused by insurance companies. Treatment decisions are taken away from treatment providers. If a treatment provider who has seen and evaluated the individual determines that a level of care is appropriate, the insurance reviewer should not be able to override this assessment. Health needs of individuals are disregarded in the interest of the insurance company. Patients and providers make treatment decisions based on finances and not medical need.

Parity is also undermined by the reality that many of the mental health providers in Connecticut do not take insurance. Unless a patient has out-of-network benefits, their insurance may be of limited usefulness. We need the mental health providers to be willing to be on insurance provider lists. We need insurance plans to provide meaningful timely coverage and reimbursement for providers.

Too often, it is difficult to find adequate resources for detoxification and/or quality treatment. When there is an acute crisis, finding a bed for an adult woman can be especially challenging. The waiting list for inpatient, partial-hospitalization programs, intensive outpatient programs, and outpatient treatment tends to be weeks or months. When there is a mental health or substance use disorder crisis, we need to be able to act immediately and when the person is willing and ready for treatment. Delays in treatment hurt the patients and hurt society.

In 2012, shame, prejudice, and stigma remain an overwhelming barrier for mental health and substance use treatment. We need to show that we respect mental health treatment by making it available and affordable, and encouraging the best providers to be on our insurance panels. We need to make clear that mental health is not an area where people can cut corners or do minimum treatment or that the least amount of treatment possible is acceptable.

HAVEN is willing to participate in any task forces, committees, or other groups that the Office of the Healthcare Advocate deems necessary to move this issue forward so that we may no longer be speaking about these problems, but we may be part of the solutions for breaking down these barriers.

Respectfully submitted:

Maureen Sullivan Dinnan, J.D.
Executive Director

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Testimony before the Office of the Healthcare Advocate
October 17, 2012
Michaela I. Fissel

Good Afternoon! Thank you, members of the Office of the Healthcare Advocate, for taking the time to consider the barriers that the recipients of behavioral health services experience while seeking and accessing care within the State of Connecticut. My name is Michaela I. Fissel and I am addressing you today as a Behavioral Health Advocate, Consultant, and most importantly, a young adult Consumer. I would more correctly describe myself as a young person in long-term recovery. Although I can stand before you today as a secure and confident professional – it has not always been this way.

In my adolescents I struggled to cope with extreme emotions. As I completed the normative milestones that mark the transition through adolescents, I could not understand why I felt so… alone. I 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. I adapted self-destructive habits in an attempt to manage my emotions through substance use, self-mutilation, and through an eating disorder. After barely graduating from high school, my life was heading in a downward spiral, which eventu ended in 2007 when I attempted suicide.

After I was admitted to the Institute of Living in Hartford, CT I began to awaken to a new reality – I was mentally ill, and I needed treatment. Receiving a behavioral health diagnosis of Bipolar disorder was both empowering and a barrier in itself. It was empowering because I was part of the 40 percent of young adults that experience moderate to severe symptoms of mental illness, and even more exciting, I am co-occurring, and therefore I fit even more specifically with the 70 percent of individuals with a mental health diagnosis who also experience substance abuse or dependence.

My experiences in the hospital were frightening. As a recipient of Husky A insurance benefits, I was told by my Treatment Coordinator at IOL that I could only stay for a few days, maybe a week tops. Upon the start of Day 6, I was told I would be discharge the next day because I was complying with my treatment plan. Is that justification for an individual admitted for a heart attack to be discharged – because they are allowing their blood pressure to be taken and they are swallowing their pills?

I would like to believe that since the Paul Wllstone & Pete Domenici Mental health Parity & Addiction Equity Act (MHPAEA) was signed into law in 2008, things are different, however they aren't. I am still unable to access age and developmentally appropriate behavioral health services because I do not meet the criteria for a serious and persistent mental illness. The best that the Husky Program will offer me is access to a Clinician for psychotherapy within a Clinic if I am also complying with Medication Management through a Clinic Psychiatrist or APRN.

Why is it that the rate of behavioral health diagnosis amongst 18 through 25 year olds in the State of Connecticut exceeds the national average by more than 4% and the only way to access comprehensive behavioral health services is by being accepted in DMHAS Young Adult Services? Why is it that privatized and public insurance doesn't cover comparable behavioral health services for Young Adults within Connecticut?

Did you know that three quarters of chronic lifetime cases of mental health and/or substance related disorders are diagnosed by the age of 24? This indicates that young adulthood is the last stage that early intervention can occur. The vulnerability of this population is further supported when considering the strong association between mental illness and negative outcomes. For example, young adults with serious mental illness have been found to have significantly lower rates of educational success, while having higher rates of unemployment, homelessness, unplanned pregnancies, and involvement in the criminal justice system.

Over the past year I have been conducting a literature review for my master's thesis on young adults with serious mental illness. Based on the research, young adults need to be considered a unique service population

that requires developmentally appropriate services to assist in achieving recovery. We are lucky enough within our state to provide for that need through DMHAS Young Adult Services – however these services are medically necessary for every young person within our State who experiences the symptoms of a behavioral health diagnosis.

It is wonderful that my generation is the first generation not to face long-term institutionalization despite the onset and setbacks of behavioral health diagnosis, but without effective community-based services, our generation will pose a burden on society.

In conclusion, I am here today as an individual and as a representative of all young adults within the State of Connecticut, to respectfully ask you to work as diligently as you are capable of working to ensure that the MHPAEA of 2008 is properly enforced. With the removal of systematic barriers that prevent young people from seeking, achieving, and maintaining recovery, you will allow the emerging cohort of young adults to live meaningful lives as contributing members of our society. Please allow us the equal opportunity to live a life of purpose.

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Office of the Healthcare Advocate
Mental Health and Substance Use: Access to Prevention, Treatment, and Coverage
Public Hearing
Legislative Office Building, Room 2C
October 17, 2012
10:00 AM to 4:00 PM
Hearing Notice: http://www.ct.gov/oha/lib/oha/Public_Hearing_Notice_10-17-12-_FINAL.pdf

TESTIMONY
SUBMITTED BY PAUL GIONFRIDDO

Thank you for the opportunity to make these comments. For many years, I worked on behavioral health policy as an 11-year member of the Connecticut House of Representatives. But I have had two experiences since then that have underscored (1) the importance of access for all to behavioral health services and parity in coverage and (2) how far we still have to go to achieve these things.

The first happened more than ten years ago, when my insurer said that my son Timothy had exhausted his lifetime mental health benefits while still a teenager.

Tim has given permission for his story – much of which took place in Connecticut – to be told publicly. And the September 2012 issue of the national health policy journal *Health Affairs* published an essay that tells it in some detail. The essay shows how poorly we have supported the community services needed to prevent and treat behavioral illnesses over the past 30 years. It also discusses problems in Connecticut and other states that persist to today. There is a link to the essay at the end of this testimony.

Tim was diagnosed with serious mental illness as a child, becoming one of the 6% of Americans who must live with such a condition. Serious mental illness has lifetime costs and consequences. The idea that someone could exhaust a lifetime of coverage in a few short years is astounding.

Fortunately, Tim was covered by a Connecticut insurer subject to Connecticut's state parity law. As a result – and only because of this – the insurer continued to pay for Tim's care for two more years.

Tim later lost his private insurance coverage. As a 20-something, he no longer met the criteria for physical or developmental disability his new insurer said he had to meet to remain on a parent's policy at the time.

In the past four years, we have come a long way toward making things better with the passage of both the Mental Health Parity and Addition Equity Act of 2008 and the Affordable Care Act.

But we haven't come as far as we think.

My second, more recent experience, explains why. It happened after both laws were passed.

I am now a resident of Florida, covered by a Connecticut insurer. I learned late last year that Blue Cross Blue Shield of Florida had sent nearly all of its behavioral health providers termination notices. It then offered to take them back, but only if they agreed to significant reductions in reimbursement. This only happened to behavioral health providers.

Here's what this meant. Before the reductions, a psychologist was receiving just under $52 for an hour counseling session. This is less than the $65 per hour earned by the average carpenter, the $75 per hour earned by the average electrician, the $90 per hour earned by the average plumber, and the $100 per hour earned by the average auto repair person.

After the reductions, today that same psychologist gets only $46 per hour.

You may wonder what this Florida example has to do with Connecticut.

This is it. Out-of-State Blues pay only in each state what the Blue Cross Blue Shield provider in that state decides to pay.

So the $46 is what Anthem Blue Cross Blue Shield of Connecticut – my current insurer - pays that psychologist. In this instance, "parity" for a Connecticut insurer is only as good as it is defined in Florida.

We must understand that what happens outside of Connecticut makes a difference in Connecticut. And, conversely, we must also understand – as do the insurers – that what is done in Connecticut can help build a wave that will travel through the rest of the country. We need Connecticut's leadership now more than ever.

Thank you.

Link to Health Affairs Narrative Matters Essay:
http://content.healthaffairs.org/content/31/9/2138.full.pdf+html

NASW National Association of Social Workers / Connecticut Chapter

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Raymie H. Wayne, Ph.D., JD, MSW, President
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Mental Health and Substance Use: Access to Prevention, Treatment and Coverage
Public Hearing of the Office of Health Care Advocate

Medicaid Expansion of Providers to Licensed Clinical Social Workers in Private Practice for HUSKY C & D

Submitted By: Stephen A. Karp, MSW

The National Association of Social Workers, CT Chapter representing over 3,200 professional social workers statewide calls upon the State of Connecticut, through the Department of Social Services to authorize Licensed Clinical Social Workers (LCSW) in independent practice to be eligible for provider status under HUSKY C & D. Such an expansion will be in keeping with, and provide parity with the current eligibility of LCSWs as providers for the HUSKY A & B program.

LCSWs have been authorized for third party reimbursement in Connecticut since 1990. All major private insurance companies offer provider status to LCSWs in private practice in both the group and individual plans. Federally, licensed clinical social workers are recognized providers under Medicare, the Federal Employees Health Benefits Program and TRICARE/CHAMPUS. Perhaps of greatest relevance, LCSWs are valuable independent providers for Medicaid HUSKY A & B.

The HUSKY C & D population has significant mental health needs that may not be fully met under the current program due to limited access to qualified mental health providers. This population often presents complex situations with multiple needs where case management services are necessary along with more traditional behavioral health treatment. Having providers who are trained in biopsychosocial needs, who understand systems theory and can offer a person-in-environment approach to a client's presenting issues is critical to properly serving the HUSKY C & D enrollees. The training of professional social workers fits exactly with this needed approach.

In February 2012 NASW/CT conducted a survey of our members in private practice to determine the interest level in being a provider under HUSKY C & D. A total of 167 social workers responded and 62.3% indicated they would like to be able to serve the adult Medicaid population. Of the remainder, 25.1% were not sure and only 13.2% did not want to accept HUSKY covered adults. These results should be of no surprise as social workers historically have a professional commitment to working with low income individuals and families and vulnerable populations.

In past discussions between NASW/CT and DSS questions were raised by the Department as to response time of private practitioners and collaborative relationships between a LCSW and a prescriber. Our survey answered these questions by finding that 69.8% of the respondents accept after hour calls and 58.4% said they respond to calls within 8 hours, and within 12 hours 78.9% said they respond to a call. All respondents indicated they return calls within 24 hours. As for working with a psychiatrist or other prescriber, 65.6%

reported having a collaborative relationship with a practitioner who can prescribe medication, with 28.6% saying the prescriber accepts Medicaid, 38.1% were not sure and only 34.1% said the prescriber was not a Medicaid provider.

NASW/CT was able to identify 10 states where clinical social workers are Medicaid providers, including Rhode Island and Vermont. Since not all of our inquiries were responded to we would expect that there are additional states where clinical social workers are authorized providers.

Nationally clinical social workers provide two-thirds of all mental health services and we estimate this to be the case in Connecticut. LCSWs practice in all areas of the state thus offering increased access to care, which addresses geographical barriers to care. LCSWs provide cost effective care and as our survey clearly indicated are willing to accept Medicaid reimbursement rates. LCSWs are effectively providing mental health services to the HUSKY A & B enrollees and HUSKY C & D enrollees deserve the same opportunity to choose a licensed clinical social worker as their mental health provider.

My name is Cathy Morelli and I'm here today to talk about my 14 year old daughter's fight for treatment of her mental illness which includes an eating disorder, extreme self- harm behaviors, anxiety and depression.

Her first hospitalization began on March 6, 2012 due to suicidal ideations and self-harming behavior that included cutting on her legs. Within 6 days of this hospitalization our health insurer, Anthem, denied her continued stay in this hospital. The hospital kept her for a total of 12 days and they continue to battle the denial of treatment by Anthem as I speak today. Within a day of being released from that first hospital she again attempted suicide and engaged in serious self-harming behaviors involving cutting into her thigh. She spent the next 14 days in an emergency department of a hospital because this hospital could not find a psychiatric bed in the state that would take my then 13 year old daughter. Within 6 hours of being released from the emergency department, she again attempted suicide and was struggling significantly with an eating disorder and spent the next 8 days medically admitted to the hospital. After 8 days, she was then transferred to Brattleboro, VT to a psychiatric hospital. This hospital had to battle nearly daily with my insurer, Anthem, to allow my daughter to remain inpatient while they treated her myriad of mental health issues. After 12 days inpatient in VT the battle ended and Anthem won and my daughter was sent back home. Numerous hospital admissions followed and each and every time her inpatient stay was prematurely denied by Anthem.

In between each hospital admission it was an incredibly stressful period of time not only for myself and my husband, but for my 2 other daughters ages 16 and 10. My daughters were so nervous when their sister was home and they felt a sense of obligation to watch her every move

and report back to us if they suspected she was engaging in self-harming behaviors. At one point they became so afraid of her that they refused to sleep in their rooms at night because their sister had started threatening to not only harm herself but now she was threatening to harm others, including her parents. Her stays at home were brief as were her stays in the hospital thanks to a steady stream of denials issued by Anthem.

In 5 months, from March 2012 until August 2012, Anthem had issued a total of 13 denials for hospital admissions personally to my 14 year old daughter. When I say personally, I mean they actually sent the denial letters addressed to my minor daughter. I'll read an excerpt from a letter addressed to my daughter on July 16, 2012. I quote "We cannot approve the request for hospital admission as of July 16, 2012. The hospital gave us information about you. This did not show that hospital care is medically necessary. You have recently been in the psychiatric hospital for about one month due to behavior problems and trying to hurt yourself. You have had these problems for a long time. You had to go into the medical hospital for a few days and now the medical hospital wants you back in the psychiatric program. You had not been getting better in a significant way for at least the last 30 days. There is no plan to do anything different. It does not seem likely that doing the same thing will help you get better. You need treatment that will likely help you get better…" Interestingly Anthem had paid for only 1 day of the 30 days they speak about in this letter. What they fail to mention is she had a suicide attempt and nearly succeeded while inpatient at this psychiatric hospital but in spite of that Anthem still maintained their denial of coverage for her stay there. I find it interesting that they acknowledge that she needs treatment that will help her get better because Anthem only denies any attempt to get her that very treatment they speak about in their letter.

Pretty early on in her treatment we applied to DCF for voluntary services to assist in the care of our mentally ill daughter. They provided us with in home psychiatric services, known as IICAPS, which was in addition to the outpatient providers we had her seeing. Despite the outpatient providers and IICAP's best efforts it was clear my daughter wasn't making any progress and her condition was worsening. In fact, they all agreed early on that she could no longer be managed on an outpatient basis yet the denials from Anthem continued and the basis of most of their denials was that she *could* be managed on an outpatient basis.

For the past 8 weeks now she has been at Cumberland Hospital in VA. Her self- harming behaviors remain out of control and she poses a danger to herself. Past self- harming behaviors ended with her receiving stitches for her wounds because her cutting is that extreme. As most of us know, a cut in the wrong place could easily end my daughter's life. Unfortunately she is oblivious to the danger her cutting poses. Apparently Anthem is as well based on their steady stream of denials for treatment of her very serious condition.

I'm thankful for CT Husky plan for paying for my daughter's current treatment because Cumberland Hospital was Anthem's 13th denial. She's getting the treatment Anthem said she needed in their July 16, 2012, yet they denied her access to this treatment. Without the help of DCF and CT Husky my daughter would no doubt continue to be in and out of hospitals because of Anthem's denials.

The Voice of Behavior Analysis in Connecticut

PO Box 138 • Milford CT • 06460-0138
www.ctaba.org

October 16, 2012

To Whom This May Concern:

This letter is regarding the Public Hearing on Mental Health and Substance Use: Access to Prevention, Treatment and Coverage to be held on October 17, 2012.

The Connecticut Association for Behavior Analysis (CTABA) is a professional organization that seeks to assist in the development and advancement of the field of behavior analysis within the state of Connecticut through research, education, and dissemination of information. CTABA represents Board Certified Behavior Analysts (BCBA) in Connecticut, with a current membership of over 200 persons certified by the Behavior Analysis Certification Board (BACB).

Public Act No. 09-115: An Act Concerning Health Insurance Coverage for Autism Spectrum Disorders went into effect on January 1, 2010. PA 09-115 put into effect insurance payments for Applied Behavior Analysis (ABA) services for children diagnosed with Autism Spectrum Disorders (ASD).

There are three types of insurance policies that are not covered by PA 09-115: self-funded policies, policies that originate out of state, and Medicaid policies, e.g., Husky Health Care. As a result, families with these types of insurance policies are not able to access ABA services for their children because they are unable to pay the high cost of the services. In addition, children from low-income families and children who are wards of the state are not receiving services under the Connecticut Law.

Two states, Ohio and Florida have already been mandated to provide reimbursement for ABA services for children in Medicaid programs.

It is crucial that all children diagnosed with ASD are provided with the same opportunities to receive treatment under the Connecticut State Law, regardless of the type of insurance policy their parent have and regardless of a family's income.

Sincerely,

Elizabeth C. Nulty, MS, BCBA
President, CTABA

STATE OF CONNECTICUT
DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

DANNEL P. MALLOY
GOVERNOR

PATRICIA A. REHMER, MSN
COMMISSIONER

Testimony by Patricia A. Rehmer, MSN, Commissioner
Department of Mental Health & Addiction Services
Before the Office of Health of the Care Advocate

October 17, 2012

Good morning Ms Veltri, I am Patricia Rehmer, Commissioner of the Department of Mental Health and Addiction Services, and I am here this morning mainly to listen to the individuals and the experts talk about the difficulties experienced when trying to access mental health and addiction services in Connecticut, but also to give you a short synopsis of DMHAS's role in providing behavioral health care to Connecticut's citizens.

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.

We provide funding to over 170 private not for profit programs in Connecticut communities including 7 local mental heath authorities, operate Connecticut Valley Hospital which serves over 550 individuals per year needing significant inpatient mental health and substance use services, and operate 6 mental health authorities that provide services in our urban hubs as well as an additional 100 inpatient beds. We collaborate with the Judicial Branch on jail diversion, competency exams, and probation programs and we work with DOC in reaching those who enter their system and need behavioral health care as they are leaving. We also work with DCF to transition young adults with significant behavioral health needs from the children's system into DMHAS and we partner with DSS on waivers to help individuals leave nursing homes, and the clinical management of the Husky D program. We fund prevention programs in many of Connecticut's cities and towns, at our universities, and in our schools and also have a small program for problem gambling.

We work hard to assure that individuals leaving an inpatient unit have a follow-up outpatient appointment within a reasonable time period, that individuals have access to peer supports, sponsors, warm lines, recovery telephone supports and immediate access to medications.

(AC 860) 418-7000
410 Capitol Avenue, P.O. Box 341431, Hartford, Connecticut 06134
www.dmhas.state.ct.us
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We continue to build on our belief that a recovery-oriented system of care for individuals with psychiatric disabilities and substance use disorders is much more than taking a prescription drug and attending intermittent talk therapy. A recovery-oriented system of care provides for a smooth transition from one level of care to another, it offers choice, it is person-centered and it is responsive to the clinical and recovery needs of the individual.

DMHAS has been recognized nationally for the work we do here in Connecticut. 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.

Thank you for taking the time to hold this forum and for allowing me to talk a bit about the public system of care. I appreciate your time and attention to this matter.

CAAP

Connecticut Association of Addiction Professionals

I am Roby Rowe, LADC, LMFT, Public Policy Chair of the Connecticut Association of Addiction Professionals. I want to begin by thanking you for the open, transparent arena that this hearing provides as Connecticut strives to lead the nation in developing the needed structures to implement the Affordable Care Act. The ability to have input is invaluable to us not only as a provider group, but to the citizens of Connecticut now and in the future. So, thank you for this forum.

Substance use disorders are the nation's number one public health issue and are often at the root of symptoms that present as psychiatric, mental health, or even medical symptoms. Persons with these disorders occupy much of the focus of the legal and correctional systems, and related behaviors are behind much school and family dysfunction, leading to the expenditure of still more public dollars as well as insurance dollars for treatment related to accidents. A physician friend of mine stated that he was well prepared to deal with the mangled bodies hovering on the edge of life which he regularly encountered in his emergency room work, but not with the challenge of sorting out urgent and repeated requests for addictive medications as he strove to tell which were driven by substance use disorders. Substance abuse professionals, specifically Connecticut state licensed LADC's (Alcohol and Drug Counselors) bring to the table the specific training to identify and deal with the manipulation that comes with this primary disease, as well as to discern the stage of progression of the disease and hence, type of treatment needed. Further, they have the skills to provide consultation to other providers who may be frustrated by addictive behaviors.

There are now 11 states that provide for licensure of substance abuse counselors / therapists / professionals. When the statute creating the LADC license in Connecticut was passed, it was recognized as having some of the highest standards in the nation. The process for becoming licensed is lengthy and complex, and provides the state with detailed, verified documentation of the applicant's education (master's degree in a behavioral health field at a minimum,) post-graduate training, work experience, and qualified supervision specific to the identification and treatment of substance use disorders.

Some employers such as insurance companies who operate across state lines, have recently leaned toward hiring social workers (LCSW's) whose education is standardized to a degree by a national body. However, covering broader areas of

study in generally the same number of graduate hours, and requiring fewer, if any specific post-graduate training hours in substance abuse, their overall preparation specific to substance abuse is less, with rare exceptions. In Connecticut we are fortunate to have a workforce of highly screened and qualified LADC's who have met uniform state-specific standards. This uniquely prepares them to sort through complex mental health symptoms and discern how substance abuse may be affecting the whole picture, hence to deal with patients having co-occurring disorders (dual diagnosis.)

Consistent with the recognized need for workforce integration required by the ACA, many primary care settings are moving toward having LADC's on staff. Addiction treatment programs can expect increased demand for services from such primary care settings, as well as because of the greater number of insured individuals overall. Title V or the ACA provides for scholarships and loan repayment for certain qualified professionals. It includes "substance abuse disorder prevention and treatment professionals" as one of 11 provider groups eligible for this program under the title of "mental health service professionals."

It would be a loss for the citizens of Connecticut if our behavioral health provider system were to return to the old medical model where doctors, nurses, and social workers were seen as the primary legitimate providers. To exclude LADC's from provider status in Connecticut's insurance exchange or other parts of our implementation of the ACA would be a giant step backwards. It would deprive citizens of the skills this uniquely credentialed professional group has to offer. Furthermore, it would put the state at risk of wasting taxpayer dollars as *other providers quite highly skilled and credentialed their own areas* struggled to identify and treat disorders that LADC's are uniquely prepared to do.

(Ms.) Roby Rowe, LADC, LMFT
Public Policy Chair
Connecticut Association of Addiction Professionals

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WESTERN CONNECTICUT HEALTH NETWORK

DANBURY HOSPITAL • NEW MILFORD HOSPITAL

TESTIMONY OF

Danbury Hospital and New Milford Hospital
As the Western Connecticut Health Network

SUBMITTED TO THE OFFICE OF THE HEALTHCARE ADVOCATE
Public Hearing - October 17, 2012

Western Connecticut Health Network appreciates the opportunity to submit testimony concerning
Barriers to Accessing Mental Health and Substance Abuse Services

Pursuant to section 38a-1041 of the general statutes

Western CT Health Network is a two-hospital network operating in DMHAS Region 5. As a psychiatric case coordinator, and as Danbury Hospital's liaison to the Western Connecticut Mental Health Network in Danbury, I see the needs of people living in our community, each and every day.

While we have long been advocates for increased access over many years, the barriers to appropriate treatment for those we serve are still present. This is a growing frustration as a discharge planner, and for those at risk in our community. I'd like to highlight our perspective on those barriers in our region.

- There is an increasing lack of accessible professionals to address the needs of those with mental illness and substance abuse, particularly for those with low income or state assistance. While there are plenty of healthcare professionals in our communities, the reimbursements for the care needed are inappropriately low, and they don't allow for ongoing treatment. Hospitals have long subsidized in-patient and out-patient behavioral health programs. The economic reality is that many private practitioners choose to take only commercially insured or self-pay patients.
- Instead of appropriate programmatic funding and grants, especially for high-performing programs in identified gap areas, we experience, year-over-year cuts to hospital and community programs.
- There is a significant lack of intermediate and long-term in-patient care facilities in 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.
- The unit I work on is an acute Psychiatric unit. Our purpose is to stabilize and refer to the next level of care. Our average length of stay is a little more than a week but some patients stay as long as 4 months. Often times, chronically ill patients require a longer hospitalization. In those cases, an involuntary commitment hearing is scheduled, and if committed, the patient is put on a waiting list for the next state bed. While we've always prided ourselves on our commitment and care for those at risk, we are not the optimal point of care for this patient. An in-patient facility designed specifically to treat the mentally chronically ill is the most appropriate solution.

- There is a lack of affordable, stable and supportive housing in a supervised setting. The ability for patients to move to wellness and stability is greatly hampered without supportive housing in place.
- Often times we have patients who are ready to be discharged to supportive housing, but the few residences in the Danbury area have long waiting lists, and I'm told the wait for section 8 housing in Danbury can be 2 years or more.

We see evidence of budget tightening in light of this difficult economic environment, and it's clear that the mentally ill and substance abusing population are marginalized at best. I have to believe that if we put our heads together, we could come up with viable alternatives leading to an improved delivery of care for our patients and community.

I hope you'll give full consideration to my testimony here. As in the past, Western Connecticut Health Network is a willing volunteer for any committee or board shaping the future of the delivery system, and ensuring appropriate reimbursements, allowing for improved access to those at risk in our community and across our state.

Thank you for your consideration.

Respectfully submitted on October 17, 2012
By
Kieran Delamere, LCSW
Western Connecticut Health Network

Numerous barriers continue to exist for people to have best affordable access to quality mental health care. This document bullets several examples. Further detail and a proposal on how to correct the problems are enclosed on the barriers to mental health document.

1. A three-tier system exists**,** such that in the field of mental health a small number of therapists (psychiatrists) are paid $X[1], a moderately small number of psychologists are paid ~80% of $X, and a large number of other therapists are paid ~60% of $X. Because $X is often about 25% less than the average charges, psychiatrists make up for this be increasing their case-loads, psychologists often increase case-loads by 50%-70%, and others by up to double! Any increase in case-load means less attention to those therapists see. This results in poorer quality of care do to the nature of therapy needing a high level of attention to those seen. This also means less colleague consultations, which are well understood to be some of the best ways in which therapists can bring multiple helpful perspectives to their work w/their patients.
2. Procedure code 90801 is often limited to a single use, leaving a therapist with nothing more than a diagnostic impression to go on.
3. Wrong diagnoses are rampant, rather than thoroughly evaluating their patients for possible diagnoses. All too often an inaccurate diagnosis is used, leading to treatment that does not best help people overcome their mental illnesses. One example is how *many* psychiatrists will hear of inattention and immediately jump to the ADD/ADHD diagnosis, then prescribe medications. Pediatricians do this, too, albeit with a simple questionnaire to fill out. **However**, inattention, and even hyperactivity, are both symptoms of many different disorders. For example, inattention is found with many depressive disorders, anxiety disorders, bereavement, etc.
4. Out-of-Network is the best option for people to get the best quality of mental health care. This is because such providers are able to maintain lower case-loads because they are able to collect their actual pay rate. This changes the emphasis from quantity to quality. Unfortunately, outside of affluent areas, few therapists are able to do this. This may be partially due to an unfair competition being created by the networks having their in-network $20 co-pay therapists easily outcompeting those who might charge $120 per session. There are many other ways in which insurers make going out of network very difficult, such as:
    - setting unrealistic allowable amounts, sometimes only a fraction of the average charges, as there is no rule on how low their allowable amounts have to be.
    - randomly, and without notice, changing allowable amounts, leading to anxiety about what patients can afford. This tactic works especially well with patients who have money problems and/or anxiety disorders!
    - only sending out-of-network reimbursement, as is the case with Anthem even if the HICF is filled out to send to provider, which makes it very hard to have patients pay just the difference up-front. Requiring the full amount is a deterrent.
    - OTRs are still required out-of-network by many plans, yet since these are confusing to patients, and providers aren't contracted, they sometimes don't get done on time, leading to no reimbursement, and the patient may go in-network.

[1] $X represents the payment amount the panels contact for. Most figures used here are of the best paying panels, thus this is the best case scenario. However the aforementioned more detailed document gets into more specific detail.

Numerous barriers continue to exist for people to have best affordable access to quality mental health care. This document contains several examples, followed by proposals of how to eliminate the barriers.

I. Barriers:

1. An insurance-created three-tier system exists within mental health care, unlike several other physical-medical systems. The tiers determine pay-scale in the absence of qualitatively research to support this decision as anything other than monetary in focus. The pay scales are that psychiatrists are typically paid a set rate[1] for psychotherapy, psychologists often 80% of that rate, and all others at 60% of the psychiatrist rate. This fact holds even in the most illogical of situations, such as if a Licensed Marriage and Family Therapist performs the family therapy code (90847), they will still have a small reimbursement compared to psychiatrists who in some cases have not taken a single formal class in family therapy. The tiers results in many psychotherapists having to increase their case-loads to make up for this fact. The average psychotherapist has to approximately double their case-loads. Burn-out is not uncommon. What is particularly common is that psychotherapists have more patients than the ideal, and therefore cannot devote their full attention to those they do see. This lowers the quality of care, resulting in more cookie-cutter therapeutic strategies, and less thoroughly getting to understand each patient at sufficient depth to employ the use of therapy models.
2. Procedure code 90801 is often limited to a single use, leaving a therapist with nothing more than a diagnostic impression to go on, rather than thoroughly evaluating their patients for possible diagnoses. In most of the medical field, it is well known that the right diagnosis leads to the right treatment. Due to this system, and few viable alternatives, the wrong diagnosis is all too often made. See #3 below for more information also applicable here.
3. In many areas, in-network outpatient psychiatrists take to evaluating a person in less than an hour. A single statement from a patient of "I have trouble focusing" often leads to an ADD/ADHD diagnosis and its accompanying medication. However, depression, anxiety, bereavement, and many more diagnoses cause inattention. And, one cannot diagnose ADD by simply prescribing an amphetamine-like[2] drug. Placing people on amphetamine-like drugs leads many people, even without inattention, to increased focus, along with a variety of subtle but significant personality and emotional changes. Many in-network psychiatrists will do their evaluation in 30 minutes, and subsequent appointments in 6-10 minutes. With inaccurate diagnosing and such brief follow-up, in-network psychiatrists are all-too-often overmedicating and inaccurately medicating our population. With all this said, there is a serious shortage of psychiatric prescribers. Allowing all licensed mental health providers to subscribe if they can take additional pharmacology courses and pass difficult tests that test their ability to assess and prescribe would remedy this problem. This is already done in a number of states with psychologists.

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[1] This psychiatrist rate is often 30-40% less than their actual rates. This decrease is much more substantial than several other physical-medical fields, and increases their need to increase their number of patients seen to make up for the lower rates.

[2] Chemical similar and with a degree of similarity in results.

4. Out-of-Network is the best option for people to get the best quality of mental health care. This is because such providers are able to maintain lower case-loads because they are able to collect their actual pay rate. This changes the emphasis from quantity to quality. Unfortunately, outside of affluent areas, few therapists are able to do this. This may be partially due to an unfair competition being created by the networks having their in-network $20[3] co-pay therapists easily outcompeting those who might charge $120 per session. But, out-of-network should allow reimbursement, but there are several problems here. The 1st is the insurers are often free to set any allowable rate they want. Some allow $60 for a therapy session, after a deductible is met (with only $60 of the $120 applied each session), then pay a percent of the $60, such as 60% of $60, resulting in a reimbursement of $36! This is a substantial barrier to going out of network, while most other physical-medical fields do not have these huge discrepancies. 2nd, even in the occasion when the insurer will pay a more reasonable rate, there is no law requiring insurers to pay providers directly out-of-network even when box 13 of the HICF is signed that should[4] allow the money to go to the therapist. This generally means that only those who are able to pay up-front can see the therapist. 3rd, insurers have fluctuated their rates without notice, and CT's Insurance Commissioner does not often step in, even with a specific request. This creates uneasiness in the patient, leading to prematurely stopping or switching to in-network. 4th, treatment reports (OTRs) are often required to get more sessions, and if a deadline is missed the psychotherapist has to eat the cost, or out-of-network the client and/or therapist must eat the cost. With sometimes confusing information on what circumstances require an OTR, these deadlines are in reality occasionally missed, resulting in much havoc that may prematurely terminate the treatment.

   <u>Proposed Solutions</u>:

   - The three-tier system should be abolished, and replaced with identifying the average fee charged[5], making that the rate, and then annually adjusting it[6] for inflation.
   - Procedure code 90801 should have no limits of use, nor then have a decreased allowable amount[7]

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[3] This figure is an example, with ranges often going from $10-$45.

[4] Anthem, perhaps the widest used insurer in CT, has a policy to not send money to out-of-network providers, even if the patient did not pay up-front. There are cases where patients have occasionally convinced providers to bill them, accepting money once the patient gets it from the insurer, only to turn around and keep the money that comes in, thus profiting from seeing the therapist several times.

[5] The fee charged should be based in the out-of-network fees because many therapists who are in-network charge their contracted rate, or an amount similar to their highest contracted rate amongst the different insurers they are involved with.

[6] It should be adjusted according to inflation, because if it were to be adjusted according to the average each year, this could lead at least some providers to raise their rates in order to raise the average, and therefore get paid better.

[7] This is a great example of how insurers raise barriers when legislation does not consider what else must happen if a statute is enacted. If 90801s are treated the same as other procedure codes, but there is no system by which the insurers must create pay-rates, they can easily lower the pay on 90801s to then deter therapists from doing the hard work of more thorough diagnostics.

- Some method should be devised and enacted that will drastically lower wrong-diagnoses, such as incentives to thoroughly diagnose or refer out for diagnostics, as well as penalties for wrong-diagnosing.
- Psychiatrists should be held to more accurate coding and then not acting like a script-factory.
- Despite a tad of well-intention, OTRs remain just something most providers fill out to get more sessions, rather than a way to ensure they are providing quality of care. Insurers use OTRs mostly just to limit sessions and create barriers for patients and providers. OTRs should therefore be abolished[8].
- Psychotherapy uniquely needs legislation in this instance.

Please also see the other enclosed documents, which show how one provider tried to join the insurance panels at more reasonable rates. The majority of panels did not respond favorably to any of the requests written shown. The chart, which goes with the attached letter to an insurer, shows annotated information. However, even when insurers saw how discriminatory their practices are w/in the 3-tier system, they came up with another line, saying they pay more to some disciplines because those disciplines can offer more (such as a psychiatrist can offer medicine or a psychologist offers testing). However, they do not pay psychologists more for non-medication codes in states where they can prescribe, Licensed Marriage and Family Therapists are especially suited to provide family therapy (1/2 the training is in individual therapy), Licensed Clinical Social Workers are especially suited to provide social work (connecting w/community resources), etc. Frankly, this argument does not hold up, either. Please see the chart for more information.

Sam Schaperow, M.S., LMFT

[8] Note although controls do exist with precerts. in other medical fields, OTRs do not exist in all medical fields.

Connecticut Chart

Psycho-therapy Profes-sion/ Disci-pline	Hours of face-to-face psychotherapy training required for degree[0]	Minimum full-time years of post-secondary, degree-granting education	Percent of graduate courses directly applicable to psycho-therapy	Minimum face-to-face hours of psycho-therapy in residency	Actual per session full fees[11], *excluding* initial diagnostic interview	Minimum time in residency before licensure
Psychiat rist	0[2]-750	Six[1]	0-5%[2]	400[3]-1500+	$130-$135	192 weeks
Ph.D. Psycholo gist	0[5]-700	Seven[4]	0[5]-60%	0[2]-750	$100-$150	46 weeks, 1610 hrs
Psy.D. Psycholo gist	400-1200	Seven[4]	40-65%	0[2]-750	$100-$150	46 weeks, 1610 hrs
M.S.W.-L.C.S.W.	0[6]-350	Five[7]	0[6]-15%	0[6]-1000	$100-$135	3,000 hours
L.M.F.T.	**500[8]-700**	**Six[8]**	**95%[9]**	**1000**	**$100-$150**	**52 weeks**

[0] These figures are based on the face-to-face clinical hours of supervised psychotherapy training while completing a post-secondary, degree-granting education.

[1] Various universities have a six-year combined undergrad plus medical school degree, such as the University of Missouri-Kansas City School of Medicine, http://research.med.umkc.edu/education/default.html, or Tulane's medical school program. Other medical schools, such as University of Hawaii, admit people into their medical school with only three years of undergraduate study completed, which would bring the total to seven years if a person decides to take this longer route.

[2] Medical school, like most social work programs and a few psychology programs, have little direct psychotherapy training; therefore it is typically learned in the residency.

[3] Dr. Rachel Brown, BROWN_RM@Mercer.edu, Professor and Interim Chair of their Psychiatry department stated on 4/05: "The specifics of numbers of hours etc., depends on the residency program. The regulations say 'a sufficient number of patients.'" She did not state what that number might be, depending on whether a psychiatrist finds her or himself in a medication, research, or psychotherapy oriented program. LMARK@uasom.uab.edu, University of Alabama School of Medicine Admissions, stated on 4/05: "That would depend on the particular program and could range from a minimum of around 400 hours of supervised psychotherapy training to greater than 1500 hours."

[4] Graduate programs, unlike Medical School Programs, require a full completion of a four-year bachelor's.

[5] A psychologist is a person who learns and [typically] applies theory about the human mind. According to Connecticut state law, as is stated at http://www.dph.state.ct.us/Licensure/apps/psyc_stats.pdf, a Licensed Clinical Psychologist has no minimum psychotherapy practice or coursework requirements. While it is assumed, however, that most psychology programs will have psychotherapy requirements in their coursework, it is not legally required. This is especially true for a Ph.D. (as opposed to a Psy.D.), as some programs and some students within many programs focus on psychological testing, research, or another non-psychotherapy practice and application of psychology. Similarly, the residency has no legal requirements for psychotherapy hours. Ethically, most licensed psychologists that practice psychotherapy will obtain applicable training, but may do so after obtaining their license.

[6] Per Connecticut state law, as is stated at http://www.dph.state.ct.us/Licensure/apps/swappl.pdf, there are no minimum psychotherapy practice hours, or psychotherapy courses required in social work programs. The University of Connecticut, of example, has a master of social work (M.S.W.) program, which one can do without completing any psychotherapy courses. Typically social work programs do not even require a single DSM-IV course. Similarly, the Licensed Clinical Social Work residency has no legal requirements for supervised hours of psychotherapy practice. However, Licensed Clinical Social Workers do learn DSM-IV diagnosing theory for one of many portions of their lengthy licensing test.

[7] Example: University of Michigan: http://www.ssw.umich.edu/overview-MSW/faq.html

[8] These are the number of hours of psychotherapy experience legally mandated by law for degrees in "psychotherapy" (M.F.T.), while other degrees have other statutes requiring other non-therapy, but related human-services requirements. http://www.dph.state.ct.us/Licensure/apps/mft_stats.pdf

[9] This figure includes all family therapy theory courses, but excludes all research coursework.

[11] Based on the *limited* (small sample size) polling of a select few towns primarily in Southeastern Connecticut.

Connecticut Chart

Samuel Schaperow, MSMFT, LMFT
567 Vauxhall Street Ext.
Waterford, CT 06385
(860) 447-2047

Caren Anselmi
370 Bassett Rd.
North Haven, CT 06473

Dear Caren:

Within the last year, I have received many requests by local people for me to join your network. I am writing to you today to discuss the possibility of doing so. I contacted Roberta Adison to find out if we can resolve the fee issue *prior to* the lengthy credentialing process. I was happy to find out from her that it is possible to do so, and that I should contact you to work on this matter.

Late last year I decided to stop my charity clinic work and devote full attention to my private practice. I have been seeing people on a cash basis, receiving *$150-$225* per session. I accepted some out-of-network insurance clients as well. I did not intend on joining any insurance panels for two reasons. First, your rates are less than one-half of my usual fees. Second, you put my license at the bottom of a three-tier pay-scale. However, as many Anthem policyholders have expressed to me a desire within the last year for me to join your network, I thought it would benefit Anthem as well as Anthem's policyholders for me to try to negotiate a fee for me to join your network. I believe that my fee should reflect the high demand for my specialized services, my level of training and skill, as well as my actual fee rates for out-of-network and cash clients. I also believe that pay should be commensurate with the quality of services, which is difficult to capture through licensing categories alone. There are many factors that contribute to quality psychotherapy that cannot be captured by licensing requirements alone. Licensing requirements provide only the crudest guides to the expected (and actual) level of services.

An analogy might help. Teaching is both an art and a science, with the former being the most difficult to measure. Teachers vary significantly in their ability to engage and educate their students, and this is true whether they teach English, history, or another subject. While they are all teachers, they are teachers in different academic subjects. Studies indicate that some academic subjects tend to engage a higher percentage of students than others. Therefore, it might appear to make sense to use the academic discipline as a proxy of teachers' abilities to engage their students. However, while the engagement level does statistically vary from subject to subject, the *largest variation occurs from one teacher to another*, regardless of the subject taught. Thus, where schools are free to vary pay based on performance rather than tying it to some rigid degree-based grid, the best schools carefully calibrate their pay based on actual quality of teaching and place their greatest hiring and retention efforts into what makes them the best schools: their teachers.

Just as the best schools seek out and hire skilled teachers to conduct the best teaching, patients and healthcare providers recruit and retain good psychotherapists to provide the best treatment. Capturing the most current full-fee schedules of local therapists primarily in the towns of New London, Waterford[1], and East Lyme, my spring 2005 poll of nearly fifty psychotherapists shows that patients and the market recognize the enormous range of difference in quality of service within the same disciplines. As the attached chart shows, the full-fee range is $100-$150. This is a *50% increase* from the lowest to the highest charging therapists, even within the same disciplines! Other useful data from this poll shows that L.M.F.T.s charge anywhere from somewhat less than to significantly more than psychiatrists for psychotherapy, again showing that the market values a training *directly* dedicated to psychotherapy. And lastly, the group with the least face-to-face client contact training hours, L.C.S.W.s, on average charge less than the rest of the groups. But despite these differences, some insurance panels would initially lump me in with this group.

As I mentioned earlier, there is a high demand for therapists with my specialties. Despite the great need, few therapists in this area work with *children*, especially *down to age three*, as I do. Even fewer work with the particular disorders that I treat. These disorders include: *severe* cases of *Oppositional Defiant Disorder* (ODD),

[1] I excluded myself from being included in the results of the poll so as to obtain the most objective data.

elimination disorders (e.g., nocturnal and diurnal enuresis and encopresis), *developmental disorders* such as *Asperger's Disorder* and Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS). I also work with the more commonly diagnosed depression, anxiety, and *attention deficit disorders*.

In order to complete graduate school and to be eligible to enroll in a residency, I had to complete an extensive case study as my capstone project. I chose to focus on a family with a fifteen-year-old boy diagnosed with PDDNOS and ADHD. My extensive research of the latest case studies and literature allowed me to develop a specialty area in these two disorders. He binged on junk food, never showered on his own, often spoke in "baby-talk", and had a history of reactive attachment disorder, enuresis, and fire setting. I was his clinician at St. Francis Hospital, and I was up for the challenge of stabilizing him. Group therapy was used for my patient to talk about his underlying feelings and cognitions. The supervisor who did the intake stated that a case this severe would likely have only small improvements, especially since he has been in and out of PHP and IOP for years with only small gains each time. My school supervisor said from seeing the first videotaped session that his attention level was so severely impaired, as evidenced by how he *appeared* to not retain what he heard, that he would not be making any changes in the near future. Additionally, his father said that the majority of his issues would remain with my patient for the long-term.

Against all odds, I successfully used an innovative combination of the Solution Focused and Structural Family Therapy models to tackle his problems. For the showering issue, I *gently* discussed it with him to find what would be a powerful motivating reward. He said he wanted to play *Magic: The Gathering*, a trading card game, with his dad. His dad agreed to do this with him if he showered on his own just one time. He ended up showering on his own, played with his dad; then he did it again and again, until he was completely showering on his own without even any prompting! After observing the family, I came to the conclusion that in his case, the ADHD was more likely an expressed need for positive parental attention rather than a biological disorder that would respond well to medication. Medicating, in his case, would have cost him and his medical insurer more money and likely would have produced little positive result. For the speech problem, I noticed that he received criticism for speaking in "baby-talk". This criticism served to feed him the attention he had a deficit in. I worked with the father and step-mother to ignore his "baby-talk" and complement him when he talked more like his age. His "baby-talk" behavior gradually declined. Lastly, for the binge eating, the parents learned better ways to control the portions of food he could eat, and to limit the junk food, but the child was given control over which health foods would be purchased for his consumption. This intervention began to curb his binge eating, more than sufficiently preparing him to return to the outpatient level of care.

- In addition to individual work, I do **family therapy**. I do *not* just try to "fix the kid" and send the child back into the same system that may have created or maintained the symptomology in the first place. Based on research, the vast majority of practitioners and insurers support my methodology but are often prevented from putting the methodology in practice due to lack of training or support. For example, MHN's web site now even officially encourages "practitioners to appropriately involve family members in order to prevent relapse or to support treatment goals".[2] Consequently my patients will recover faster and retain their improvements with a far greater consistency than under providers without this extra training *and* the willingness to use it, even in the face of the most difficult family dynamics.
- I have one of the few bachelor degrees that truly helps prepare a therapist for effective counseling: a four and a half year "Bachelor of Science degree in Human Development and Family Relations, Concentrating in Counseling", including multiple graduate-level courses and one-and-a-half-years of clinical internships.
- I then proceeded to do a *four-year* combined psychotherapy and residency graduate training program.
- I have *thorough training in* cognitive-behavioral, both verbal and non-verbal expressive models of psychotherapy, family systems therapy, and brief therapy models such as Solution Focused and Strategic.

[2] See: https://www.mhn.com/practitioner/content.do?mainResource=pracNewsFamily&key=pracNews

- I have completed a certification program in stress disorders through the University of Connecticut.
- I was a member of the Catholic Charities and Family Service's ASAT program, which focuses on drug and alcohol treatment for adolescents.
- I currently supervise a Psy.D. Licensed Clinical Psychologist.
- I have five clients who come from over an hour away to see me, from two different states, and multiple out-of-network clients from whom I collect my full fee, which is $225 for the initial diagnostic session, and I typically slide down to $150 for follow-up visits.
- I have seen children that even the local partial hospitalization program, which I used to intern at, was unable to discharge with significant progress, and I have been able to stabilize a large number of these patients. And, kids deemed *beyond the scope of the milieu*, are sometimes referred directly to me by the PHP intake clinician(s).
- Already other insurance companies have either acknowledged my training level or the need for my specializations. Ahead are just a fraction of the many examples:
    - IE Shaffer, the behavioral health management company for Local 351, set up my contracted rate at $150 per session, which set their contribution at *$135*.
    - On February of this year, two boys were referred to me, the *four-year-old* for ODD, and the other for Asperger's and ODD. The out-of-network plan they had through Pequot, managed at the time by Multiplan, had a $300 deductible, then a flat $50 reimbursement rate. Pequot reviewed my unique credentials and then waived the entire deductible. They then raised their contribution from $50 to $69, therefore my *minimum total rate of pay was $89*.
    - Blue Care Family Plan, set up to pay $55 per session, agreed to pay *$75* to the sessions for all five of the patients I saw under their plan. This agreement was made in January. They even agreed to retroactively change all previously paid $55 contributions to $75, so that I would not consider referring the clients out. They knew that paying me more would more than pay for itself, and they followed through on their agreement.
    - Blue Care State POS verbally informed me, on 5/6/05, that the fee-schedule for family therapy is set at the rate of *$139 per session, and that Anthem will be contributing 80% of this figure*. This arrangement applies to all people on this plan, with varying deductibles.

I believe Anthem will find me to be a very valuable therapist to have on board its plans, as my hard work and dedication will enhance Anthem's good name, fulfill a need for the treatment of the difficult disorders I work with, and save Anthem a lot of money because often issues such as severe ODD end up requiring costly partial hospitalization because there are not enough therapists who can successfully manage these disorders in the outpatient setting. Altogether, I have more psychotherapy training and education than many psychiatrists. I would really like to become a part of the Anthem team because of Anthem's high level of professionalism and extremely efficient administration and wide reach. If my pay rate can be negotiated to be as high or higher than your top rate for psychiatrists, some of whom may not have the same kind of expertise or experience that I have, I would be especially appreciative. I do earn as much as *$150-$225 for cash and out-of-network sessions.* Of course, I understand market realities and the pressures on insurers. Thus, I would also be willing to work out a rate not greatly below my customary out-of-network and cash rates. I look forward to hearing from you an equitable offer in consideration of my specific expertise and qualifications and the market need for my unique services.

Sincerely,

Samuel Schaperow

Wednesday, October 17, 2012

Ms Victoria Veltri, JD, LLM
Healthcare Advocate
PO BOX 1543
Hartford, CT 06144

Dear Ms Veltri:

My name is Rista Luna M.A., Director of Admissions and Utilization Review at Silver Hill Hospital. I am presenting this testimony on behalf of both Silver Hill Hospital and myself.

Silver Hill Hospital is a nationally recognized, non-profit hospital for the treatment of psychiatric and addictive disorders, a place that people have relied on since 1931. When Silver Hill Hospital was founded, its guiding principles were established: Patients were to be treated with dignity and respect. They were to be active participants in their own treatments and agents of their own recovery. They were to be afforded both the best standard treatments of the day and the most innovative new treatments. They might remain at Silver Hill until they were ready to resume their normal lives. And all of this would take place in a tranquil and dignified setting designed to foster the process of recovery. The vision of our founders remains as healthy, vital, and relevant to us today as it was when it was conceived.

Today, 95% of our patients receiving acute services for mental health and substance abuse are covered by a managed care company. Most of these patients have commercial plans that adhere to the new parity regulations. However this does not ensure that they will have access to the services they need.

Most mental health services need to be reviewed for "medical necessity" before they are approved. The clinical criteria that managed care companies use is widely available to providers and consumers. However the use and interpretation of those criteria on the part of the insurance reviewers often results in denied coverage for patients that not only need the services, but would be at imminent risk if discharged to the community. 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.

We also want to emphasize that these kinds of denials create much extra work for patients, their families, and hospital staff. Not all patients and families have the resources or drive to pursue multiple levels of appeal or navigate the system in order to obtain coverage. These denials seem to ultimately result in insurance companies not having to pay for services that are covered under the consumer's benefit plan and are medically necessary.

Here are some situations and examples to illustrate our point:

- The cases of K. G. and E. R. illustrate how acutely mentally ill patients who meet the commitment standard could be denied insurance coverage for inpatient acute care:

    - **K.G.** – was a 23 year old female with Bipolar disorder (rapid cycling) and Opioid dependence referred from another facility with the presumption she was stable enough to transition to Residential Care. She presented to us debilitated with protracted depression, unable to get out of bed, despondent, despairing, unable to sustain herself in groups, overwhelmed, over-stimulated, distraught, hopeless, and unable to participate, engage, or process information. Her attending physician found that past medication trials had not been successful in abating her unrelenting depression. On admission and throughout her hospitalization, multiple medication changes were made while also working towards a trial of ECT. The patient began to lapse into intrusive thoughts of overdosing and could not contract for safety reporting ongoing ideas of suicide as she stated that she wanted to inject herself and “end it”. Subsequent to a number of alternate medication regimens, the patient was finally able to safely transition to Residential level of care.

Adverse Determination: K.G. was denied upon admission and her denial was upheld on a peer review and expedited appeal. The denial letter sent to the patient stated "she does not demonstrate a clear and reasonable inference of imminent serious harm to herself or others." And it also mentioned "There is insufficient evidence to support that her condition requires an acute psychiatric assessment/ intervention that unless managed in an inpatient setting, would have a high probability to lead to serious and imminent risk of serious harm or deterioration of her general medical and mental health".

- **E. R.** – was a 15 year old admitted during the December school break due to concerns of his psychiatrist and parents about his increasing psychosis. The father reported that E. R.s behavior was deteriorating immediately prior to admission. He had been talking to people who were not there and giving his father more and more aggressive responses to simple questions. E. R. stated that his father was intruding on his world and he was being more secretive and uncommunicative. The patient's psychiatrist reported that she became aware of E. R.'s psychosis when his Prozac was increased from 10mg to 30 mg. She stated that he had become increasingly paranoid, was hallucinating and his smoking marijuana had exacerbated the situation. E. R. described hearing voices of people giving a constant commentary on him and his psychiatrist feared that this could quickly escalate into command hallucinations or his acting out aggressively based on his history of impulsivity, aggression, and violent behaviors. The patient was denied coverage from the day of admission in spite of his acute presentation.
  Adverse Determination: The denial letter sent to the patient stated "You went to the hospital because of possibly hearing voices and having paranoid thoughts. You were keeping to yourself more than usual. You did not have any aggressive or dangerous behavior. You were not suicidal. You were still able to function at school. Your behavior and condition did not represent any risk of danger to the extent that you needed to be in a hospital. You had no plans or intent to harm yourself and you were in control and able to take care of yourself enough to be treated with outpatient services".

- The cases of J.H. and S.E. are examples of substance abuse patients that are also an imminent danger to themselves or others but are denied coverage for inpatient mental health care:

  - **J. H.** – came to Silver Hill Hospital requesting detoxification but in addition required treatment for mood symptoms. At the time of admission he reported that he felt "down" and angry towards his wife; they had been separated for over a year and she had obtained a restraining order. He had stopped taking his psychiatric medications two weeks prior to admission. He was unsure of his diagnosis but reported "ups and downs" and that he had been on Lamictal in the past. He reported not having any familial or social supports, he had been "camping out in his truck" in his brother's yard and he was working in a stressful family business. He was restarted on psych medications at the time of admission. During his hospitalization we requested that his initial authorization for detoxification be changed to a psych authorization and we were denied. That is the same day we had found out that the patient's guns were at his wife's home and that the patient had access to them. The patient's wife reported that he was "unpredictable" and that she had to call the police in the past when he had held a gun and threatened to kill her and himself. He had made numerous

similar threats often in front of their 7 and 9 year old children. At the treatment team's request she secured the guns prior to the patient's discharge.
Adverse Determination: At the time of this presentation we have not yet received a copy of the denial letter. Coverage for mental health services has been denied for J. H. at the peer review and expedited appeal levels. We only received authorization for the first 4 days of his treatment under his detoxification benefit.

- **S.E.** - age 18, came to Silver Hill Hospital from a medical facility after a 4-5 day stabilization following a near fatal overdose with IV heroin with consequent aspiration pneumonia. This overdose was the second one for the patient and it happened close to the anniversary of his father's suicide 3 years earlier just prior to the patient's 16th birthday. S.E. was admitted to our 28 day Dual Diagnosis Transitional Living Program and was being treated for Opioid Dependence and Mood Disorder. Three weeks into his stay he was given a pass with his mother so he could go to court. On the way back to Silver Hill Hospital they stopped at their home and he used five bags of heroin that he had hidden. When he returned to Silver Hill Hospital, he admitted that he was trying to sabotage his treatment. He was admitted to the inpatient unit on that date. S. E.'s history showed that he was impulsive and a high suicide risk. Like his father, S.E. was diagnosed with a Mood Disorder and while at Silver Hill Hospital he was started on a mood stabilizer and a neuroleptic to address his symptoms. He was kept on the inpatient unit until it was clinically appropriate for him to begin Naltrexone. On the last day of his inpatient stay he was given 25 mg of Naltrexone and was discharged with a prescription for 50 mg of Naltrexone daily.
Adverse Determination: We received insurance authorization for the first 3 days of S.E.'s impatient stay. The subsequent days were denied because having a chronically suicidal patient "wait" in an inpatient unit until Naltrexone could be initiated was considered "custodial care". The denial letter states "Your acute symptoms have resolved. You are not a threat to yourself…the information reviewed indicates that you have chronic problems that have not been responsive over an extended period of time to multiple acute based treatments (…) and your continued acute based treatment is not likely to change your ability to function in the community and is considered to be custodial."

The case of K.M. illustrates how inpatient care is denied, and a lower level of care (Outpatient) is recommended for patients that are already failing at an Intensive Outpatient level:

- **K.M**. - was a 53 year old female, primary caretaker for her elderly parents with whom she lives. She held an MBA and was on leave of absence from work at the time of admission. Her job was in jeopardy in relation to her psychiatric deterioration. K.M.'s depression and paranoid suspicions were interfering with her ability to function and she had very limited support from family or friends. She had taken an overdose 2 months prior to admission but she denied that it was a suicide attempt. She was referred for inpatient treatment by her IOP providers and her outpatient psychiatrist due to the patient's worsening symptoms. At the time of admission to Silver Hill Hospital, K.M. reported that "she started to feel that the people in her IOP program were not really who they said they were and it seemed to her that they were actors and everything seemed like made up". She felt that she "could not trust anyone and everything seemed just like a test for her".
Adverse Determination: The reason for denial stated in the letter sent to the patient is, "the patient was not an imminent danger to self or others. The patient was not reported to be acutely suicidal, homicidal or suffering from a treatable acute psychiatric condition, or an acute confounding medical condition requiring 24-hour

> care. It is unlikely that there was an imminent risk of serious and acute deterioration in functioning if the patient was placed in a lower level of care. It appears that the patient could be safely and effectively treated at a less restrictive level of care, such as an Outpatient Program, which is available in the patient's geographical area."

In summary, we would like to present this testimony as evidence that further changes are needed in order to insure fair coverage for patients in need of mental health and substance abuse services. We believe that as long as patients like the ones whose stories we just shared with you continue to face difficulties accessing coverage, the spirit of the parity law is not being met.

Rista Luna MA
Director of Admissions and Utilization Review
SILVER HILL HOSPITAL

From: Lisa Souza [redacted]
Sent: Monday, October 08, 2012 10:01 AM
To: Veltri, Victoria
Subject: Written testimony for Oct. 17th for CT Feat

To Whom It May Concern,

I'd like to have my testimony heard, as I cannot attend the CT FEAT meeting in person. As a single mom with as Autistic child, just earning a living in today's economy can be a challenge. Every PTO day is used on doctor's appointments, sick days for him, and specialists visits.

Having a child with Autism is, in and of itself, a challenge everyday of my and his life. His medications out of pocket expenses are well over $600 a month! He has a 55 page IEP, and we receive no help from the State of CT. He has been to Focus Alternative Learning Center in Canton but that was many years ago and I had to get DCF involved thru Voluntary Services. He doesn't qualify for that any longer.

When he did, he was attending Hartland Elementary, I have over 365 emails to the Principle documenting bullying situations that were never seen by anyone at the school! He had bruises on his back and wanted to kill himself at age 8 because he was stupid. His Psychiatrist wanted to inpatient hospitalize him if I returned him to that same school, as I had outplaced him on my dime. I went through three Special Ed Hearings representing myself, as a Special Ed Attorney wanted over $30k, which I didn't have. So, I sold my home in four days and moved to a better town.

I fight on a daily basis for my son to obtain just the basic services the school is to provide in his IEP. He has no friends, real friends, and is acutely aware of how different he is and just wants to be a normal kid. We've applied for BRS, the Autism Program, DMR, etc all to be denied because his anxiety is situational and his IQ is a maddening 3 points above the DMR threshold. Mind you, this is a child who cannot wake up on his own, cannot remember to take his expensive meds each morning, brush his teeth, make his bed, etc without consistent reminders from me. Yet, he qualifys for absolutely nothing? If I have a meeting at night and he is home with one of his sisters, he won't go to sleep until he knows I'm home. I have had to fight tooth and nail for each and every small thing that he does have in his IEP, and that goes along with an Advocate bill that is creeping up to $2k as I have had her since the Special Ed Hearings in Hartland and that consistency is key for a child like Dylan. A move, a change of teachers, a change in furniture in his room can send him in a tailspin-yet we qualify for nothing.

Kids like Dylan are all over, some diagnosed with Autism, some not fully diagnosed. These kids are growing up in a system and State that is sorely lacking, and yet they are expected to function like normal human beings their age, who are scared enough, never mind having such a disability. What happens to these kids as they age out of the school systems? Is Dylan to go to a program in town for very low functioning kids? Do I sell my house and rent so I have the cash to pay for what he really needs? If I do, I leave absolutely nothing for my children when I pass. And that is the cold hard truth of what my reality is and has been for 17 years. Dylan is just above the IQ, but if you give him a dirty look, or yell at him in frustration, he is throwing up at you're feet, and gets a migraine within a half an hour. Is this how the State wants these kids treated? The bureaucracy that I've run into over his life is enough to choke a horse, and yet I keep being vocal and keep fighting, fighting for what he absolutely deserves! I pay my taxes, take care of my children, work full time, go to school myself, and do my very best to fight for him. I can't tell you how personally frustrating to tell you how maddening it is to speak to someone at DMR and they see his first IQ score and immediately dismiss me. I'd love to see his IQ score when he's upset-it would be so different, as IQ's can change as well. The State needs a much better way to determine eligibility for kids with Autism-period!

Please help me help my child. Compared to an average child, his IQ is so low, I stay awake at night worrying about what his future will bring.

Should you need to contact me, I can be reached at the following:
[redacted]

Ms. Lisa A Souza
10 Oak Glen Court
Simsbury, CT 06070
[redacted]

BRENDA TENNYSON- LEGISLATIVE TESTIMONY (REVISED COPY)

GOOD MORNING

MY NAME IS BRENDA TENNYSON FROM ANSONIA, CT. I AM A CONSUMER OF BHCARE/VALLEY SOCIAL CLUB SERVICES. I HAVE BEEN A MEMBER FOR 26 YEARS NOW. I WOULD LIKE TO TALK TO YOU ABOUT MY SERVICES AND BENEFITS.

I HAVE USED BHCARE SERVICES FROM LEARNING HOW TO CLEAN AS A JANITOR TO HOW TO IMPROVE MY HOME AND HOW I KEEP IT. I HAVE LEARNED THE WRAP, I HAVE COME TO THE L.O.B. TO TALK WITH LEGISLATORS AND SENATORS FOR OVER 15 YEARS NOW AND I FEEL LIKE I HAVE TOLD EVERYONE THE SAME THING NOW.

I HAVE TOLD THEM TO KEEP OUR CO-PAYS AT ZERO. I HAVE ASKED THEM TO STOP THE SPEND DOWNS FROM RUINING MY LIFE AND OTHERS. IN THE PAST I HAVE TOLD GOVERNOR RELL IN A CONVERSATION WHEN WE WERE HERE TWO YEARS AGO, TO LEAVE OUR SOCIAL SECURITY ALONE!

IF THEY TOOK MY BENEFITS AWAY I COULD NOT HOLD A JOB THAT WOULD PAY ENOUGH TO SURVIVE AND THAT MEANS, HAVING AN APARTMENT, FOOD ON MY TABLE AND CLOTHES ON MY BACK. I COULD NOT PAY FOR MEDICATIONS, PHYSICAL THERAPY OR GLASSES TO SEE.

I WOULD HAVE TO MOVE IN WITH A FAMILY MEMBER, WHO I DO NOT GET ALONG WITH. I COULD END UP ON THE STREETS WITH MY HUSBAND, WHO IS ALSO DISABLED AND HAS A HEAD INJURY, WHICH COMES WITH ANOTHER SET OF PROBLEMS.

IN CONCLUSION, WE ARE NOT JUST A NUMBER IN THE SYSTEM BUT WE ARE PEOPLE TOO.

THANK YOU FOR YOUR TIME.

BEFORE THE OFFICE OF
THE HEALTH CARE ADVOCATE

Testimony of Sheldon Toubman Concerning Denials of Applied Behavioral Analysis Services for Children with Autism in Violation of Federal Medicaid Law

October 17, 2012

Good afternoon. My name is Sheldon Toubman and I am a staff attorney with New Haven Legal Assistance Association. I am here to testify concerning the policy of the Department of Social Services ("DSS") to deny access to Applied Behavioral Analysis for children with autism, in violation of federal Medicaid law. This policy improperly denies medically necessary services to needy children, and the rationale which the agency has applied in doing so indicates a misinterpretation of the long-standing requirements of the governing federal law. The Department's interpretation also renders Medicaid coverage more restrictive than commercial insurance coverage in Connecticut, and is ultimately wasteful for Connecticut's taxpayers.

DSS' Position

The specific services at issue concern applied behavioral analysis ("ABA") services for children with autism spectrum disorders. In denying coverage for these services, there has been no claim by DSS that the particular services are not medically necessary for the individuals requesting them; rather, the Department has simply stated that the services are not even **covered** under Medicaid, regardless of medical need. For example, in a denial letter issued by former Medicaid Director Mark Schaefer, in June of 2011, he provided the following rationale:

> The services your provider requested are "habilitation" services. This means they are meant to help you get new skills, ***not to restore skills or abilities that you once had but lost due to an illness or health condition***. A habilitation service that is provided by an unlicensed individual cannot be covered under the Medicaid state plan or as an EPSDT special service.

Dr. Schaefer subsequently confirmed that his position is that DSS will not pay for any therapy services to bring a child up to his or her mental or physical potential – for **any** medical condition -- unless the child previously had that level of function (or the services are provided by a licensed provider, which is extremely unlikely for ABA services). No statutory or regulatory authority for this distinction has been provided except for the assertion that the "rehabilitation"

Medicaid option under 42 U.S.C. § 1396d(a)(13) inherently applies only to individuals who are seeking to regain a function or a previous level of function.

DSS's Position Violates Federal Medicaid Law

The refusal to pay for ABA services under Medicaid is premised upon a fundamental misinterpretation of long-standing federal law. Under the Early, Periodic, Screening, Diagnosis and Treatment provisions of the Medicaid Act, otherwise known as the "EPSDT" provisions, all Medicaid enrollees up to age 21 are entitled to:

> Such other necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section [42 U.S.C. § 1396d(a)] ***to correct or ameliorate defects*** and physical or mental illnesses and conditions discovered by the screening services, **whether or not such services are covered under the State plan**.

42 U.S.C. § 1396d(r)(5).

But DSS is attempting to draw a distinction between services needed to bring a child up to a level of functioning he or she never had because of being born with a medical condition, which is it calling "habilitative services," and services to restore a function that the child had but lost, which it is calling "rehabilitative." It asserts that only the latter are covered under 42 U.S.C. §1396d(a)(13) and thus required for children under EPSDT. This proposed distinction is premised upon a discredited set of proposed regulations promulgated by the Bush Administration near the end of its term, which were blocked by Congress and then formally withdrawn. The two court decisions which dealt directly with the issue also rejected the distinction as being unfounded under federal Medicaid law.

Indeed, if there were any merit at all to DSS' claim, the states could routinely deny services to address functional limitations of children born with cerebral palsy, spina bifida, learning disabilities, mental retardation and other congenital "defects," since, after all, any improvements that services provided to these children produced would "help [the child] get new skills" which they ever had at birth. No such distinction exists under federal Medicaid law.

DSS's Position is Contrary to State Public Policy and Will Be Costly for Taxpayers

The Department's misinterpretation of federal law in this case must be contrasted with the broad public policy reflected in the legislature's recent enactments specifically concerning commercial insurance coverage for ABA services. As a matter of state law, since 2009, commercial insurers in Connecticut have been required to provide ABA services when medically necessary. *See* Conn.Gen.Stat. § 38a-514b. The legislature made the determination that it is

critical that commercial insurers provide these services, where medically necessary, because the failure to provide these services on a timely basis has lasting negative consequences for affected children. Since the passage of that requirement, commercial insurers in Connecticut have routinely approved properly prescribed and supervised ABA services. It is inconsistent with state public policy to treat poor children with autism spectrum disorders less favorably than we treat commercially-insured children.

If the Department's suggested fundamental alteration to the long-standing interpretation of EPSDT were allowed to prevail, it would be costly to Connecticut's taxpayers. If these services are not provided, in the end, the taxpayers will all pay much more as the lack of appropriate behavioral training, at a time when it would have made the most impact, results in far more costly state-subsidized services-- from costly institutional placements to involvement in the justice system-- down the road. Under the Department's misinterpretation of federal law, the taxpayers will be saddled with the long-term costs of failing to provide timely remedial services necessary to allow vulnerable children to overcome learning and other disabilities and develop the basic skills which they need to become productive members of society.

In light of the seriousness of this matter, if DSS will not reverse its position, the legislature may have to act to do so.

Thank you for the opportunity to testify today about this matter of great concern to needy children with autism, and their families, throughout the state.

10/17/12

RE: Mental Health & Substance Use Public Hearing: Access To Prevention, Treatment, and Coverage

My name is Greg Williams and I am a current resident of Danbury, CT. I am a young person in recovery from drugs and alcohol for over 10 years since age 17. I initiated my sustained recovery as a result of access to quality adolescent treatment outside of the state of CT. As my family was going through the most difficult time in their lives, they chose this treatment option after I was involved in a near fatal car accident. It was the best option for me because even though we were privately insured and had "good" health benefits, it was clear that the options for treatment of adolescents in CT were limited. The insurance company authorized only 5 days of treatment while the professional health care provider's assessment recommended that I needed at least 4 weeks of intensive inpatient care. So facing this baffling reality, my family did what any family would do if they had the ways and means to do it: **They paid up front for the recommended treatment in an attempt to save my life and opted to fight the insurance battle at a later point in time.**

Our family was lucky, we won my battle with adolescent addiction, and it took another 3 years but we also eventually won our battle with the insurance company through the external appeal process. Unfortunately, this is the story of only a few. For the majority of CT adolescents struggling with substance use disorders their families are unable to access the proper care for their health problem.

- ***"Over 90% of people with abuse/dependence started using under the age of 18 and met criteria by age 20. Treatment and recovery supports in the first 10 years of use (basically adolescents & young adult hood) is associated with cutting the years of use by decades and key to reducing long term costs to society (Dennis, M. – Chestnut)."***

After attending multiple heart-breaking funerals of young friends of mine whose families were not as lucky as my family, I grew angry and frustrated at the system in place for treating adolescents like me. Young people with asthma, diabetes, or severe emotional disorders are not being denied or limited the care that health professionals have deemed is medically necessary to save their lives by insurance companies. **So, why is it that us adolescents with addiction aren't given access to proper care?** The answer to this question is as complex as the nature of the illness, but one prevailing theme transcends all others: **discrimination**.

- ***In Connecticut approximately 16,000 adolescents between the ages of 12 and 17 need treatment for illicit drug use but do not receive it, and another 18,000 adolescents need treatment for alcohol use but don't get it either (CASAC - 2008).***

Changing the discrimination that families and young people continue to face from healthcare payers has become not only a passion, but has engendered a sense of purpose for me. I will be graduating in September from New York University with a Master's Degree specifically related to health finance and public policy. It is the culmination of this research and my volunteer work with stakeholders from around the state as a Co-Founder of Connecticut Turning To Youth and Families that has led me to these conclusions as the root of some of the troubles facing CT families struggling with drug and alcohol problems:

- ***Insurance Benefit Management:*** Medical necessity criteria used by healthcare payers to manage and authorize treatment is not transparent, public, or consistent. Furthermore the 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). 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: http://www.reclaimingfutures.org/blog/adolescent-substance-abuse-treatment-access-CTYF

- ***No Recovery-Oriented System of Care Exists for CT Adolescents:*** DCF, DHMAS, JJ, and CSSD professionals, parents, and schools have been on the front lines witnessir 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 (See 2009 SAMHSA Report: *Designing a Recovery-Oriented Care Model for Adolescents and Transition Age Youth with Substance Use or Co-Occurring Mental Health Disorders*).

- ***No SAPT-BG Funds Spent on Adolescents:*** After review of DHMAS's 2012-13 SAPT Block Grant Application it is alarming that in 2012 CT continues to neglect allocating any of this money towards advocacy, developmentally appropriate substance use treatment, and recovery services for adolescents and families that cannot be funded by existing financing mechanisms. As a result adolescents with substance use disorders continue to fall through the cracks, costing CT taxpayers billions of dollars in increased associated costs (See 2010 JAACAP Article: *Access to Treatment for Adolescents With Substance Use and Co-Occurring Disorders: Challenges and Opportunities*).

- ***An Increase In Access to Acute Treatment Is Not Enough To Combat A Chronic Health Condition:*** Improving access to detoxification, residential, and outpatient treatment services would be a wonderful step, but what comes after that for young people with substance use disorders? If we want to be efficient with the resources spent on acute treatment these are some of the items that research, The National Drug Control Policy, and CT stakeholders recommend will help sustain recovery for young people:

    - Safe, sober, and age appropriate housing options
    - Recovery-oriented education options currently available in many other states
    - Peer life skills coaching (peer recovery coaching)
    - Family involvement, support, and education
    - System navigation/coordination
    - Building bridges to existing youth recovery capital in CT

Thank you for the opportunity to submit this testimony,

Greg Williams, Board Member, Connecticut Turning to Youth and Families
Email: gregw@ctyouthandfamilies.org
Mobile: 203.733.8326
www.ctyouthandfamilies.org

The Voice of Behavior Analysis in Connecticut

PO Box 138 • Milford CT • 06460-0138
www.ctaba.org

October 16, 2012

To Whom This May Concern:

This letter is regarding the Public Hearing on Mental Health and Substance Use: Access to Prevention, Treatment and Coverage to be held on October 17, 2012.

The Connecticut Association for Behavior Analysis (CTABA) is a professional organization that seeks to assist in the development and advancement of the field of behavior analysis within the state of Connecticut through research, education, and dissemination of information. CTABA represents Board Certified Behavior Analysts (BCBA) in Connecticut, with a current membership of over 200 persons certified by the Behavior Analysis Certification Board (BACB).

Public Act No. 09-115: An Act Concerning Health Insurance Coverage for Autism Spectrum Disorders went into effect on January 1, 2010. PA 09-115 put into effect insurance payments for Applied Behavior Analysis (ABA) services for children diagnosed with Autism Spectrum Disorders (ASD).

There are three types of insurance policies that are not covered by PA 09-115: self-funded policies, policies that originate out of state, and Medicaid policies, e.g., Husky Health Care. As a result, families with these types of insurance policies are not able to access ABA services for their children because they are unable to pay the high cost of the services. In addition, children from low-income families and children who are wards of the state are not receiving services under the Connecticut Law.

Two states, Ohio and Florida have already been mandated to provide reimbursement for ABA services for children in Medicaid programs.

It is crucial that all children diagnosed with ASD are provided with the same opportunities to receive treatment under the Connecticut State Law, regardless of the type of insurance policy their parent have and regardless of a family's income.

Sincerely,

Elizabeth C. Nulty, MS, BCBA
President, CTABA

CAAP

Connecticut Association of Addiction Professionals

I am Roby Rowe, LADC, LMFT, Public Policy Chair of the Connecticut Association of Addiction Professionals. I want to begin by thanking you for the open, transparent arena that this hearing provides as Connecticut strives to lead the nation in developing the needed structures to implement the Affordable Care Act. The ability to have input is invaluable to us not only as a provider group, but to the citizens of Connecticut now and in the future. So, thank you for this forum.

Substance use disorders are the nation's number one public health issue and are often at the root of symptoms that present as psychiatric, mental health, or even medical symptoms. Persons with these disorders occupy much of the focus of the legal and correctional systems, and related behaviors are behind much school and family dysfunction, leading to the expenditure of still more public dollars as well as insurance dollars for treatment related to accidents. A physician friend of mine stated that he was well prepared to deal with the mangled bodies hovering on the edge of life which he regularly encountered in his emergency room work, but not with the challenge of sorting out urgent and repeated requests for addictive medications as he strove to tell which were driven by substance use disorders. Substance abuse professionals, specifically Connecticut state licensed LADC's (Alcohol and Drug Counselors) bring to the table the specific training to identify and deal with the manipulation that comes with this primary disease, as well as to discern the stage of progression of the disease and hence, type of treatment needed. Further, they have the skills to provide consultation to other providers who may be frustrated by addictive behaviors.

There are now 11 states that provide for licensure of substance abuse counselors / therapists / professionals. When the statute creating the LADC license in Connecticut was passed, it was recognized as having some of the highest standards in the nation. The process for becoming licensed is lengthy and complex, and provides the state with detailed, verified documentation of the applicant's education (master's degree in a behavioral health field at a minimum,) post-graduate training, work experience, and qualified supervision specific to the identification and treatment of substance use disorders.

Some employers such as insurance companies who operate across state lines, have recently leaned toward hiring social workers (LCSW's) whose education is standardized to a degree by a national body. However, covering broader areas of

study in generally the same number of graduate hours, and requiring fewer, if any specific post-graduate training hours in substance abuse, their overall preparation specific to substance abuse is less, with rare exceptions. In Connecticut we are fortunate to have a workforce of highly screened and qualified LADC's who have met uniform state-specific standards. This uniquely prepares them to sort through complex mental health symptoms and discern how substance abuse may be affecting the whole picture, hence to deal with patients having co-occurring disorders (dual diagnosis.)

Consistent with the recognized need for workforce integration required by the ACA, many primary care settings are moving toward having LADC's on staff. Addiction treatment programs can expect increased demand for services from such primary care settings, as well as because of the greater number of insured individuals overall. Title V or the ACA provides for scholarships and loan repayment for certain qualified professionals. It includes "substance abuse disorder prevention and treatment professionals" as one of 11 provider groups eligible for this program under the title of "mental health service professionals."

It would be a loss for the citizens of Connecticut if our behavioral health provider system were to return to the old medical model where doctors, nurses, and social workers were seen as the primary legitimate providers. To exclude LADC's from provider status in Connecticut's insurance exchange or other parts of our implementation of the ACA would be a giant step backwards. It would deprive citizens of the skills this uniquely credentialed professional group has to offer. Furthermore, it would put the state at risk of wasting taxpayer dollars as *other providers quite highly skilled and credentialed their own areas* struggled to identify and treat disorders that LADC's are uniquely prepared to do.

(Ms.) Roby Rowe, LADC, LMFT
Public Policy Chair
Connecticut Association of Addiction Professionals

860.956.8473
rarowe@snet.net
publicpolicy@ctaddictionprofessionals.org

To: Vicki Veltri
CT Healthcare Advocate

From: Eric Arzubi, MD
Co-Chair, Keep the Promise Coalition
Fellow, Yale Child Study Center

Date: 17 October 2012

Take-home points:

1. Private insurance companies have strong financial incentives to deny coverage or reimbursement for mental health services when possible.
2. Poor coverage of mental health services leads to unnecessary and avoidable deaths.
3. Please use all necessary means to keep market forces from hurting our citizens at the most vulnerable time of their lives.

- I am one of two Co-Chairs of the Keep the Promise Coalition, and I am a child and adolescent psychiatry trainee at the Yale Child Study Center. Also, I am a member of the Executive Committee of the CT Council of Child and Adolescent Psychiatry.
- I do not claim to speak for everyone from each of these organizations; however, my connection to them does indeed inform my testimony.
- Before I started medical school in 2003, I had the good fortune to work on Wall Street for nearly a decade. First as a financial news reporter for Bloomberg Business News, then as a trader for a hedge fund and for Morgan Stanley. The biggest lesson I took away from those wonderful experiences is that money makes the world go round. I am not against big business and corporate America - I just happen to understand the business world pretty well.
- Therefore, I am not naive when it comes to analyzing the issue of mental health parity. The top health insurance companies are publicly traded companies with leadership that answers to shareholders. Insurance companies generate revenue by collecting premiums. They aim to keep costs to a minimum in an effort to maximize profit. The delivery of mental health services represents a cost to insurance companies that they are seeking to contain. Insurance companies are doing a great job for shareholders:

Company	FY'11 Operating Income	YTD FY'12 Operating Income
UnitedHealth Group (United Behavioral Health)	$8.5 billion	$4.5 billion
Cigna	$2 billion	$1.3 billion
Aetna	$3.3 billion	$1.4 billion
WellPoint (Anthem/Blue Cross Blue Shield)	$4 billion	$2.3 billion
TOTAL	$18.4 billion	$9.5 billion

I only picked a few big, publicly traded companies. It's a little harder to get the information for Connecticare as it is a privately held company.

Here are some other numbers as a way to offer perspective:

- DMHAS annual budget is around $800 million.
- Dept of Developmental Services annual budget is about $1 billion.
- DCF annual budget is about $900 million.

Why are these numbers relevant? Every year the executive and legislative branches go at it, nickel and diming each other over the budget, fighting shrinking tax revenues. Wonder where the money is going? See above!

How does this happen? Insurance companies engage in corporate strategies designed to make recovering mental health care costs onerous and difficult. How do I know? During my psychiatry training, I've worked at 6 different hospitals, each of which has faced the same problems obtaining reimbursement from private insurers. It is not uncommon for private insurers to deny coverage for inpatient hospitalization or a partial hospital program, even for a patient who is at risk for committing suicide. By denying first and asking questions later, insurance companies often hurt patients and their families in what are often the most difficult times of their lives. I have spent countless hours speaking with insurance companies in an effort to fight denials of coverage - I only appeal these denials when they are in fact "medically necessary" in the true sense of the phrase.

Many private insurers are violating the letter and spirit of the mental health parity law in a quest to satisfy shareholders and to meet quarterly profit forecasts published by Wall Street. I've been on both sides of the business.

Another popular strategy employed by insurance companies is "cost-shifting". Publicly traded insurance companies know that many patients have secondary or tertiary insurance coverage. In other words, if the primary insurer denies coverage, a secondary or tertiary insurance policy is likely to cover services. I've seen this dozens of times in child mental health: a publicly traded insurance company denies coverage for inpatient hospitalization in the case of a suicidal child. That insurer knows that the family has secondary coverage through the BHP, the mental health arm of HUSKY or Medicaid. BHP often does the right thing and pays for the services, shifting the costs to taxpayers.

Another important example of cost shifting is the use of CT's unique EMPS. Did you know that 33% of children referred to EMPS have private health insurance? EMPS is a DCF-funded service that is NOT reimbursed by private insurers. Taxpayers are fully funding this.

According to the WHO, depression is the #1 global cause of years of health lost to disease in both men and women. Mental illness is a very real medical problem that costs lives and damages quality of life. Antipsychotic medications are the top-selling class of prescription drugs in the country at more than $14 billion in annual sales...and we're still fighting for "mental health parity"?

I'm not against big business or corporate America. People who work at publicly traded insurance companies are NOT bad. The trouble is that in their world, shareholders come first, and patients come second. I NOW live in a world where patients come first. I am here to ask that you use the legal tools at your disposal to make sure that the market forces do not lead to unnecessary and avoidable deaths.

Take-home points:

1. Private insurance companies have strong financial incentives to deny coverage or reimbursement for mental health services when possible.
2. Poor coverage of mental health services leads to unnecessary and avoidable deaths.
3. Please use all necessary means to keep market forces from hurting our citizens at the most vulnerable time of their lives.

From: angelica fontanez
To: Veltri, Victoria
Subject: Fw: barriers to treatment
Date: Wednesday, October 17, 2012 9:14:37 AM

----- Forwarded Message -----
[redacted]
Sent: Wednesday, October 17, 2012 6:10 AM
Subject: barriers to treatment

Barriers to treatment in substance abuse:

I have over twenty years experience with multiple family members having substance abuse troubles. I can provide a few notes on issues I have seen. These will likely line-up with the observations of others.

The first barrier to treatment is in the recognition and willingness of the individual to accept that there is a problem and to seek treatment. **Perhaps a continuing public campaign aimed at the individuals awareness of the problem and options for treatment would help.**

Once the individual decides to seek treatment there are barriers of insurance and available space within programs. It often takes up to two weeks for even state insurance programs to be activated. The individual continues to use the substance while waiting for activation of insurance. This time lapse often changes the course of potential treatment, with other events occurring in the interim. This may be, death from overdose, incarceration, or a loss of desire for treatment. **Perhaps a pool of money in a fund can be immediately available to treatment facilities to bridge the time-gap between contact of facility and client insurance activation.**

The parole and probation departments use clinics, hospitals, etc., for treatment, when their individuals need treatment. The individual is told to seek treatment, often left to their own ability to seek and set-up treatment. One primary issue with substance abuse is the individuals inability to coordinate treatment. Perhaps the Parole and Probation departments need quick access to ready facilities, possibly back within the jail hospitals, or direct links to outside services. Immediate re-

incarceration is better than continued substance abuse on the street, as these individuals very often are committing crimes to support the substance abuse. This leads to deeper legal troubles and further societal damage. **Perhaps direct mandatory access to treatment should be at the parole and probation officers disposal and discretion.**

It seems that hospital substance abuse and mental heath treatment is up to the hospital to build a program. **Perhaps, it would greatly stem the tide of substance abuse and homelessness if all hospitals had mandatory treatment program development with direct channels of treatment branching out from the emergency rooms.** Individuals often receive acute care and are released. This time period does not sufficiently interrupt or break the habit.

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.**

Thank you for the opportunity to provide these thoughts. I would be interested in helping to create a public campaign and have the resources, references and professional contacts for doing so.

Raymond Currytto
22 Milandale rd.
Fairfield, ct. 06824
[redacted]

From: Mary Lombardo [redacted]
Sent: Wednesday, October 17, 2012 10:40 AM
To: Veltri, Victoria
Subject: Public Hearing October 17th 2012

October 17, 2012

To Whom it May Concern:

Re: Barriers to Mental Health and Substance Abuse Services, treatment and coverage for needed services under state and federal laws.

Hearing: October 17, 2012

I am a Masters Level Clinician and have been an In Network Provider for several insurance companies in the State of Connecticut for over 20 years. It has become increasingly difficult to provide services under the insurance companies' current rate of reimbursement for outpatient mental health. 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. This practice results in profits for insurance companies at the expense of its members and its in network providers.

This practice of denying Providers an increase in reimbursement rates has remained constant even during good economic times. It has been difficult for myself and other providers to try and negotiate a higher rate of reimbursement from the insurance companies that is commensurate with our experience and expertise. The insurance companies rarely respond to telephone calls and letters by Providers; when they do the response is often one of "you can drop out of the network".

As a result, more and more clinicians, myself included, have been forced to drop out of the various networks in order to keep up with our own financial obligations and cost of living increases. Dropping out of networks makes it difficult for Members (the Consumers) to use their insurance benefits to find available experienced providers. With the dwindling pool of experienced in network clinicians, coupled with the increasing cost of Members' copayments, Members often decide to give up on seeking mental health services altogether or drop out of treatment prematurely. And, if they choose to use out of network benefits, their out of pocket expenses create a financial burden that eventually becomes unmanageable.

I believe that the barriers to receiving outpatient mental health treatment are increasing as we go forward into the year 2013. I believe that this is due, in large part, to the resistance by insurance companies to reasonably price Members' insurance costs and to reimburse providers equitably.

Thank you so much for your attention to this matter.
Mary Lombardo, LCSW

To the Office of the Healthcare Advocate,

My name is Mary Denise Moller. I am a psychiatric-mental health APRN dually certified as an adult clinical nurse specialist and as a psychiatric rehabilitation practitioner. I am dually licensed as an APRN in CT and as an ARNP (Advanced Registered Nurse Practitioner) in WA State and have worked in the field of psychiatry since 1978. I am an Associate Professor at the Yale University School of Nursing where I have been the director of the Psychiatric-Mental Health Nurse Practitioner program since January of 2009. In this capacity I visit psychiatric sites around the state securing clinical placements for our APRN students. This has afforded me a comprehensive snapshot of services in Connecticut. Prior to 2009 I was the owner, clinical director and a staff provider at the first APRN independently owned and operated outpatient psychiatric clinic in the US located in Spokane, WA. A state that has a nurse practice act that allows for autonomous practice—that is, no physician collaboration or supervision is required. I am currently in practice one day a week at the Yale Behavioral Health Services of Hamden, a state and city funded community mental health center serving the public sector patient. I am a former president of the American Psychiatric Nurses Association and serve as the psychiatric-mental health APRN representative on the Connecticut APRN Coalition. Thank you for the opportunity to provide testimony on behalf of the Psychiatric-Mental Health APRN community. I surveyed the APRN community and have compiled the responses for this testimony. The responses grouped under 5 major concerns.

What is clear is that there is a small, but committed Psychiatric Mental Health APRN workforce standing ready to serve the population with psychiatric needs across the lifespan throughout this state. In the US there are approximately 93,000 psychiatric registered nurses; of this number approximately 16,000 are certified as APRNs with a mean age of 51. There are approximately 750 active in CT. Annually APRN programs graduate around 375 students. In the United States there are 3,712 Mental Health Professional Shortage Areas with 87.7 million people living in them. It would take 5,834 practitioners to meet their need for mental health providers (a population to practitioner ratio of 10,000:1). In CT 5 of the 8 counties fall into this category.

The first major issue impeding public access to the APRN is the lack of available physicians willing to enter into the legislatively mandated collaborative relationship. The collaborative relationship requires unnecessary duplication of services and decreases time that could be spent seeing patients. As a result, many CT APRN graduates leave the state after graduation and move to surrounding states that have eliminated this antiquated legislation allowing the APRN to practice independently in the full scope of the role as highlighted by the recent Institute of Medicine Report on the Future of Nursing. This issue is being addressed, once again, with the recent APRN submission to the Scope of Practice committee in yet another attempt over the past 20 years to remove the collaborative practice agreement. This would bring Connecticut into the 21st century along with 27 other states, and foster a climate that would encourage APRN creativity in developing a treatment resource like I did in WA State.

The second major issue is the lack of continuity in reimbursement forcing a two-tier system of care as has occurred in all other states. These tiers are the private insurance company reimbursement versus the public sector Medicaid and Medicare reimbursement. These two tiers obviously do not serve the uninsured who are not eligible for entitlement programs leaving many thousands without access to mental health care. Additionally, not all insurance companies reimburse the APRN who is an out-of-network provider, in particular, the federal employees health program.

Although CT actually has developed Medicaid protocols through the various Husky programs that allow for sufficient outpatient psychiatric visits in comparison to many states--including the state I came from that often limited Medicaid patients to only 12 visits per year. The difference is the reimbursement rate is so low that many providers cannot afford to provide the necessary services-for example, Husky D only reimburses a mental health center $25 for a visit. This low 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.

A third major concern is the 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. The consequences of the reduction in CT inpatient beds to less than 741 beds (175 for children/adolescents) for a population of over 3 million are staggering. An example of the effect of this is what recently happened on October 12 when both Yale New Haven Psychiatric Hospital and St. Raphael's were on diversion and patients had to be sent to Bridgeport due to lack of available beds. Additionally, I am concerned about the increase in the prison population of individuals with mental illness. Nationally this is on the rise and to me; the criminalization of those with mental illness is an appalling commentary on the failure of deinstitutionalization. In fact, the largest inpatient psychiatric treatment center in the United States is the Los Angeles County Jail. Connecticut is one of only six states that do not authorize involuntary treatment in the community, often called "assisted outpatient treatment (AOT) " or "outpatient commitment." Such laws often make it possible for people with mental illness to receive medical care before they are so ill they require hospitalization or experience other consequences of non-treatment.

A fourth major concern is the dramatic decreases in state budget funding for community based care. For example, at Connecticut Mental Health Center the caseload per clinician is on average 45 patients. The clinician is responsible for medication management and case management since there are no case managers due to the lack of reimbursement for case management. While a clinician could handle a larger caseload, the complexity of the case management needs severely delimits the ability to handle more patients. For instance, it is not unusual to be on hold for 45-60 minutes waiting for insurance pre-authorization for needed medications or filling out forms to access free medications from various pharmaceutical patient assistance programs, not to mention the time spent trying to find emergency housing, food stamps, etc. Each treatment team is at maximum capacity and they often have to stop taking new patients. One of my faculty members provided emergency assessments one

afternoon/evening a week, but her position and two others were recently cut—further decreasing the available clinicians. The STEP program (an early intervention program for people diagnosed with psychosis) has been closed recently due to State budget constraints. There is no Intensive Outpatient Program for uninsured patients forcing these patients to emergency departments to receive care. Patients with substance abuse issues have the ACCESS program, however, underlying psychiatric problems are not addressed in this program. These kinds of funding cuts were responsible for the closing of my psychiatric clinic in WA leaving nearly 1000 patients in need of finding services. In fact I am still providing services via telehealth to several patients who could not find a provider when I left.

A fifth major concern is the serious deficit in providers trained in children's psychiatric care. Many of those who are specialized in this population take only private pay due to the lack of reimbursement. Recognizing that 75% of psychiatric illnesses have their onset before age 18, significant adult psychiatric impairment could be reduced by early childhood prevention and intervention. It is not uncommon for a family to have a 6 month waiting period to be seen by a child/adolescent psychiatrist or psychiatric APRN. There are some school districts that employ a Psychiatric APRN in a school-based clinic, however, this is dependent on the availability of a collaborating physician.

I am committed to advocacy for those who do not have a voice—those citizens of our state who suffer with a serious mental illness who do not have the luxury of insurance or the ability to pay out of pocket. Since I moved to Connecticut I have provided pro bono services at Fair Haven CHC and now at Yale Behavioral Health in Hamden because neither of these facilities have any money to pay for psychiatric providers. I am able to do this because I serve as a preceptor for our students and am salaried by my University. Several of my graduate students have accompanied me because they are concerned about the welfare, resources, and access to care for the patients and families they will soon be serving as APRNs. I know they are committed to improving the system and I am grateful for their dedication to this most underserved population. Thank you for providing this forum and for allowing me to present this testimony.

Submitted Testimony
Melissa L. Olive, Ph.D., BCBA-D
Applied Behavioral Strategies, LLC

Introduction

Hi and thank you for taking the time to listen to consumers, providers, and advocates. I am here today as a behavioral health provider. I am a Board Certified Behavior Analyst and my company, Applied Behavioral Strategies, LLC provides Applied Behavior Analysis (ABA) therapy services to children with autism under Public Act No. 09-115.

Autism Insurance Bill

Under Public Act No. 09-115, children under the age of 15 are eligible to receive ABA therapy if their parents have certain types of health insurance.

Success!

While I have only been in business 2 years, you will be pleased to know that all of the children on my caseload who receive services through mandated insurance coverage have made growth as a result of ABA therapy. For example,

- "Matthew"
    - Learning to go on community outings without screaming when dogs pass
    - Learning to take a shower independently
    - Learning to shave
- Casper
    - Used to request to avoid many school classes (specials), now participates in all instruction and specials
    - Before our therapy, he had no friends. Now he has friends and makes play dates
    - Historically engaged in aggression with his parents and siblings, we haven't seen aggression in many months
- "Joanna"
    - After living off pureed food for 8 years, she learned to eat table food!
    - She is learning to wear different shoes, hats, gloves
- "Sammy"
    - Learned to sit and relax by playing games on his iPad or watching music videos
    - Decreased self-injurious behaviors
    - Improving his spontaneous communication

- "Charlie"
    - Decreased head banging
    - Learning to tolerate work at home
    - Learning to ride in the car without thrashing his head when his parents go a different route
- "Clark"
    - After being restrained repeatedly in his public school, Clark attends a private school with support and only a few outbursts
    - In the past, cried because he didn't want to do school work, now gets upset if he cannot finish his work

The "Unlucky" Ones

Those case studies illustrate how state policies improve the quality of lives for individuals with behavioral health challenges. But unfortunately, a group of clients exist who are not eligible for these services because they don't have the right type of insurance, or their insurance originates from a different state, or even worse, they are too financially disadvantaged to have insurance and are covered by Husky.

It is for these clients, I am begging for your ear. These clients and their families will never share joys described to you previously because they will not receive the ABA therapy. They cannot afford to pay for it out of pocket so they do without. Even as I write this, it feels like I'm writing about a different century or a third world country. How can this be? These clients and their families have just as many needs, if not more, than the clients who are receiving therapy. But as a result of not receiving therapy, their behavioral health needs worsen which only serves to exacerbate the mental health needs of their parents. And all of this costs more in the long run.

Provider Issues

But even worse than not having the appropriate insurance, are the clients who have the right insurance but cannot find a provider because there are not enough providers who accept insurance. Let me tell you why providers do not accept insurance:

- The reimbursement rates are drastically reduced from fair market value
    - My highest rate of reimbursement is still 50% less than my billable rate
- The insurance companies do not reimburse for services in a timely manner
    - Cigna currently owes me $18,000 on ONE client
    - The stress I experience at each payroll period is overwhelming because I am not sure if my cash flow is sufficient to pay my employees
- The amount of administrative time that is needed to follow up with insurance in order to get paid is almost a full-time position
    - The reimbursement for services does not cover my income and that of an administrative assistant (see rates above).

Amazing Resource

The Office of the Healthcare Advocate has been extremely helpful for me and my clients as staff (Vicki and Jody) have assisted my clients (and many others that are not my clients) in obtaining the coverage to which they are entitled. I am extremely grateful for their assistance over the past two years.

Summary

In closing, I feel fortunate that ABA services are available to children in this state. Thirty years ago, these services were not available to my brother. I cannot help but wonder where he would be today, had he received the services that my clients receive today.

Thank you for taking the time to listen to us today and please do not hesitate to contact me if you have questions regarding this testimony.

From: Lustbader, Andrew
To: [redacted] Veltri, Victoria
Cc: [redacted]
Subject: FW: Legislative testimony 0HA 10/17/2012
Date: Wednesday, October 17, 2012 4:22:58 AM

Is this the right tone, or does it need to be more clinical

Legislative testimony 0HA 10/17/2012

The 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.

As a Child and adolescent psychiatrist and pediatrician, I have worked in many different settings. Some of the hats that I wear that are relevant to today include: being the chairman of the joint leadership committee of the Connecticut American Academy of pediatrics and the Connecticut American Academy of Child Adolescent Psychiatry, the medical director of the child guidance center of mid Fairfield County, an assistant clinical professor at Yale with joint appointments in the department of pediatrics and in the department of nursing, and the director of the therapeutic Center for children and families which is a multidisciplinary private practice group. Because of my unique position, I have dedicated much of my professional life to helping those who have psychiatric issues and who are insurance dependent obtain necessary treatment. We have envisioned viable solutions to these problems which we have laid out in our blueprint on how to revise the system so it can deliver quality mental health care for Connecticut's children; but I am here now to first discuss the need.

I Work in a not-for-profit clinic that serves as a safety net for the towns of Norwalk, New Canaan, Weston, Westport, and Wilton. Like the other clinics that serve as a safety net, we cannot turn away anyone who does not have the ability to pay. However, because our therapeutic resources are so scarce, people who have commercial insurance are given a list of community providers that are on the insurance panels. Often they return back to us, not able to find adequate treatment in the community.

As the safety net, We provide services that range from prevention programs, to once a week therapy, to therapy with medications, and finally to a model intensive, after school program, which allows children who would otherwise be in and out of hospitals, to remain in their homes and in the community. However, Commercial insurance companies either refuse to pay outright, or give a very brief approval period. Often, In the inpatient and intensive outpatient world, when asked to describe our treatment, If it does not include a change of or an addition of a medication, the treatment is denied. Obviously, as a child psychopharmacologist, I am aware of how little I want to give medications. Very often, medications are not warranted, but the insurance companies will not pay unless we medicate. In this lose-lose situation, the choice sadly is quite clear: We won't get paid for the treatment. Even more sadly, when we have to discharge prematurely, often a child might come back and then require medication.

The structure of these insurance companies is such that upwards of 30 or even 40% of their mental health dollars are retained for profit and/or denial of claims. They are well aware of the steep drop off in patients and providers not appealing these denials.

I remember a doctor to doctor appeal that we had initiated for a young child in our extended day program. He was a bright eight-year-old boy who had been ostracized by his peers, was doing poorly in school, and was having trouble with his family at home. His acting out had caused the school to suspend him numerous times, and he was feeling so sad at times he was feeling suicidal. After two months in the program, he was doing much better, developing friends, doing better in his academics, and most importantly, things had improved dramatically at home. This was very much due to the family approach taken in the program -- all without medication. Then, suddenly,his grandfather died, causing him to take a turn for the worse for a few days.

He had been denied treatment by the insurance company after the first few days. The doctor to doctor appeal that I was engaged in went something like this: When I got on the phone with him I asked him if there was any way in which he would approve the treatment. His reply indicated this was a common question. After I told him about the case, he denied it-- based on the fact that treatment was clearly not progressing. Although this preposterous denial closely resembled a work of comedy, it is the sad reality of the world of these children who have mental health needs. The trajectory of their life could be dramatically changed by the proper interventions, but there is so much that prevents them from getting these needed services.

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From: Lustbader, Andrew
To: [redacted]
Cc: Veltri, Victoria
Subject: clinical vignette for the record
Date: Wednesday, October 17, 2012 4:28:43 AM

I am furnishing a rather schematic vignette meant to capture cost transfers to the public schools (funded by the property tax, the most regressive tax) as well as to DCF. I know about the case because I was asked to evaluate the student in question. At the time of the most recent evaluation the student was nearly 17 and in the 11th grade at one of the Fairfield County public high schools. I had seen him two years before and in the ensuing two years things have gone from bad to worse. At the initial evaluation, chronic deficits across all domains of social functioning were evident and these were tied to problems with executive functioning, mood regulation, and learning difficulties. As if these difficulties were insufficient, his parents were at war with each other and were using the student and his younger brother as pawns in their conflict. At PPT, placement at a very decent therapeutic day program was arranged and the school provided a range of counseling and other supports. Although the parents were both employed in Fairfield County and had ostensibly decent insurance coverage, the therapy available through insurance was limited to medication maintenance and weekly therapy with a social worker or psychologist. Practitioners on the list hardly had the skill set needed to intervene with the family and to promote the student's growth and stability. Without the additional supports the school provided, the student would have deteriorated quickly

As it was, the young man settled into the therapeutic day program and appeared to be progressing decently. Escalation of difficulties at home, however, led to the student reporting his mother, with the support of his disaffected father, to DCF for sexual abuse. The investigation failed to substantiate his allegations. In the aftermath, he sabotaged his therapeutic day program and became involved in a set of truly problematic sexual misadventures. At one point, when he was quite depressed, he attempted suicide. A brief (5 to 7 day) hospitalization and several weeks of IOP were provided through the insurance. Meanwhile the regression induced by the family events to which I alluded had led to global and extreme compromises in social functioning. Academic performance had deteriorated and heroic special educational interventions were unhelpful. Peer and family relations had hit a nadir. The student fought with his brother and father and this necessitated the involvement of the police on several occasions. The family was pressuring the school to arrange a therapeutic residential placement at huge expense to the school system already strapped financially. Eventually DCF agreed to provide a level to Level II group home placement, since remaining at home was increasingly imperiling family members, as well as and mortgaging the students future. (The legal system had already been involved and further infractions of the sexual nature might well have led to his incarceration.) The school agreed to pay for an appropriate therapeutic educational day program, as well.

The insurance, however, even though any reasonable indicators were met for intermediate term psychiatric hospitalization and extended step down treatment, as would of been done a few years ago, provided nothing in this situation beyond a brief hospitalization, far too brief IOP, and inadequate individual psychotherapy and medication maintenance. The public sector saved the day, while insurance profited from the clever transfer of responsibility and risk to the public sector.

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From: Lustbader, Andrew
To: [redacted] Veltri, Victoria
Subject: Fwd: Vignettes for hearing
Date: Wednesday, October 17, 2012 10:44:24 AM

Sent from my iPhone

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Andrew Lustbader, M.D., F.A.A.P.
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Medical Director–Child Guidance Center of Mid-Fairfield County
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Begin forwarded message:

[redacted] <dorothy.stubbe@yale.edu>
Date: October 17, 2012, 8:01:38 AM EDT
To: "Lustbader, Andrew" <andrew.lustbader@yale.edu>
[redacted]
Subject: Vignettes for hearing

Hi,
Thanks so much for being our representatives for the hearing today! I have 2 vignettes—names and any identifying info removed:

<!--[if !supportLists]-->1. <!--[endif]--> Joe is an 11-year-old boy who was admitted to the Children's Psychiatric Inpatient Service at YNHH for out of control behavior. Over the two months prior to admission, his life, and his behavior, had been in shambles. He lived with his grandmother, as his mother had difficulties with substances and had not been a stable influence. His grandmother had a steady job and private insurance. However, had been hospitalized for congestive heart failure and learned that she had diabetes, 4 months prior. She was back to work full time, but appeared fatigued and not

to be feeling well. His mother had moved into the home 5 months ago, as she did not have another place to live. Although she had been helping out initially and seemed to be getting her life together, the grandmother suspected that she was using substances again, as her behavior had gotten more erratic. The boy had begun acting out—his mood was irritable, he threw things when he was frustrated, and he got into a fight at school. He was sent to the hospital from school, as he had thrown over a chair and run from the building. He had been in no prior mental health treatment. The treatment team agreed that the initial plan of care would be to understand the family and the boy more thoroughly, to see if his behavioral dyscontrol and mood difficulties were a reaction to the obvious stresses in the home, to provide a thorough psychiatric evaluation, and obtain collateral information from the school, family, and primary care physician--,to teach the boy coping skills, help the family communicate more effectively, and work with the school regarding a plan to help Joe maintain behavioral control and be available emotionally for learning. However, after 48 hours, the boy was calmer and the treatment plan was being followed. The insurance plan denied coverage because there was "no active treatment" occurring. On the "doc-to-doc" review, the insurance reviewer asked if a medication was started. When he was told "no", he stated that there was "no active treatment" being provided and denied further hospital coverage. The treatment team determined that the boy would not be safe to be discharged without services in place and stabilizing treatment (non-pharmacologic) provided. He stayed another 4 days with no hospital payment.

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From: Lustbader, Andrew
To: [redacted] Veltri, Victoria
Subject: Exended Day concept and case examples
Date: Wednesday, October 17, 2012 4:32:21 AM

> A serious problem with commercial insurance is that they don't endorse/ cover EDT level of care, which is approx 6 months of 5 days a week treatment,3 hours a day. EDT provides intensive group, parent, family, psychiatric, and individual therapy as needed. EDT also includes an intensive level of collaboration with school, dcf, and outside providers. EDT is an important Level of care that both prevents costly hospitalizations, sub acute placements, and partial hospital programs. Hospitalizations, residential facilities, and partial hospital programs are emotionally costly to parents and young children and financially costly for insurance companies. They often occur outside of the child's community and can be difficult transitions into and out of these programs. EDT can also serve as an essential component of a successful discharge plan from a hospitalization. The use of EDT can shorten a hospital stay and it can prevent re-hospitalization. Husky covers this service and we see huge success with this treatment.
>
> Commercial insurance has been paying for a shortened stay and then denying further days. We have had several children who continue to need this level of care. We have been absorbing the cost due to the on going psychiatric need of these children. If effect non profits and the state are subsidizing commercial insurance in order to provide the appropriate and ethical level of care

I have made some changes to the child's age and other demographics for confidentiality....

Joey was an 8 year old boy who was adopted at birth and lived with his upper middle class parents and non- biological older brother. He was referred to the extended day treatment program by his out patient clinician due to depression, suicidal ideation, daily crying and tantrums and loss of functioning at home and at school. He was unable to make use of out patient individual therapy and his parents made limited use of family and parent therapy. The whole family felt hopeless, isolated, and ashamed. Through their participation in our EDT program, Joey was able to learn to identify and talk about his feelings. He was able to learn and use coping skills to regulate his affect. We were able to better engage both of his parents and to help them feel more empowered to meet joeys needs and to understand and contain his feelings. We, as a treatment team, were able to make significant paychophamacological changes on an outpatient basis due to the high level of treatment and daily collaboration with school. however, Joey continued to cry and feel suicidal on a daily basis for 3-4 months. Commercial insurance denied authorizing his treatment after approx 30 days and felt he could step down to out patient therapy. Joey was absolutely not ready to step down to out patient therapy. He was at risk of hospitalization and outplacement from his home school district. He was able to make use of the EDT daily groups and discuss his feelings and learn from his peers. similarly, his parents were able to make connections with other parents in similar situations and modify their expectations, boundaries, routines, and rewards/ consequences. We were able to maintain him safely in the community due to the intensity of the EDT program. Joey continued in the program for 6 months and graduated to routine outpatient therapy. joey was not hospitalized and was not placed in a therapeutic school. joey did not follow through on his suicidal ideation and he is alive and doing well today. His parents are grateful for the therapeutic EDT program and by our financial accommodations.

Joey's parents appealed insurance and had the intelligence, support system, and stamina to fight insurance. 2 years later they won their case and insurance paid for the whole treatment. However this is the exception. Most parents are unable or feel unable to appeal commercial insurance. In these cases, mid-Fairfield child guidance center generally picks up the cost and runs at a deficit to continue to provide ethical and essential services to our community of children and families. We have also worked with many children who stop program prematurely because the parents are scared of incurring a cost when commercial insurance denies. These children ate often re- referred in the future and often end up having 211/ EMPS or 911 calls from home or school, in patient hospitalization and therapeutic school placements. We want to provide an intensive level of therapeutic care the prevents these traumatic and disruptive events. We know the EDT level of care works and want to fairly provide it to our clients with husky insurance as well as commercial insurance.

To: The Office of the Health Care Advocate, State of Connecticut
From: Margo Maine, PhD, FAED, CEDS
Re: Testimony for Public Hearing:
Mental Health and Substance Use: Access to Prevention, Treatment, and Coverage
October 17, 2012

Today I represent the National Eating Disorders Association, having been a founding member, a longtime board member and now a senior advisor to the board. I am also a local psychologist, having specialized in the treatment of eating disorders in CT for over 3 decades. When we first started seeing girls with these problems at Newington Children's Hospital, my supervisors and mentors advised not to specialize in eating disorders, as they were just a "fad." I wish that had been true. Instead, eating disorders have become a major public health problem in the US and across the globe, although they remain largely unrecognized, misunderstood, and undertreated in the health care system. Today, minimally, a total of 30 million people suffer from anorexia nervosa, bulimia nervosa, and related eating disorders. Although 90% of these are women, these are equal opportunity diseases, occurring in every race, ethnicity, socio-economic class, and increasingly in adult women, young children, and males.

The fact is that eating disorders are the 3rd most common chronic illness among female adolescents in the US, behind asthma and diabetes. Young women who develop Anorexia Nervosa suffer a mortality rate 12 times higher than the death rate of all other causes of death. The mortality rate is 3 times greater than in depression, schizophrenia, or alcoholism. The mortality rates associated with Bulimia Nervosa and with Eating Disorders Not Otherwise Specified are unknown due to serious gaps in research, but are likely to be as high or higher, as sufferers are identified and treated later in the illness process, if at all.

Eating disorders are multidetermined conditions, and although they are classified as psychiatric, they affect every system in the body. Medical complications can occur quickly, despite long-term medical stability and normal laboratory values, and can result in sudden death. Some of the most common medical issues are:

- Cardiac- slow rate, arrhythmias, CHF, impaired structure and function, arrest
- Cognitive dysfunction affecting concentration, memory, thought processes and affect regulation; brain tissue loss
- Electrolyte imbalances
- Dehydration
- Kidney failure
- Hypothermia

- GI problems- gasteroparesis; acid indigestion; increased risk of esophageal pre-cancers, cancers; bleeding; constipation; diarrhea
- Aspiration
- Dental cavities, loss of enamel and teeth
- Compromised immune system
- Endocrine dysfunction- menstrual irregularities; decreased bone mineral density; increased risk for osteopenia and osteoporosis; fertility issues
- Musculoskeletal system- stress fractures; aches/pains; weakness
- Psychomotor slowing
- Seizures, coma, sudden death

Despite these facts, most who suffer from eating disorders are untreated or undertreated. Only one-third of people with anorexia and only 6% of those with bulimia receive mental health services. Furthermore, as many as 80% of those who access care for their eating disorders do not get the intensity of treatment they need to achieve recovery. They may not have access to specialists or to the appropriate level of care. If hospitalized, they are often sent home weeks earlier than the recommended stay. In fact, despite a strong correlation between length of stay and treatment outcome, research tells us that the length of hospitalization for eating disorders has decreased 95% since 1984. A 2009 study tells us that delayed, inadequate, and truncated care has contributed to rates of recidivism (both relapse and re-hospitalization) that range from 25-50%. Another study shows that more than half of patients with anorexia nervosa who were underweight at the time of discharge required re-hospitalization, but fewer than 10% of the patients discharged at normalized weight sought additional inpatient treatment. Both research and clinical experience tell us that specialized treatment for eating disorders is preferable and cost effective, and that recovery takes place over a long period of time.

The good news is that people can get better from eating disorders. 76% of one group studied for 10-15 years after admission met criteria for full recovery, but time to recovery ranged from 5 to 7 years. Another10% met criteria for partial recovery. Patients with bulimia nervosa demonstrate a better recovery rate if they receive treatment early in their illness. When treated within the first 5 years, the recovery rate is 80%. For those who are not treated till after 15 years of symptoms, recovery falls to 20%.

The bad news is that, without treatment, up to 20% of people with serious eating disorders die. With treatment, that number falls to 2-3%. The mortality rate increases with the duration of symptoms. Eating 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.

People suffering from these potentially life-threatening conditions need help early and often. Insurance and health maintenance organizations must provide coverage and reimbursement for the level of care the individual needs. For example, although much of recovery takes place in outpatient settings, little or limited reimbursement is available for this, so patients often get worse and need a more intense and expensive level of care, that can range as high as $2,000/day. The average cost for a month of inpatient treatment is $30,000. Many individuals with eating disorders need anywhere from 3 – 6 months of inpatient care. Treating patients in the community at an early stage of their illness not only can save lives but also saves parents from bankruptcy and insurers (and ultimately tax payers) from paying far more than they otherwise would have if the insurance companies had paid for the cost of early treatment in the community. The reality is that families are too often forced to choose between bankruptcy and their loved one's life. This is not a choice anyone should have to face.

Because I treat people with eating disorders, I have met some of the finest and most trustworthy and responsible people on this earth. But, as one mom described, when the eating disorder enters their lives, "they go dark." The problems develop due to a deep sense of personal inadequacy, so when an insurance company denies care, people suffering with eating disorders only feel worse about themselves, more worthless and hopeless, and undeserving of anything. They believe they are not "sick enough" or that their eating disorder is "not good enough" to deserve care. They often give up. Suicide is a frequent outcome of their despair. Today we have clear standards for the treatment of eating disorders provided by the American Psychiatric Association. Relative to other accepted medical interventions, the treatment of eating disorders has been shown to be cost-effective and, in fact, quite reasonable. We have more and more evidence of the effectiveness of treatment but few have access to comprehensive care.

The American people understand much of what I have said. In fact, a national study by a major global market research group commissioned by the National Eating Disorders Association found that:

* 3 out of 4 Americans believe eating disorders should be covered by insurance companies just like any other illness.

* Americans believe that government should require insurance companies to cover the treatment of eating disorders.

We need the insurance companies and the health care system to have the same common sense that the American people have. Eating disorders are not lifestyle choices- they are debilitating and life threatening illnesses. Connecticut needs to do a better job to prevent these problems,

to identify cases earlier, and to provide appropriate care to patients and families. Time is of the essence: we cannot lose another life.

*Dr. Margo Maine, cofounder of the Maine & Weinstein Specialty Group, is a clinical psychologist who has specialized in eating disorders and related issues for over 30 years. Author of :***Treatment of Eating Disorders: Bridging the Research- Practice Gap,** *co-edited withBeth McGilley and Doug Bunnell (Elsevier,2010);* ***Effective Clinical Practice in the Treatment of Eating Disorders: The Heart of the Matter,*** *co-edited with William Davis and Jane Shure (Routledge , 2009);* ***The Body Myth: Adult Women and the Pressure to Be Perfect*** *(with Joe Kelly, John Wiley, 2005);* ***Father Hunger: Fathers, Daughters and the Pursuit of Thinness*** *(Gurze, 2004); and* ***Body Wars: Making Peace With Women's Bodies*** *(Gurze, 2000), she is a senior editor of* ***Eating Disorders: The Journal of Treatment and Prevention****. Dr. Maine was a founding member and longtime board member and vice president of the Eating Disorders Coalition for Research, Policy, and Action. A Founding Member and Fellow of the Academy for Eating Disorders and a member of the Founder's Council and past president of the National Eating Disorders Association, she is a member of the psychiatry departments at the Institute of Living/Hartford Hospital's Mental Health Network and at Connecticut Children's Medical Center, having previously directed their eating disorder programs. Dr Maine is the 2007 recipient of The Lori Irving Award for Excellence in Eating Disorders Awareness and Prevention, given by the National Eating Disorders Association. She lectures nationally and internationally on topics related to the treatment and prevention of eating disorders, female development, and women's health. Dr. Maine devotes much time and energy to addressing federal policy related to eating disorders through her work for the National Eating Disorders Association and the Eating Disorders Coalition for Research, Policy, and Action, having chaired the policy section of the FREED Act (Federal Response to Eliminate Eating Disorders), which was introduced into Congress by Representative Patrick Kennedy in February, 2009 and by Senator Harkin in 2010.*

From: Sherrie Sharp
To: Veltri, Victoria
Subject: Thank you for the panel yesterday
Date: Thursday, October 18, 2012 8:12:42 AM

Dear Ms. Veltri,

Thank you very much for the opportunity to give testimony yesterday. I appreciate that you and your staff made yourselves available to hear from the community what it's like out there from the patients' and providers' points of view.

Reflecting on my testimony I realized two things: I forgot to thank the group clearly and I didn't explain one of the insurance issues well. I had cut my remarks significantly to stay within the five minute timeframe.

Towards the end I mentioned the 6-year-old boy who was on a medication for ADHD that also impacts blood pressure. His mother is an employee of the State of Connecticut. Due to non-compliance issues I wrote for a 30 day prescription. I interacted with CVS Caremark several times to get an exception to the 90 day rule. They did a couple of things that are concerning: 1) During this process they entered my 30-day prescription (with no refills) into the system as a 90 day prescription with instructions to mail out 30 days worth at a time-BUT AUTOMATICALLY. In essence they altered a physician's prescription without the authority to do so. 2) They gave this mother such a run-around that there was no way she could make good decisions about how to maintain continuous treatment. They told her multiple times that the medication was in the mail, but then when she would call back she could tell by the response the next time it had not been mailed. Also when the medication arrived the postal stamp indicated that it was much later that medication was stamped by the postal service.

The effect was that this boy went on and off his medication multiple times during the course of treatment.

The other impact that the 90 rule has in Child Psychiatry is that parents do not bring their child in monthly to be seen if they have medication at home. That makes it much more likely that they get off track and then we see the families in crisis instead of being able to prevent the crisis by seeing them more regularly. For any patient following up monthly the 90 day rule impedes care.

Again, thank you for listening. Please let me know if I can help provide clearer information to help with this issue or other issues. I appreciated being at the meeting and hearing the other testimony as well.

Sincerely,

Sherrie Sharp, MD
Child and Adolescent Psychiatrist
Child and Family Agency of Southeastern Connecticut
860-437-4550 Ext. 222

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This message has been scanned for viruses and
dangerous content by MailScanner, and is
believed to be clean.

October 17, 2012

To Whom It May Concern:

My name is Paul Rao, and I am a Yale-trained, board-certified psychiatrist who works with children, adolescents, and adults. I presently work as a child psychiatrist for DCF at Solnit Center, North Campus, a Psychiatric Residential Treatment Facility, and as a staff psychiatrist at Clifford Beers Child Guidance Clinic. I have been chief resident of the Yale-New Haven Psychiatric Hospital's adult treatment unit. I am also on the teaching faculty of the Yale School of Medicine in the Departments of Psychiatry and Yale Child Study Center.

The majority of the people I work with suffer from chronic mental illness and extreme psychosocial stressors that perpetuate the illness. Many are underserved in healthcare in general. Those families who do not meet formal federal criteria for poverty could be accurately described as "the working poor." Many of the families I see do have private insurance but face considerable barriers to obtaining appropriate care.

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.

Though these 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 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.

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

Inpatient stays now serve the purpose of brief stabilization and coordination of care such that all parties involved are unified in their goals - they set the groundwork for the necessary longer-term processes of alliance-building and treatment of the illness itself. 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.

As long as insurers are not held liable for harm that befalls a patient or family due to premature discharge, I see little motivation for insurers to change their ways.

Thank you for reading, and I hope this is useful information.

Sincerely,

Paul Rao, M.D.
Principal Psychiatrist
Department of Children and Families

Testimony for the Office of the Healthcare Advocate

October 17, 2012

Anonymous

Good morning/afternoon:

I am the parent of a 23 year old son who has been insured for many years under his father's traditional health insurance plan. Recently, our son was hospitalized for a chronic mental health condition. At the same time, the medical insurance plan at his father's workplace is changing from a traditional health plan to a high deductible health plan. Father has decided to discontinue son on the family plan due to the large open ended nature of the deductibles for the plan.

At the time of transport to the hospital, I was asked whether my son had health insurance or not. The fact that he currently has health insurance through a traditional plan meant he could go to the facility requested. Next year, without health insurance, I am not sure where my son will be able to receive emergency and stabilizing treatment, if needed.

The shift in the private insurance industry from traditional health insurance programs 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 as more employers opt to offer only a high deductible health care plan.

Please submit anonymously as I do not want difficulty.

Thank you

A serious problem with commercial insurance is that they don't endorse/ cover EDT level of care, which is approx 6 months of 5 days a week treatment,3 hours a day. EDT provides intensive group, parent, family, psychiatric, and individual therapy as needed. EDT also includes an intensive level of collaboration with school, dcf, and outside providers. EDT is an important Level of care that both prevents costly hospitalizations, sub acute placements, and partial hospital programs. Hospitalizations, residential facilities, and partial hospital programs are emotionally costly to parents and young children and financially costly for insurance companies. They often occur outside of the child's community and can be difficult transitions into and out of these programs. EDT can also serve as an essential component of a successful discharge plan from a hospitalization. The use of EDT can shorten a hospital stay and it can prevent re-hospitalization. Husky covers this service and we see huge success with this treatment.

Commercial insurance has been paying for a shortened stay and then denying further days. We have had several children who continue to need this level of care. We have been absorbing the cost due to the on going psychiatric need of these children. If effect non profits and the state are subsidizing commercial insurance in order to provide the appropriate and ethical level of care.

Stephanie Ehrman

Testimony before the Office of the Healthcare Advocate
October 17, 2012
Nikkole Emmerich, Bridgeport, CT

Good morning/afternoon. My name is Nikkole Emmerich and I am 23 years old and suffer from a psychiatric illness.

I have been on psychiatric medications for most of my life. I was on psychiatric medications that were not brand names and were expensive to pay for. I couldn't afford them. Then I was put on name brand psychiatric medications that have co-pays that I also couldn't afford. I was then put on a psychiatric medicine that was a name brand and went to fill the prescription at my local pharmacy and later went to pick up my medicine and found out that even though the medicine was a name brand my insurance wouldn't pay for it.

I have been off of psychiatric medicines for more than a year now because my insurance won't pay for most psychiatric medications that I need to be on due to my illness.

Without the psychiatric meds I can't focus on anything and my behavior is unacceptable when I am off of them. I say hurtful things to people and go into rages that I can't control.

Sometimes, it is people like me who need the insurance to pay for psychiatric medicines to help keep things under control.

Thank you for your time and thank you for listening to me talk.

Nikkole Emmerich

To: Office of the Healthcare Advocate
Public Hearing on Mental Health & Substance Use:
Access to Prevention, Treatment, & Coverage
From: Pamela G. Hine
Date: October 17th, 2012
Re: Testimony

Thank you for allowing me to speak today. I want to tell you what it has been like to try to access benefits for my son, Alex.

Alex is now 18, but he first showed atypical behaviors when he was 3. He first said he wanted "to be dead" at 6, the same age he was when he received his first psychiatric diagnosis. He was diagnosed as bipolar at 10, and by this past spring he was carrying six more labels and at various times had carried several others. He has had a very difficult life for one so young.

Alex entered a therapeutic residential school at 14, following his first hospitalization. He has been hospitalized 5 more times since. Every time I have had to tangle with Anthem over keeping him in long enough that he would be safe when released, never mind functional.

That first time, October 2008, he was released with a GAF score of 45, which as you may know indicates "Serious symptoms or impairment of functioning". Seven months later, in May 2009, he was released with a GAF of 40. If got worse every time.

The most egregious denials by Anthem were this past spring. Alex was admitted to Yale Psychiatric Hospital for 6 days in early February. When released he was still so unstable that he was unable to function in school. He came home to await an opening in a unique neuropsychological residential treatment program suggested by his school, our 1st hope in a long time. But the wait was too long.

Alex declined steadily over the next 5 weeks. There were threats of violence, holes in the walls, broken objects, and worse. This was more than living life walking on eggshells – it was more like treading lightly between closely spaced land mines.

On March 13th, in the quiet, wee hours of the morning, when he just could not take his hellish existence any longer, Alex attempted suicide – he swallowed 16,000 and 19,000mg of Tylenol, using a full bottle of Nyquil to wash it down. He chose Tylenol because he knew it couldn't be dialyzed from his blood.

For reference, taking 7,000mg puts a person at high risk of liver failure, while 10,000-12,000 is almost always fatal. I was taken aside in the ER and told that I should be prepared that Alex might well die.

Fortunately, Yale-New Haven's remarkable doctors gave him two new drugs, one experimental, and to everyone's astonishment, he not only survived, he has no liver damage. He was transferred once again to Yale Psychiatric Hospital.

Five days after his admission for the suicide attempt, when he was still suicidal and talking daily of how he was going to succeed next time, Anthem refused further treatment and said Alex should be released. I was told by multiple hospital staffers what I already knew from sad experience, that Anthem *never* allows a stay beyond 5 days – this refusal of benefits is standard procedure for Anthem in cases of psychiatric hospitalization.

We immediately appealed, and were, of course, once again denied. The supposed "Peer Review" of Alex's case trivialized his suicide attempt, portraying it as a childish gesture, the implication being that he was seeking attention. The review stated that Alex was "not actively suicidal"; when I asked about this, I was told that this indicated he had not tried to commit suicide *while in a psychiatric hospital*. This is a locked unit where patients are not even allowed to have shoe laces or go to the toilet alone, and the fact that Alex had not tried to commit suicide while under constant supervision was Anthem's reason for

saying he was ready for release. They further stated that Alex had "no suicidal ideation , harmful intent, or psychosis".

Alex's GAF at this point was a 10, meaning he was "In Persistent Danger of Severely Hurting Self or Others". The psychiatrist at Yale, Alex's own psychiatrist, and the Yale psychologist assigned to him all concurred on this score. Yet Anthem's "Findings and Recommendations / Rationale" claimed that Alex's case "does not show medical necessity" and, most unbelievable of all, "you have not harmed yourself to such a degree that has caused serious medical problems."

I find this incredible. A fleet of Yale's extraordinary doctors were able to pull off a miracle, Anthem was denying benefits apparently based of the fact that Alex managed to survive – he didn't manage to *permanently* harm himself (this time), so Anthem used that to claim he had not caused himself "serious medical problems".

Through the amazing help I received from the OHA, Anthem finally allowed Alex to enter a remarkable neuropsychiatric program in Texas. Teasing out rare neurological disorders takes time, but Meridell finally succeeded where no one else had ever been able to, and they found a frontal lobe dysfunction that explained why poor Alex had been unresponsive to 14 years of attempts to help him. Alex *finally* began to improve.

Anthem, of course immediately denied further benefits. This was *two days* after he had last voiced suicidal ideation, and tried cutting behaviors. It was before the second of the two medications needed to stabilize his newly-discovered neurological problem had even been started. This time they sent the appeal of Alex's case to one of the most notorious paid hacks in the insurance industry – Dr. Timothy Jack, of California.

If you ever have a moment, look this terrible man up on a reputable physician rating site, such as Vitals.com – he has the absolute lowest ratings possible. The comments section, limited to the last 18 months, is a litany of outrage, including eleven physicians encouraging complaints to California's medical and insurance boards. The most recent, on the 28th of last month, read: "Disgraceful. Actually appears to enjoy denying care to deserving patients. A complete sell out. Only positive I can see is that he is so blatantly incompetent and hostile that I, and many other physicians, are pursuing formal complaints with the medical board and attorney general's office." Dr. Jack's entire career appears to be denying claims for Anthem and other insurers. This is who Anthem pretends is an objective reviewer.

In Alex's case, on 5/26 – Dr. Jack wrote: "He (Alex) has had a tendency to have outbursts with suicidal behaviors, the last on 5/24. There is no report of Suicidal Ideation, Harmful Intent, or Psychosis." That's two sequential sentences that directly contradict one another. And these comments are just the beginning of a long list of distortions so massive that they are more honestly called lies. When Meridell's physician spoke with this odious, sham doctor, Dr. Jack said, and I quote (as Dr. Hageman wrote down every word) "If he (Alex) is better he should be released, and if he isn't, he needs custodial care."

Once again the OHA came to my rescue and helped me keep Alex at Meridell long enough for him to achieve enough stability that he can is now not only succeeding in school, he has straight A's and is talking about eventually going on to college in engineering, an ambition his school is encouraging.

Because the neurological problem underlying more than a decade of mental illness was finally teased out and treated, Alex is literally a new person, with real hope of a leading a good and productive life. Anthem stood in the way of every step and did everything they could to deny Alex the treatment he was fully entitled to, the treatment that made his future possible.

Does Anthem provide parity in mental health coverage? NO. Absolutely not.

On behalf of both Alex and myself, thank you for allowing me the opportunity to speak here today.

Office of the Healthcare Advocate

Public Testimony October 17, 2012

It is a shame that we have a claim submitted to Anthem BCBS for a child with a clear drug addiction/alcohol/depression problem, verified with not 1, not 2, but 4 attending physician statements, all stating that it is fully deemed medically necessary for my son to be admitted as an inpatient in order to receive the proper treatment for his disease. Instead the Anthem BCBS Ins. Co. feels they can diagnose the case without any consideration of the 4 doctor statements, who were the actual hands-on people treating the child for the disease. If someone were to come down with another disease such as diabetes would Anthem also disregard that patient's attending physician statements and determine the treatment of the condition to be not covered by the plan, even if you had 4 doctors stating it to be medically necessary. Each is a disease requiring long term treatment.

I certainly can see the public abuse in the area of alcohol/drug/mental & nervous disorders, but if the claim has been fully backed by a noted professional team showing the full necessity for the inpatient care, why isn't the claim recognized?

Thank you for your time and further thought to my claim and the many others you have received. Please advise me to your findings as soon as possible.

Vincent Mitchell

Brookfield, CT 06804

Testimony before the Office of the Healthcare Advocate
October 17, 2012
Barbara Sloan, Wallingford, CT

My name is Barbara Sloan. I am a retired mental health and addictions counselor and program manager. I have been disabled since 1994 and on Medicare since 1996. I also have a supplemental health insurance policy.

Despite this insurance coverage for mental health treatment, it is very difficult to get good treatment. When my former psychiatrist stopped accepting Medicare, I paid him a reduced out-of-pocket rate for several years until he downsized his practice. I had to find a new doctor.

Eventually, I ended up at a community mental health center because private doctors were either unavailable or wanted up-front payment that I could not afford to put out while waiting for reimbursement from Medicare.

This has not been satisfactory, since my community mental health center does not employ the specialists I need to treat Post-traumatic Stress Disorder, which is complicated by depression and several physical disorders that often cause severe pain. I have also experienced set-backs due to frequent staff turnover.

Last year, I learned of a private clinic that serves people with trauma-related mental illnesses. I started to attend this center that accepts Medicare and my supplement as full payment.

However, the reality has been that though the therapist was well trained, she had so many patients and duties that she was unable to see me on a regular basis. This is exactly the same problem I had with the community mental health center.

In both cases, every time I made progress, I became a loser: a loser of appointment times, a loser of regular treatment by the counselor I trusted and finally a loser of a counselor I knew. Starting over with a new therapist takes a lot of resources and time that could be better utilized in helping a patient make progress. It's not like getting a new dentist who starts where the former one left off.

Continuity is as vital to treatment success as access is. The "system" needs to support well-trained therapists with the time to work with their patients. Skilled therapists and doctors need to be available so that patients are not shuffled aside as soon as they feel a bit better.

It seems to be some doctors and therapists in small private practices who choose not to see patients without prepayment. Thus patients must continuously be out-of-pocket hundreds of dollars they can ill afford while waiting for Medicare and Medicaid to pay. I am not blaming these practitioners, who understandably want to maximize their own cash flow and are trying to see patients who need them. Still, it is a problem.

If these issues can be adequately addressed, patients will have better access and better continuity of care. The skills of doctors and therapists will be better utilized. Parity, in the sense of access to skilled practitioners, not just to some practitioners, will become a reality. And most importantly, patients will have a better chance at making a full recovery or at least improving their mental health.

Thank you for considering my remarks.

Barbara J. Sloan, M.Ed.
575 Pilgrim's Harbor
Wallingford, CT 06492

Testimony before the Office of the Healthcare Advocate
October 17, 2012

"Barriers I Encountered in the Mental Health System"

Good day. My name is Catherine Kriss and I am a proud member of the CHR Second Wind Clubhouse in Enfield, Connecticut. I have been registered in the mental health system since November, 2005. Many thanks, Office of the Healthcare Advocate, NAMI and Keep the Promise members, Carol McDaid and consumers, providers, advocates...for listening to me today.

I am so appreciative that we have this venue to speak on our experiences with barriers to the mental health system. In particular, I can relate two incidents painfully learned.

First, as some of you may know, I was honored to serve in the "Day In The Life" program, part of the North Central Regional Mental Health Board, from April 2008-June, 2012. I was not an original member of the Day In The Life Team, but was offered the opportunity by the Director, Judy Shaw, a few years after it started. As part of this Team, I was paid a certain sum of money periodically and this money, coupled with money earned at my part-time stipend position at the CHR Second Wind Clubhouse, eventually upset the equilibrium of my SSI and DSS Food Stamp benefits. Of course, I stayed in constant touch with the SSI and DSS workers, declaring any changes in income reported for the Day In The Life activity, but to no avail. On October 10, 2011, I received a letter from SSI stating that through a large overpayment retroactively, I owed them approximately $1,700, of which SSI was deducting $67.40 from my monthly SSI benefit check, starting in January 2012. Without that needed SSI money, I was compelled to live a different lifestyle than accustomed to. I managed to qualify for DSS Cash Assistance and receive enough money to barely meet my monthly rent and utility expenses.

As a result, I join the others out there that feel penalized for securing financial, emotional, and psychological opportunities in projects like the Day In The Life Team.. I undertook this opportunity to improve my mental health recovery, as I am chronically paranoid schizophrenic.
As I understand, I fully realize that I have not suffered as much as some disabled clients out there, but am curious as to the structure of how things work. I am cognizant that we, as disabled clients, are not supposed to benefit or capitalize from the system, but I am barely making ends meet and the cost of living is increasing...

The second barrier situation I experienced was a conflict with the DSS Food Stamp program -- the food stamp redetermination form. In specific, I dutifully completed my 2012 six-month redetermination form as requested and sent it certified mail one week before the due date. Through a problem with the Enfield Street Post Office and the Stamford Mail Distribution Center, my certified mail package became lodged in a bizarre mail loop going around in circles and had not been delivered yet as of the due date. In a panic, because I was extremely concerned and upset that my DSS food stamps would be terminated (as that rejection form is automatically generated days following non-receipt of the DSS redetermination form), I faxed a copy of my redetermination form package (27 pages) to the DSS office. At this point, I was doubly concerned because two forms existed and this would cause processing problems with my original redetermination form. In a previous instance, my redetermination form was lost and I received one of those rejection letters. Does this DSS rejection form have to be generated as early as it is? As upsetting as it is to receive it, I am hoping that it must be just as upsetting for DSS to send it out that early?
Whatever the case may be, I hope this form can be generated in a later, more accurate fashion. This action would help those of us in our thinking that we are not just numbers in the mental health system, but are worthwhile members of our communities.