



CONNECTICUT

Health Strategy

Behavioral Health Insurance Coverage and Payment
Parity in HUSKY, Private Insurance, and Medicare
Advantage
Final Report

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Acronyms

ACA	Affordable Care Act
APCD	All-Payer Claims Database
BA	Behavioral Analyst
BH APRN	Behavioral Health Advanced Practice Nurse
BHD	Behavioral Health Disorder
BH PA	Behavioral Health Physician Assistant
CHIP	Children's Health Insurance Program
CI	Commercial Insurance
CPT	Current Procedural Terminology
DMHAS	Department of Mental Health and Addiction Services
DOL	Department of Labor
ED	Emergency Department
ERISA	Employee Retirement Income Security Act of 1974
HRSA	Health Resources and Services Administration
IOP	Intensive Outpatient Program
MFT	Marriage and Family Therapist
MA	Medicare Advantage
MHD	Mental Health Disorder
MHPAEA	Mental Health Parity and Addiction Equity Act
OHS	Office of Health Strategy
PH	Partial Hospitalization
SW	Social Worker
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder

Glossary

All-Payer Claims Database (APCD): Connecticut's claims database, which includes data from HUSKY, MA, and CI issuers. The database contains medical and pharmacy claims as well as patient eligibility and provider information. The CI data include claims and eligibility data for all fully insured commercial lives (employer-sponsored small and large groups plans and individual plans purchased on the health insurance exchange – Access Health CT) and State employee/retiree self-insured plans and municipalities in the State's CT Partnership 2.0 plan. These data exclude all employer-sponsored Employee Retirement Income Security Act of 1974 (ERISA)/self-insured plans and indemnity plans.

Behavioral Health Disorder (BHD): Individuals were defined as having a behavioral health disorder if they had either a mental health disorder or a substance use disorder as defined below.

Behavioral Health Payment Parity: Behavioral health payment parity is achieved when payment for behavioral health services is comparable to payment for other medical services.

Benchmark Rates: Reimbursement rates that were constructed to use as comparison rates in the behavioral health payment parity analysis. The benchmark rates for physician-provided services were based on the 2022 Medicare Physician Fee Schedule and the benchmark rates for non-physician practitioners were calculated by computing the median reimbursement rates for each CPT code, for each provider type across the CI issuers represented in the APCD.

Current Procedural Terminology (CPT®): Numerical system developed by the American Medical Association to code medical procedures and services that patients receive. *CPT Copyright 2024 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association.*

HUSKY: Connecticut's Medicaid program.

Mental Health Disorder (MHD): The claims data were used to identify enrollees with an MHD. Enrollees were identified as having an MHD if they had one inpatient claim or at least two outpatient claims (on different days) with a primary diagnosis code for a mental health condition listed in Table 3.1 of the report. Note that the diagnoses are based on claims data and may under-represent individuals with who do not come into contact with a health care provider and have their diagnosis documented in the claims.

Mental Health Workforce Shortage Areas: Designation of a geographic area, population, or facility as having a shortage of mental health professionals. This is determined primarily by the number of health professionals relative to the population (30,000 to 1, or 20,000 to 1 if there is a high need for care in the area).

Narrow Provider Network: When insurance companies or managed care entities contract with a small number of providers; may result in having too few in-network providers to meet the demand for particular specialty service type, for example, contracting with fewer than a third of eligible clinicians or hospitals in a given geographic or service area.

Out-of-Pocket Costs: Share of health care services paid for by enrollees. This includes costs for deductibles, copayments, and coinsurance as reported in the claims data.

Reimbursement Rate: Amount paid to providers for the services and procedures they provide. For the purposes of this report, it includes the amount paid by the health insurance issuer plus any copayments, coinsurance, or deductible paid by the patient.

Rural Residence: For the purposes of this report, rural was defined as residing in either Litchfield or Windham County. All other counties are classified as urban.

Substance Use Disorder (SUD): The claims data were used to identify enrollees with an SUD. Enrollees were identified as having an SUD if they had one inpatient claim or at least two outpatient claims (on different days) with a primary diagnosis code for alcohol use disorder or a drug use disorder or having one or more claims for medication treatment for alcohol or opioid use disorder. Note that the diagnoses are based on claims data and may under-represent individuals with who do not come into contact with a health care provider and have their diagnosis documented in the claims.

EXECUTIVE SUMMARY

In 2022, the Connecticut legislature authorized a study of (1) the rates at which health carriers in the State reimburse health care providers for covered physical, mental, and behavioral health benefits, and (2) whether payment parity exists between:

- providers of behavioral and mental health services and providers of other medical services in the private insurance market,
- providers of behavioral and mental health services and providers of other medical services within the HUSKY Health program (Connecticut’s Medicaid program), and
- providers of behavioral and mental health services in the HUSKY Health program and their counterparts in the private insurance market (Public Act 22-47 §§ 57-58).

This report summarizes the findings from the study, presenting comparisons of 2022 behavioral health reimbursement rates in HUSKY, private insurance (referred to as commercial insurance (CI) in this report),¹ and Medicare Advantage (MA); and analyses of behavioral health payment parity (1) within HUSKY, within CI issuers, and within MA and (2) between HUSKY, CI, and MA. Additionally, the study examined behavioral health service use among individuals with a mental health disorder (MHD) and individuals with substance use disorder (SUD), collectively referred to as any behavioral health disorder (BHD); financial drivers of behavioral health service use; and the financial impact of behavioral health treatment across HUSKY, CI, and MA (for select analyses). The analyses used claims data from the 2022 Connecticut All-Payer Claims Database (APCD). This Executive Summary summarizes the key findings from the analyses.

Behavioral Health Reimbursement Rates in HUSKY, CI, and MA

The reimbursement rate analysis compared reimbursement rates for common outpatient behavioral health services between CI, HUSKY, and MA to examine the extent to which 2022 behavioral health reimbursement rates vary across Connecticut payers.

- HUSKY and MA reimbursement rates were lower than CI reimbursement rates for many common behavioral health services, such as psychiatric diagnostic evaluation and psychotherapy.

¹ The CI data include claims and eligibility data for all fully insured commercial lives (employer-sponsored small and large groups plans and individual plans purchased on the health insurance exchange – Access Health CT) and State employee/retiree self-insured plans and municipalities in the State’s CT Partnership 2.0 plan. These data exclude all employer-sponsored Employee Retirement Income Security Act of 1974 (ERISA)/self-insured plans and indemnity plans.

- A notable exception was that HUSKY paid comparable rates to CI for 60-minute psychotherapy sessions.
- The largest discrepancy in behavioral health reimbursement rates between HUSKY and CI was for established patient office visits by psychiatrists and behavioral health advanced practice nurses (BH APRNs) and behavioral health physician assistants (BH PAs). HUSKY rates for 20-29-minute office visits and 30-39-minute office visits were 49% and 47%, respectively, of the CI rates for psychiatrists. HUSKY rates for 20-29-minute office visits and 30-39-minute office visits were 67% and 56%, respectively, of the CI rates for BH APRNs and PAs.

Behavioral Health Payment Parity

The Mental Health Parity and Addiction Equity Act (MHPAEA), as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), requires that impacted health insurance issuers ensure that the financial requirements, quantitative treatment limits, and non-quantitative treatment limits on mental health and substance use disorder benefits be no more restrictive than those applied to medical and surgical benefits. Examining payment parity addresses compliance with the MHPAEA financial requirements. The payment parity analysis conducted for this study compared reimbursement rates for behavioral health and other medical services against benchmark rates established for this study. The analysis also evaluated whether behavioral health rates were systematically lower than their corresponding benchmark rates as compared to how close reimbursement rates for medical services were to their respective benchmark rates.² The payment parity analysis is not determinative of a parity violation but is intended to highlight potential patterns of reimbursement that may warrant further scrutiny. The results on their own, do not constitute non-compliance with mental health parity regarding payment parity.³

- Reimbursement rates in HUSKY were lower than established benchmark comparison rates across all behavioral health and other medical services included in the parity analysis. However, there was no disparity between the rates for behavioral health and other medical services in HUSKY, that is, HUSKY paid comparably low rates for both behavioral health and other medical services.

² US Department of Labor. (2020). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)*.

³ The Connecticut Insurance Department's Market Conduct Division performs an annual survey and analysis of health carrier's mental health parity compliance, including but not limited to reimbursement parity. These findings are published annually and reported to our legislature. The latest report issued in 2024 for calendar year 2023 is located here: <https://portal.ct.gov/cid/-/media/cid/reports/nonquantitative-treatment-report/2024-nonquantitativetreatmentlimitationreport.pdf>.

- Several ratios for MA psychiatrists were lower than the ratios for the other physician specialties. These findings suggest that physician-provided behavioral health services are not in parity with other physician-provided services in MA.
- Four CI issuers—Anthem, Cigna, ConnectiCare, and United Healthcare—had evidence of disparities between their behavioral health and other medical service rates based on within-issuer comparisons of behavioral health and medical service rates against established benchmark rates. Their rates for other medical services were near or above the established benchmark rates, whereas several of their behavioral health rates were lower than the benchmark rates.

Behavioral Health Service Use

The service use analysis investigated the types of behavioral health care provided in HUSKY, CI, and MA and how service use varied by enrollee demographic characteristics in HUSKY and CI.

- Use of outpatient behavioral health services⁴ among individuals with MHD was high in both HUSKY (79%) and CI (77%). However, it was considerably lower in MA (54%).
- Inpatient hospitalization and emergency department (ED) use were higher in HUSKY than in CI and MA: 7% of HUSKY enrollees with MHD had an inpatient hospitalization compared to 2% of CI enrollees; 12% of HUSKY enrollees with MHD had an ED visit compared to 3% of CI enrollees. Over one-quarter (28%) of HUSKY enrollees with SUD had a behavioral health-related ED visit compared to 18% of CI enrollees with SUD.

⁴ Outpatient services included: office-base care, psychotherapy, care coordination, evaluation, home-based care, intensive outpatient/partial hospitalization, SUD treatment including medication treatment for alcohol or opioid use disorder, telehealth, hypnotherapy, and electric shock therapy.

Figure ES.1. Percentage of Enrollees with MHD Who Received Any Behavioral Health Treatment by Insurance Type

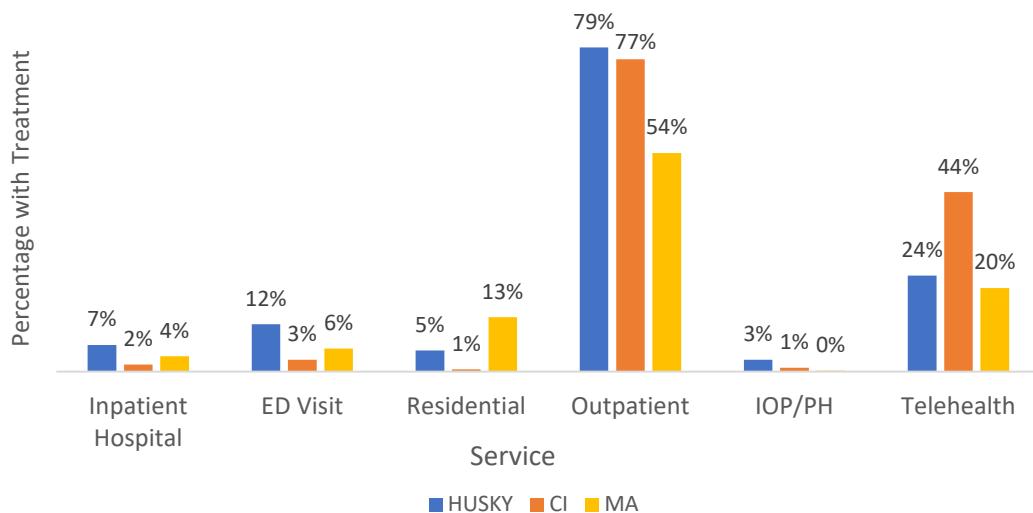
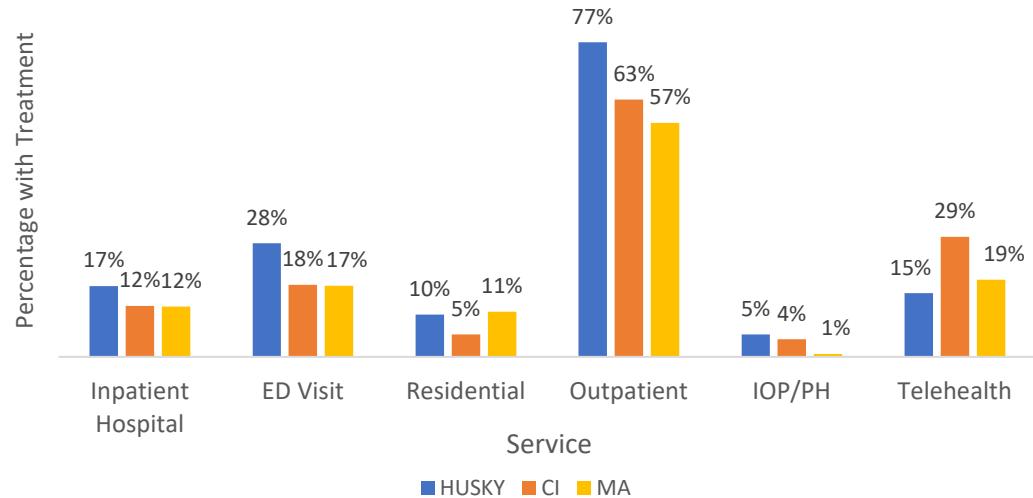


Figure ES.2. Percentage of Enrollees with SUD Who Received Any Behavioral Health Treatment by Insurance Type



- Youth ages birth to 19 with MHD in both HUSKY (83%) and CI (82%) had high rates of outpatient service use. However, just over half of youth with SUD in HUSKY and CI (59% in both groups) had outpatient service use, as represented in the claims. It may be the case that they received SUD services paid through some other source.

- In HUSKY, males with MHD were more likely than females to have inpatient hospitalizations (9% versus 5%) and ED visits (14% versus 10%).
- There were no notable differences in service utilization in counties defined as rural (Litchfield and Windham) compared to the other counties in the State.

Follow-up Services after an ED Visit or Inpatient Hospitalization Due to an MHD or SUD

In addition to the overall service use analysis, we examined rates of receiving outpatient follow-up care after an inpatient hospitalization or ED use for MHD or SUD.

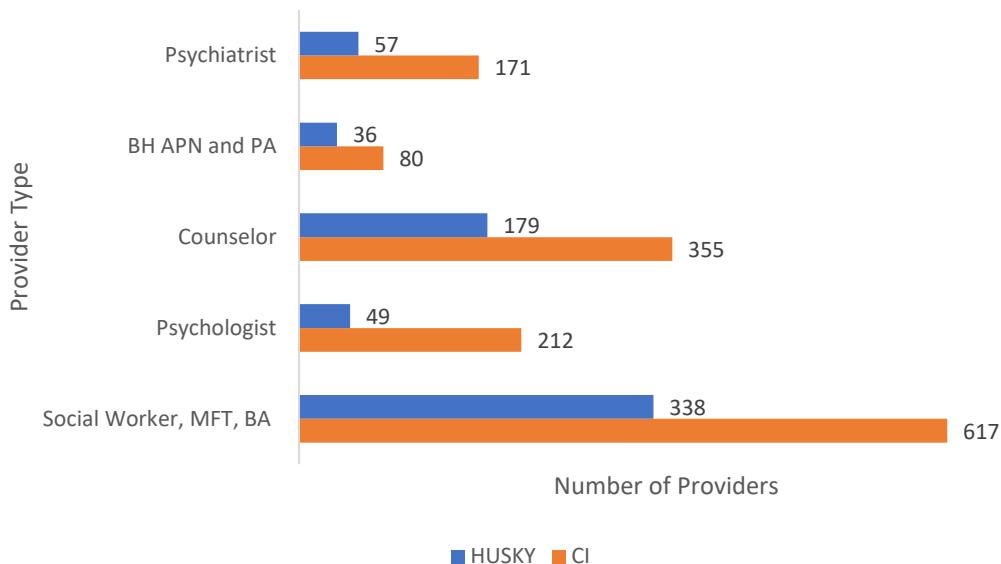
- Among youth ages 6 to 19, 30-day follow-up rates after both inpatient hospitalizations and ED visits for MHD were similarly high in HUSKY and CI, at around 80%.
- The patterns for follow-up care after inpatient hospitalization or ED use for SUD were more varied for youth. In CI, nearly all youth (96%) received a follow-up visit after hospitalization for SUD, whereas approximately one-third (32%) received a follow-up visit after an ED visit for SUD. In HUSKY, 66% had a follow-up visit within 30 days of hospitalization and half (51%) had a follow-up within 30 days following an ED visit.
- Among those ages 20 years and over, follow-up rates after an inpatient hospitalization for MHD were higher for CI enrollees compared to HUSKY and MA enrollees after both 7 and 30 days: 7-day follow-up rates were 58% in CI, 49% in HUSKY, and 43% in MA; 30-day follow-up rates were 81% in CI, 72% in HUSKY, and 68% in MA. This trend was the same for follow-up after hospitalization for SUD.
- Follow-up rates after an ED visit for MHD were higher for adult CI enrollees (70%) compared to HUSKY (63%) and the same for MA enrollees (70%). However, follow-up rates after an ED visit for SUD were higher for HUSKY enrollees (49%) compared to CI (43%) and MA enrollees (48%).

Provider Supply in HUSKY and CI

To better understand behavioral health workforce issues, we compared the number of behavioral health providers in CI and HUSKY as well as provider service volumes for common behavioral health provider types.

- There were significantly fewer behavioral health providers who saw HUSKY enrollees compared to the number who saw CI enrollees, particularly psychiatrists and psychologists.
- Despite there being fewer available providers in HUSKY, HUSKY enrollees with a BHD received a comparable volume of behavioral health services compared to CI enrollees; however, their care was concentrated among fewer providers.

Figure ES.3. Number of Providers per 100,000 Enrollees in HUSKY and CI



Financial Drivers of Service Use

To explore potential financial levers that could be used to expand access to behavioral health care, we examined (1) whether higher reimbursement rates for specific psychotherapy services were associated with greater use of these services in HUSKY compared to PI and (2) whether higher out-of-pocket costs were associated with lower behavioral health service use in CI.

- Over 80% of psychotherapy claims in HUSKY were for 60-minute psychotherapy, whereas approximately 20% of psychotherapy claims were for 45-minute or 30-minute psychotherapy. The higher use of 60-minute psychotherapy in HUSKY may signal that the competitive reimbursement rate for 60-minute psychotherapy in HUSKY (compared to CI) may be driving up use of this service, while the low utilization rates for 30- and 45-minute psychotherapy deter use of these services.
- Among CI enrollees with MHD who paid any out-of-pocket costs, those with higher average out-of-pocket costs per visit for outpatient behavioral health visits had a lower average number of outpatient behavioral health visits. This shows a negative association between out-of-pocket costs and number of behavioral health visits, however, it may be explained by how out-of-pocket costs are applied: as enrollees meet their deductibles, and their out-of-pocket costs are spread across more visits, the average per-visit out-of-pocket cost across all visits is lower.

Financial Impact of Behavioral Health Treatment

The final analyses estimated (1) the potential financial impact of increasing HUSKY reimbursement rates for common behavioral health services to better align with the benchmark rates established for the payment parity analysis and (2) examined whether spending for outpatient behavioral health treatment offset other short-term health care costs, focusing on ED visits.

- Focusing on increasing rates for the services with the largest discrepancies between the HUSKY rates and the benchmarks (i.e., office visits by psychiatrists, APRNs, and PAs) would cost an estimated additional \$7,568,712. This represents a 5.2% increase in total 2022 spending for the behavioral health services included in the analysis.
- While no cost-offsets were observed for enrollees with MHD, among HUSKY and CI enrollees with SUD, those with a higher number of outpatient behavioral health visits had lower total all cause ED costs per enrollee. However, any overall cost savings were offset by the cost of the outpatient behavioral health care. The cost-offset literature suggests cost savings from behavioral health treatment can take up to three years to achieve, a finding that would not be captured in our six-month cost-savings analysis.

Study Limitations

Several limitations to these analyses should be acknowledged.

- The analytic results presented here are based solely on medical claims data from the APCD. The APCD does not include self-insured claims. Other sources of State funding that supplement public and private insurance payments—for example, grant funds provided through the Department of Mental Health and Addiction Services (DMHAS)—are not represented in the APCD and are not accounted for in the analyses.
- The Payment Parity Analysis does not include payments for behavioral health services billed by facilities, although the individually-billed services could have been provided in facilities such as outpatient behavioral health clinics, nor does it include other sources of State funding for behavioral health services, for example State-operated behavioral health services including inpatient, outpatient, clinics, mobile crisis, and grant funds provided through DMHAS.
- Because of the complex funding for facility-based behavioral health services, the analyses focused on professional medical claims (claims billed by individual doctors or other practitioners). Therefore, the Reimbursement Rate Analysis and the Payment Parity Analysis are relevant to professional claim payments to practitioners. This would include

some services provided in facilities and billed by individual practitioners, but does not include payments billed by facilities or licensed behavioral health clinics.

Recommendations for Consideration

This study involved a detailed analysis of behavioral health reimbursement rates and payment parity using 2022 claims data from HUSKY, CI, and MA, as well as an examination of service use, provider supply, and financial factors related to spending for behavioral health care. Based on the findings from these analyses, the list below contains recommendations for the State's consideration.

- Examine HUSKY reimbursement rates for behavioral health services in relation to Medicare fee-for-service rates and median CI rates, prioritizing the services with the largest discrepancies between HUSKY and CI, i.e., established patient office visits by psychiatrists and behavioral health advanced practice nurses (BH APRNs) and behavioral health physician assistants (BH PAs).
- Conduct a closer examination the four CI issuers identified in the Payment Parity Analysis as having reimbursement rates suggestive of parity concerns.
- Expand the types of providers who can enroll in HUSKY and bill directly for services, in particular consider enrolling peer support specialists in HUSKY.
- Further examine access to services for youth with SUD to determine if there are access problems or if SUD services are available, but funded through other services.
- Monitor behavioral health service use in MA and consider avenues to improve access to care for MA enrollees.
- Consider follow-up analysis of costs and utilization of services not addressed in this study, e.g., access to telehealth and inpatient psychiatric hospitalization.
- Improve data collection for services offered at behavioral health facilities.

1 INTRODUCTION

In 2022, Connecticut passed Public Act 22-47, “An Act Concerning Children’s Mental Health,” which included several provisions to promote access to mental health treatment and address shortages in the supply of mental health professionals, provided funds to support grant programs to enhance mental health care access in schools. The Act authorized the Connecticut Office of Health Strategy (OHS) to conduct a study of (1) the rates at which health carriers in the State reimburse health care providers for covered physical, mental, and behavioral health benefits, and (2) whether payment parity exists between:

- providers of behavioral and mental health services and providers of other medical services in the private insurance market,
- providers of behavioral and mental health services and providers of other medical services within the HUSKY Health program (Connecticut’s Medicaid program), and
- providers of behavioral and mental health services in the HUSKY Health program and their counterparts in the private insurance market (Public Act 22-47 §§ 57-58).

This report was undertaken on behalf of OHS and presents the findings from these two studies.

Mental health disorders (MHDs) and substance use disorders (SUDs), collectively referred to as behavioral health disorders (BHD), have become more prevalent in recent years, highlighting the need for comprehensive and affordable behavioral health treatment. In Connecticut, an estimated 573,000 individuals ages 18 years or older (~20% of that age group) experienced an MHD in 2021 and an estimated 489,000 individuals ages 12 years or older had an SUD. Drug overdoses in the State also increased from 11.2 to 42.3 per 100,000 from 2011 to 2021, markedly higher than the national average of 32.4 per 100,000.⁵ An environmental scan completed in support of these studies found that increased demand for behavioral health care puts more pressure on providers and contributes to behavioral health care workforce shortages. As of June 2023, 1.54 million people lived in mental health workforce shortage areas in the State.⁶ A 2019 survey by the Connecticut Psychological Association also reported declines in psychologist

⁵ SAMHSA. (2022). *2021 National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia.)*

<https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf>

⁶ Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U. S. D. of H. and H. S. (2023). *Designated Health Professional Shortage Areas Statistics Third Quarter of Fiscal 2023 Designated HPSA Quarterly Summary as of June 30, 2023.*

participation in certain insurance types.⁷ Low reimbursement rates have commonly been cited as a main reason for declining participation. For example, a 2024 report by the Connecticut Department of Social Services found that HUSKY reimbursement rates for behavioral health services were lower than Medicare fee-for-service rates.⁸ Low reimbursement rates may cause fewer providers to accept insurance, exacerbating the workforce shortages and further limiting access to behavioral health care.^{9, 10}

This report uses 2022 claims and enrollment data from the Connecticut All-Payer Claims Database (APCD) to investigate disparities in behavioral health reimbursement rates between public and commercial payers and between behavioral health and other medical services within the same payer. Other medical services include services such as office visits with non-behavioral health providers and physical and occupational therapy services. The report also explores behavioral health service utilization in the State, examines financial drivers of behavioral health service use, and estimates the potential financial impact of increasing behavioral health care reimbursement rates in the State. The descriptive analyses are based on hundreds of thousands of claim records, which yields very large statistical power, such that very small differences are highly statistically significant using standard statistical methodology. Any observed differences can be taken at face value, as there is little margin of error when analyzing the universe of claims (rather than a sample of claims). The results of the analyses should be interpreted from the standpoint of clinical or practical significance, rather than statistical significance.

2 BEHAVIORAL HEALTH REIMBURSEMENT RATES

National data show that provider participation in insurance, particularly among behavioral health providers, has declined in recent years, and that these declines are especially pronounced in Medicaid.^{11, 12} Recent studies also have found that behavioral health provider networks have become more “narrow,” i.e., do not contain enough providers, resulting in a higher proportion of behavioral health services being accessed out-of-network, where enrollees typically pay a larger

⁷ Souter, C. R. (2020, February 5). Are more psychologists serving only self-pay patients? Difficulties with insurance companies highlighted. *New England Psychologist*. <https://www.nepsy.com/articles/leading-stories/are-more-psychologists-serving-only-self-pay-patients-difficulties-with-insurance-companies-highlighted/>

⁸ Connecticut Department of Social Services. (2024). *Phase 1 Report: Studies of Medicaid Rates of Reimbursement*. <https://s3.documentcloud.org/documents/24421604/ct-medicaid-rate-study-phase-1-final-report-february-2024.pdf>

⁹ Benson, N. M. et al. (2020). Psychiatrist participation in private health insurance markets: Paucity in the land of plenty. *Psychiatric Services*. <https://doi.org/10.1176/appi.ps.202000022>

¹⁰ National Council for Behavioral Health. (2017). The Psychiatric Shortage: Causes and Solutions. *National Council for Behavioral Health*.

¹¹ Bishop, T. F. et al. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry*. <https://doi.org/10.1001/jamapsychiatry.2013.2862>

¹² Wen, H. et al. (2019). Medicaid Acceptance by Psychiatrists Before and After Medicaid Expansion. *JAMA Psychiatry*, 76(9), 981–983. <https://doi.org/10.1001/jamapsychiatry.2019.0958>

portion of the cost of care.^{13, 14} These trends in provider participation make behavioral health care harder to access and less affordable.

One of the most commonly cited reasons for these declines in participation is low reimbursement rates for behavioral health services. The literature has documented significant disparities in reimbursement rates for (1) behavioral health services between different insurance types, i.e., between Medicaid and CI; and (2) similar types of services provided by behavioral health providers compared to other medical service providers, e.g., for office visits or evaluation and management services paid to psychiatrists versus other health care specialists.^{15, 16, 17, 18, 19, 20} These disparities persist despite passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), which requires individual and most group health insurance plans that offer coverage for mental health conditions or SUDs to make these benefits comparable to medical and surgical benefits; and the Affordable Care Act (ACA), which extended parity requirements to Medicaid Alternative Benefit Plans and the Children's Health Insurance Program (CHIP).^{21, 22}

This section of the report examines these two issues. Section 2.1 compares reimbursement rates for common outpatient behavioral health services between CI, HUSKY, and Medicare Advantage (MA) to see the extent to which 2022 behavioral health reimbursement rates vary across Connecticut payers. Section 2.2 evaluates compliance with the financial requirements of the MHPAEA by comparing reimbursement rates between behavioral health services and other medical services within HUSKY and MA and for CI issuers. Medicare is not subject to the federal parity requirements; however, we include MA in the analysis for comparison purposes.

¹³ Melek, S. P. et al. (2017). *Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates; A quantitative approach to investigating nonquantitative treatment* (Issue December).

¹⁴ Zhu, J. M. et al. (2023). Psychiatrist Networks In Medicare Advantage Plans Are Substantially Narrower Than In Medicaid And ACA Markets. *Health Affairs (Project Hope)*. <https://doi.org/10.1377/hlthaff.2022.01547>

¹⁵ Mark, T. L. et al. (2020). Comparison of Medicaid reimbursements for psychiatrists and primary care physicians. *Psychiatric Services*. <https://doi.org/10.1176/appi.ps.202000062>

¹⁶ United States Government Accountability Office. (2014). *Medicaid Payment: Comparisons of Selected Services under Fee-for-Service, Managed Care, and Private Insurance*. July, 32. <http://www.gao.gov/assets/670/664782.pdf>

¹⁷ Zhu, J. M. et al. (2023). Medicaid Reimbursement For Psychiatric Services: Comparisons Across States And With Medicare. *Health Affairs*, 42(4), 556–565. <https://doi.org/10.1377/hlthaff.2022.00805>

¹⁸ Zuckerman, S. et al. (2021). Medicaid physician fees remained substantially below fees paid by Medicare in 2019. *Health Affairs*. <https://doi.org/10.1377/hlthaff.2020.00611>

¹⁹ Zuckerman, S. et al. (2004). Changes in Medicaid physician fees, 1998-2003: Implications for physician participation. *Health Affairs*. <https://doi.org/10.1377/hlthaff.W4.374>

²⁰ Melek, S. P. et al. (2017). *Addiction and mental health vs. physical health: Analyzing disparities in network use and provider reimbursement rates; A quantitative approach to investigating nonquantitative treatment* (Issue December).

²¹ www.congress.gov/110/plaws/publ343/PLAW-110publ343.pdf

²² <https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of>

2.1 Reimbursement Rates for Outpatient Behavioral Health Services

Reimbursement rates²³ were constructed using the 2022 APCD, which includes CI,²⁴ HUSKY, and MA enrollees based on individually-billed services (i.e., on professional medical claims). The analysis does not include payments for behavioral health services billed by facilities, although, the individually-billed services could have been provided in facilities such as outpatient behavioral health clinics. Behavioral health services were identified using Current Procedural Terminology (CPT) codes for office visits, psychiatric diagnostic evaluation, and psychotherapy sessions performed by practitioners directly billing CI, HUSKY, or MA. Appendix A lists and defines the specific CPT codes used in the analysis. Services were classified as behavioral health based on the CPT codes for specific behavioral health services (psychiatric diagnostic evaluation or psychotherapy) or if they were provided by a behavioral health specialist, including psychiatrists, behavioral health advanced practice nurses (BH APRNs), behavioral health physician assistants (BH PAs), psychologists, social workers (SWs), marriage and family therapist (MFTs), behavioral analysts (BAs), and counselors. Table 2.1 compares median reimbursement rates for several common behavioral health services between CI, HUSKY, and MA. It also includes HUSKY and MA rates as a percentage of the CI rate.

CI reimbursement rates were higher for nearly all of the common behavioral health services compared to HUSKY. One notable exception was 60-minute psychotherapy by non-physician providers, where HUSKY had comparable rates to CI. The most extreme discrepancies between CI and HUSKY were for established patient office visits performed by psychiatrists, APRNs, and PAs, where the HUSKY rates were less than 70% of the CI rates. The lowest rates for established patient office visits were for psychiatrists for 20-to-29- and 30-to-39-minute office visits, where rates were 47% and 49% of CI rates, respectively. Group psychotherapy rates were also consistently low for HUSKY compared to CI; with the exception of BH APRNs and BH PAs, all provider types had HUSKY rates that were lower than 60% (ranging from 53% to 57%) of the CI rates. Rates were closer for psychiatric diagnostic evaluation, where HUSKY rates ranged from 84% (for psychiatrists) to 97% (for psychologists) of CI rates. The largest discrepancies between MA and CI rates were for family and group psychotherapy, where several of the provider types had MA rates that were lower than 70% of the CI rates.

²³ The reimbursement rates represent the median amount paid to the provider for the service, which includes the amount paid by the insurance company plus deductible, copay, and coinsurance amounts, if applicable.

²⁴ The CI data include claims and eligibility data for all fully insured commercial lives (employer-sponsored small and large groups plans and individual plans purchased on the health insurance exchange – Access Health CT), and state employee/retiree self-insured plans and municipalities in the state's CT Partnership 2.0 plan. These data exclude all employer-sponsored ERISA/self-insured plans and indemnity plans.

Table 2.1 Median Reimbursement Rates for Common Behavioral Health Services in CI, HUSKY, and MA, 2022

Behavioral Health Service	Type of Provider	Reimbursement Rate			Percentage of HUSKY Rate to CI Rate	Percentage of MA Rate to CI Rate
		CI	HUSKY	MA		
20-to-29-minute office visit	BH APRN and PA	\$58	\$39	\$60	67%	104%
	Psychiatrist	\$88	\$43	\$79	49%	90%
30-to-39-minute office visit	BH APRN and PA	\$105	\$58	\$63	56%	61%
	Psychiatrist	\$138	\$65	\$136	47%	98%
Family psychotherapy	BH APRN and PA	\$105	\$99	\$85	94%	81%
	Counselor	\$96	\$80	\$66	83%	69%
	Psychiatrist	\$173	\$117	\$96	67%	56%
	Psychologist	\$105	\$97	\$104	93%	99%
	SW, MFT, BA	\$96	\$80	\$80	83%	84%
Group psychotherapy	BH APRN and PA	\$40	\$31	\$43	77%	108%
	Counselor	\$44	\$25	\$29	56%	65%
	Psychiatrist	\$60	\$34	\$49	57%	82%
	Psychologist	\$46	\$24	\$29	53%	62%
	SW, MFT, BA	\$44	\$24	\$40	55%	91%
Psychiatric diagnostic evaluation	BH APRN and PA	\$148	\$133	\$111	90%	75%
	Counselor	\$125	\$107	\$120	86%	95%
	Psychiatrist	\$164	\$138	\$153	84%	93%
	Psychologist	\$134	\$130	\$121	97%	90%
	SW, MFT, BA	\$125	\$107	\$113	86%	90%
30-minute psychotherapy	BH APRN and PA	\$67	\$48	\$38	71%	56%
	Counselor	\$55	\$45	\$62	81%	112%
	Psychiatrist	\$90	\$70	\$66	78%	73%
	Psychologist	\$65	\$54	\$50	83%	77%
	SW, MFT, BA	\$55	\$45	\$49	81%	90%
45-minute psychotherapy	BH APRN and PA	\$84	\$81	\$80	97%	95%
	Counselor	\$81	\$66	\$74	81%	91%
	Psychiatrist	\$119	\$90	\$100	76%	84%
	Psychologist	\$95	\$80	\$83	84%	88%
	SW, MFT, BA	\$81	\$66	\$74	81%	91%
60-minute psychotherapy	BH APRN and PA	\$104	\$122	\$126	117%	121%
	Counselor	\$98	\$98	\$117	101%	119%
	Psychiatrist	\$139	\$135	\$126	98%	91%
	Psychologist	\$107	\$120	\$136	112%	127%
	SW, MFT, BA	\$98	\$98	\$100	101%	102%

2.2 Behavioral Health Payment Parity with Other Medical Services

The MHPAEA, as amended by the Affordable Care Act, requires that impacted health insurance issuers ensure that the financial requirements, quantitative treatment limits, and non-quantitative treatment limits on mental health and substance use disorder benefits be no more restrictive than those applied to medical and surgical benefits. Examining reimbursement rates addresses compliance with the MHPAEA financial requirements. The United States Department of Labor (U.S. DOL) Payment Parity Warning Signs Analysis methodology²⁵ evaluates behavioral health payment parity for health insurance issuers. The analysis compares reimbursement rates for behavioral health and other medical services against benchmark rates and evaluates whether behavioral health rates are systematically lower than their corresponding benchmark rates as compared to how close reimbursement rates for other medical services are to their respective benchmark rates.²⁶

This section of the report provides a high-level description of the Warning Signs methodology and a summary of the payment parity analysis results for HUSKY, MA, and the seven CI issuers that were represented in the 2022 APCD. A more detailed description of the methodology and results can be found in Appendix A.

At a high level, the Warning Signs methodology:

1. Calculates reimbursement rates for a set of behavioral health and other medical services for a given issuer.
2. Creates benchmark rates to use as comparison rates for each calculated reimbursement rate.
3. Computes the ratio of each reimbursement rate (from Step 1) to its respective benchmark rate (from Step 2).
4. Reviews the ratios to see whether they are consistent across behavioral health services and other medical services. Higher ratios (above 100) indicate that the issuer pays a higher rate relative to the benchmark; lower ratios (below 100) indicate rates that are lower than the benchmark. A preponderance of ratios for behavioral health services that are lower (relative to their benchmarks) than the ratios for other medical services suggests potential parity concerns.

²⁵ The Provider Reimbursement Rate Warning Sign analysis methodology, as specified in the DOL Parity Self-Compliance Tool (DOL Tool): <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>.

²⁶ US Department of Labor. (2020). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MPHAEA)*.

The results of the analysis are summarized below. As described above, the Warning Signs analysis results are interpreted subjectively based on looking at the overall pattern of ratios across the range of behavioral health and other medical services included in the analyses. The DOL does not give specific guidance on using the Warning Signs results to make compliance determinations, as they are intended to highlight potential patterns of reimbursement rates that may be problematic and warrant further scrutiny, hence the name “Warning Signs.” The results on their own do not constitute non-compliance with mental health parity regarding payment parity.²⁷

HUSKY. The analysis showed that HUSKY reimbursement rates were lower than the benchmark rates across all behavioral health and other medical services and all provider types included in the analysis. However, HUSKY reimbursement rates for other medical services were lower relative to their respective benchmark rates than HUSKY rates for behavioral health services. While the lower reimbursement rates across all services may be cause for concern, there is no specific concern regarding behavioral health payment parity in HUSKY.

MA. Several ratios for MA psychiatrists were lower than the ratios for the other physician specialties, including 20-29-minute office visits, psychiatric diagnostic evaluation, and 60-minute psychotherapy. These findings suggest that physician-provided behavioral health services are not in parity with other physician-provided services in MA.

CI. The CI analysis included seven issuers that were represented in the 2022 APCD. Three of the seven issuers in the State had rates that were near their benchmark or higher for nearly all behavioral health and other medical services. The behavioral health services from these issuers had ratios that were in a similar range as the ratios for other medical services. There are no parity concerns for these issuers. These issuers included Aetna, Harvard Pilgrim Health Care, and Tufts Health Plan. Four issuers had a preponderance of ratios for behavioral health services that were lower than the benchmark, including several that were less than 90 percent of the benchmark. In contrast, most ratios for other medical services were near or above the benchmark. These four issuers included Anthem, Cigna, ConnectiCare, and United HealthCare.

²⁷ The Connecticut Insurance Department’s Market Conduct Division performs an annual survey and analysis of health carrier’s mental health parity compliance, including but not limited to reimbursement parity. These findings are published annually and reported to our legislature. The latest report issued in 2024 for calendar year 2023 is located here: <https://portal.ct.gov/cid/-/media/cid/reports/nonquantitative-treatment-report/2024-nonquantitativetreatmentlimitationreport.pdf>.

3 BEHAVIORAL HEALTH SERVICE USE

Increases in the rates of BHDs, especially among children, have resulted in increased demand for behavioral health treatment.^{28, 29, 30} However, several factors can affect a patient's ability to access care, including an inadequate supply of providers and high out-of-pocket costs for care. In some cases, patients do not receive the care they need and their behavioral health conditions go untreated.^{31, 32} Nationally, behavioral health service use has been found to vary significantly across insurance types, demographic groups, and geographic areas.^{33, 34, 35, 36} The analyses in this section investigate the types of behavioral health care being provided and how care is distributed across individuals based on insurance type (HUSKY, CI, MA), enrollee demographics such as age (birth to 19, 20-64, and 65+) and sex (male, female), and geography (urban, rural).³⁷ Understanding how patients currently use behavioral health services provides a basis on which additional investigations and analysis can be performed to identify potential areas of focus to improve access to care. Section 3.1 examines enrollee use of behavioral health services by service type, insurance type, and enrollee demographic characteristics. Section 3.2 presents the results of analyzing care use patterns following an emergency department (ED) visit or inpatient hospitalization related to a BHD. Finally, Section 3.3 examines the supply of behavioral health service providers as well as provider service volumes.

²⁸ Leeb, R. T. et al. (2020). *Emergency Department Visits Among Children Aged <18 Years During the COVID-19 Pandemic - United States, January 1-October 17, 2020*. <https://www.cdc.gov/mmwr/volumes/69/wr/mm6945a3.htm#suggestedcitation>

²⁹ SAMHSA. (2022). *2021 National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia.)* <https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf>

³⁰ Theberath, M. et al. (2022). Effects of COVID-19 pandemic on mental health of children and adolescents: A systematic review of survey studies. In *SAGE Open Medicine*. <https://doi.org/10.1177/20503121221086712>

³¹ Conroy, J. et al. (2020). Why People Aren't Getting the Care they Need. *Monitor on Psychology*, 51(5). <https://www.apa.org/monitor/2020/07/datapoint-care>

³² SAMHSA. (2022). *Key Substance Use and Mental Health Indicators in the United States: Results from the 2021 National Survey on Drug Use and Health*. <https://www.samhsa.gov/data/sites/default/files/reports/rpt39443/2021NSDUHFFRRev010323.pdf#page=65&zoom=100,0,602>

³³ Morales, D. A. et al. (2020). A call to action to address rural mental health disparities. *Journal of Clinical and Translational Science*, 4, 463–467. <https://doi.org/10.1017/cts.2020.42>

³⁴ Panchal, N. et al. (2022). *How Does Use of Mental Health Care Vary by Demographics and Health Insurance Coverage?* Kaiser Family Foundation. <https://www.kff.org/mental-health/issue-brief/how-does-use-of-mental-health-care-vary-by-demographics-and-health-insurance-coverage/>

³⁵ Rapfogel, N. (2022). *The Behavioral Health Care Affordability Problem*.

<https://www.americanprogress.org/article/the-behavioral-health-care-affordability-problem/>

³⁶ Walker, E. R. et al. (2015). Insurance status, use of mental health services, and unmet need for mental health care in the United States. *Psychiatric Services (Washington, D.C.)*, 66(6), 578. <https://doi.org/10.1176/APPI.PS.201400248>

³⁷ Rural was defined as residing in either Litchfield or Windham county. All other counties are classified as urban.

3.1 Service Use by Insurance Type

This analysis used 2022 APCD claims data to understand how enrollees with BHDs engage with behavioral health services and how service use is distributed across insurance types. The claims data were used to identify enrollees with an MHD or SUD. Enrollees were identified as having an MHD if they had one inpatient claim or at least two outpatient claims (on different days) with a primary diagnosis code for any of the MHD conditions listed in Table 3.1. Enrollees were identified as having an SUD based on having one inpatient claim or two outpatient claims (on different days) with a primary SUD diagnosis or having one or more claims for medication treatment for alcohol or opioid use disorder. Note that the diagnoses are based on claims data and may under-represent individuals with MHD or SUD who do not come into contact with a health care provider and have their diagnosis documented in the claims. Table 3.1 lists the conditions used to identify MHD and SUD. BHD refers to having either an MHD or SUD.

Table 3.1 MHD and SUD Conditions

Condition	Diagnostic Categories
MHD	Attention Deficit Hyperactivity Disorder, Conduct Disorder, and Hyperkinetic; Adjustment Disorder; Anxiety; Autism Spectrum Disorder; Bipolar Disorder; Other Childhood Disorders; Depression; Dissociative Disorder; Eating Disorder; Other Mental Health Condition; Mood Disorder; Psychotic Disorder; Personality Disorder; Pre/Post-partum; Rett Syndrome; Schizophrenia; Somatic Symptom Disorder; Suicidal Behavior
SUD	Alcohol Use Disorder, Drug Use Disorder
BHD	Either an MHD or SUD

Table 3.2 summarizes the number and proportion of enrollees with BHDs, MHDs, and SUDs across the insurance types. The groups are not mutually exclusive, as some enrollees have both MHD and SUD.

Table 3.2 Number and Percentage of Enrollees by Diagnosis and Insurance Type, Overall and by Age Group

Age Group	Disorder	HUSKY		CI		MA	
		Number of Enrollees	Percentage of Enrollees	Number of Enrollees	Percentage of Enrollees	Number of Enrollees	Percentage of Enrollees
All Ages	Total Enrollees	1,050,073	100.0%	1,057,898	100.0%	381,551	100.0%
	Any BHD	275,031	26.2%	207,636	19.6%	98,009	25.7%
	MHD	247,225	23.5%	201,754	19.1%	92,520	24.2%
	SUD	78,248	7.5%	14,148	1.3%	14,705	3.9%
Birth to 19	Total Enrollees	401,758	100.0%	228,104	100.0%	-	-
	Any BHD	72,814	18.1%	38,088	16.7%	-	-
	MHD	70,963	17.7%	37,791	16.6%	-	-
	SUD	4,566	1.1%	794	0.3%	-	-
20 to 64	Total Enrollees	607,589	100.0%	768,699	100.0%	35,401	100.0%
	Any BHD	188,592	31.0%	161,495	21.0%	18,821	53.2%
	MHD	163,633	26.9%	152,267	20.3%	17,639	49.8%
	SUD	70,941	11.7%	12,694	1.7%	4,778	13.5%
65 and Over	Total Enrollees	40,726	100.0%	61,094	100.0%	346,150	100.0%
	Any BHD	13,625	33.5%	8,053	13.2%	79,188	22.9%
	MHD	12,629	31.0%	7,696	12.6%	74,881	21.6%
	SUD	2,741	6.7%	660	1.1%	9,927	2.9%

Note: MA enrollment was limited to adults ages 24 and over.

Rates of BHD ranged from 19.6% among CI enrollees to 26.2% in HUSKY. MHD was considerably more common than SUD across all three insurance types. HUSKY enrollees were more likely to have an MHD or SUD than CI enrollees. HUSKY enrollees had a significantly

higher rate (7.5%) of SUD compared to CI (1.3%) and MA (3.9%). CI enrollees had the lowest rates of both MHD and SUD, at 19.1% and 1.3% respectively. MA enrollees had the highest percentage of enrollees with an MHD.

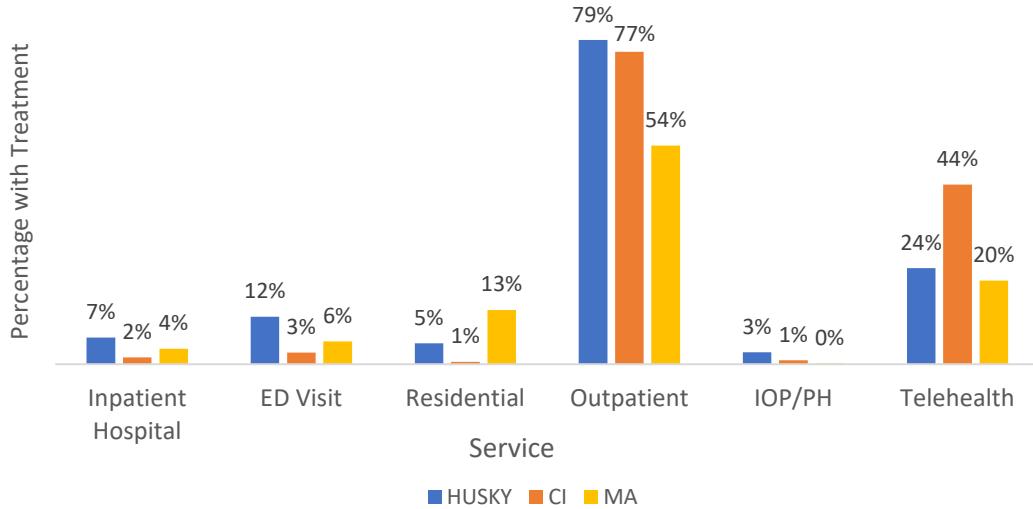
When broken out by age group, enrollees ages 20 to 64 were most likely to have an SUD compared to other age groups regardless of their insurance type. MA enrollees in this age group were also more than twice as likely as those ages 65 and over to have a BHD and had the highest rate (49.8%) of MHD across all age groups and insurance types. Youth ages birth to 19 had the lowest rates of SUD (HUSKY 1.1%; CI 0.3%). HUSKY enrollees ages 65 and over were more likely to have a BHD compared to HUSKY enrollees in other ages groups. However, CI enrollees in this age group were less likely to have a BHD compared to younger CI enrollees.

3.1.1 *Behavioral Health Service Use by Service Type*

The next set of results (Figures 3.1 and 3.2) show the percentage of enrollees with behavioral health service use by service type across insurance types for enrollees with MHD and SUD. The APCD medical claims were used to define the following types of behavioral health treatment: inpatient hospital, ED, residential (including nursing home care), any outpatient treatment,³⁸ intensive outpatient (IOP) and partial hospitalization (PH), and telehealth. Outpatient BH treatment was identified by any medical claim with a primary MHD or SUD diagnosis code with a CPT code indicating BH treatment taking place in an outpatient setting. The outpatient treatment category includes IOP/PH and telehealth. Enrollees with both MHD and SUD are counted toward both the MHD and SUD results.

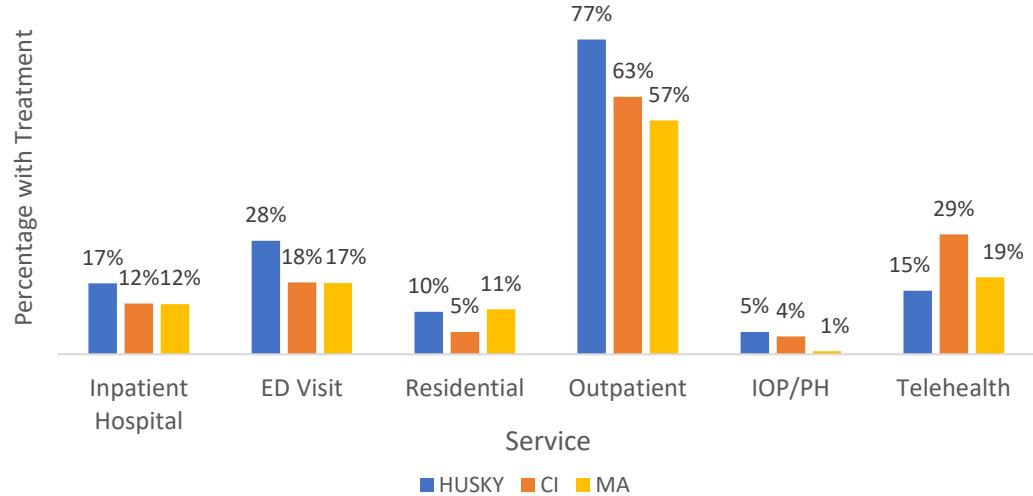
³⁸ Outpatient services included: office-base care, psychotherapy, care coordination, evaluation, home-based care, intensive outpatient/partial hospitalization, SUD treatment including medication treatment for alcohol or opioid use disorder, telehealth, hypnotherapy, and electric shock therapy.

Figure 3.1 Percentage of Enrollees with MHD Who Received Any Behavioral Health Treatment by Insurance Type



As seen in Figure 3.1, inpatient hospital, ED, outpatient, and IOP/PH services had higher service utilization rates among HUSKY enrollees compared to CI and MA. However, outpatient utilization rates were similar between HUSKY and CI enrollees. Residential services, which includes nursing home care, was higher in MA, while telehealth use was highest in CI.

Figure 3.2 Percentage of Enrollees with SUD Who Received Any Behavioral Health Treatment by Insurance Type

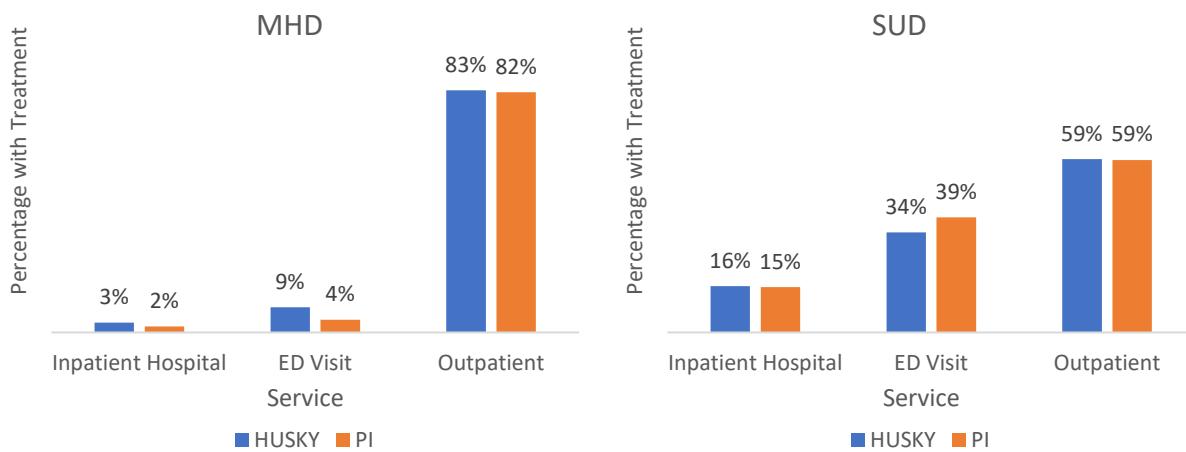


Similarly, use of inpatient, ED, outpatient, and IOP/PH services were higher for HUSKY enrollees compared to CI and MA. Additionally, use of residential services, which includes nursing home care, was higher in MA, while telehealth services were more commonly used in CI. Overall, the utilization patterns across insurance types were similar for enrollees with MHD and SUD, although enrollees with SUD tended to use inpatient hospital, ED, and residential services at higher rates than those with MHD (Figure 3.2).

3.1.2 Behavioral Health Service Use by Enrollee Characteristics

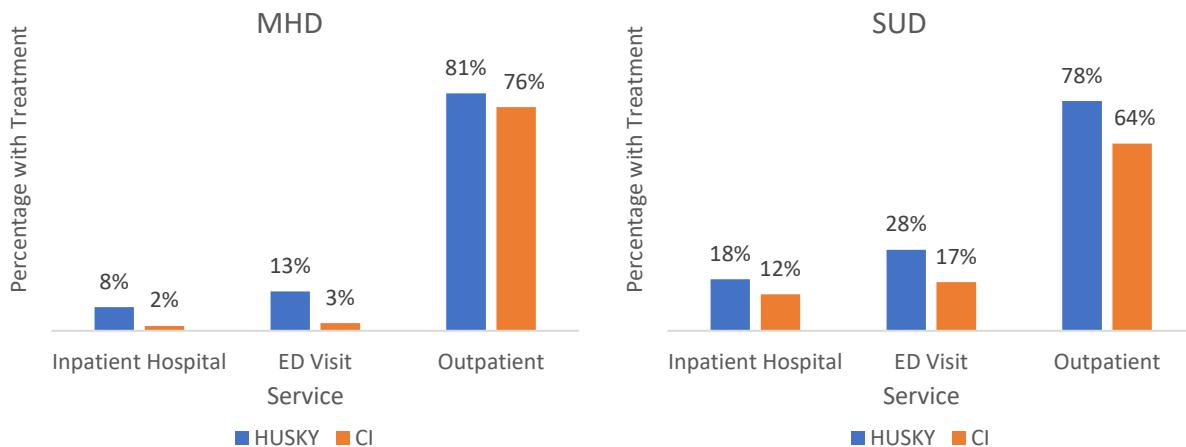
The following figures show the percentage of enrollees with MHD and SUD who received inpatient hospital, ED, and any outpatient care by age, sex, and geographic area. As in Section 3.1.1, enrollees diagnosed with both MHD and SUD are included in both the MHD and SUD results.

Figure 3.3 Percentage with Treatment for Enrollees with MHD and SUD, Ages Birth to 19 by Insurance Type



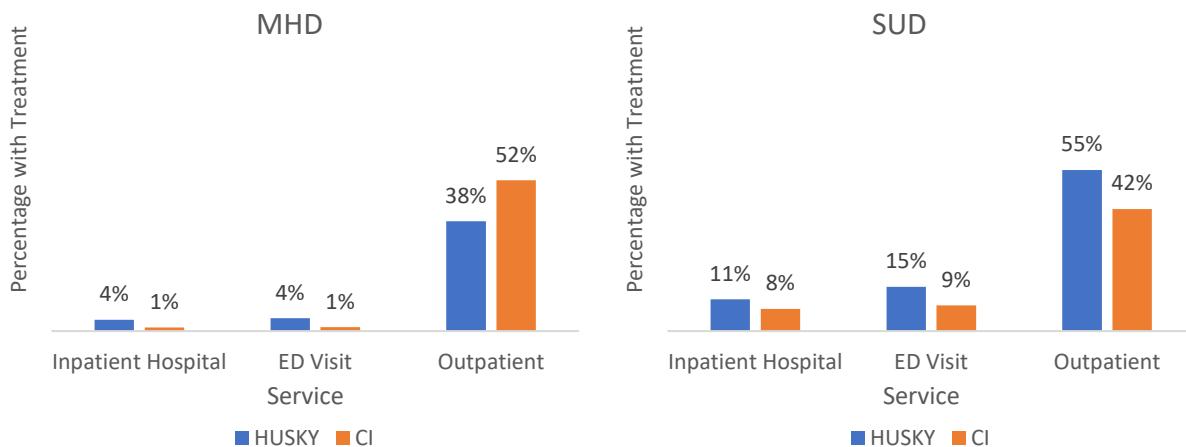
HUSKY and CI enrollees ages birth to 19 had similar rates of inpatient and outpatient service use for MHD and SUD. HUSKY enrollees with MHD had higher rates of ED use; whereas CI enrollees with SUD had a higher rate of ED use compared to HUSKY (Figure 3.3).

Figure 3.4 Percentage with Treatment for Enrollees with MHD and SUD, Ages 20 to 64 by Insurance Type



HUSKY enrollees ages 20 to 64 used all three service types at higher rates than CI enrollees for both MHD and SUD. Enrollees with SUD (in both HUSKY and CI) used inpatient hospital and ED services at higher rates than those with MHD, while enrollees with MHD had higher outpatient service utilization (Figure 3.4).

Figure 3.5 Percentage with Treatment for Enrollees with MHD and SUD, Ages 65 and Over by Insurance Type

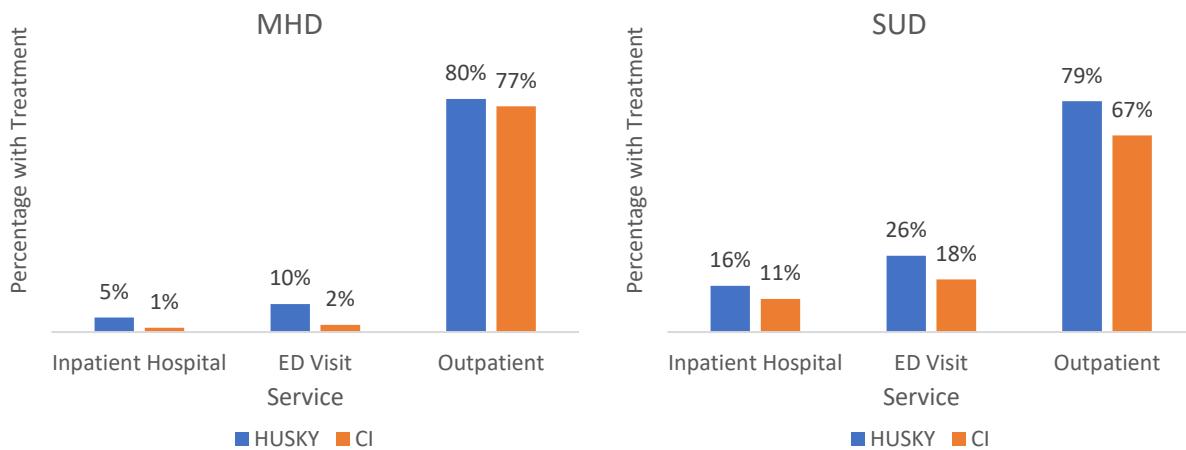


Inpatient hospital and ED utilization rates were lower for enrollees ages 65 and over with MHD than those with SUD regardless of insurance type. HUSKY enrollees used both of these service types at higher rates than CI enrollees. However, while HUSKY enrollees with MHD used outpatient services at a lower rate than enrollees with SUDs, CI enrollees with MHD used outpatient services more than those with SUD (Figure 3.5).

Rates of outpatient service use had the highest variation across age groups compared to the other two service types for both MHD and SUD. While utilization rates for outpatient services showed little difference among enrollees ages birth to 19 with MHD (HUSKY 83%; CI 82%) (Figure 3.3), there was notable variation in outpatient services among those ages 65 and over with MHD (HUSKY 38%; CI 52%) (Figure 3.5).

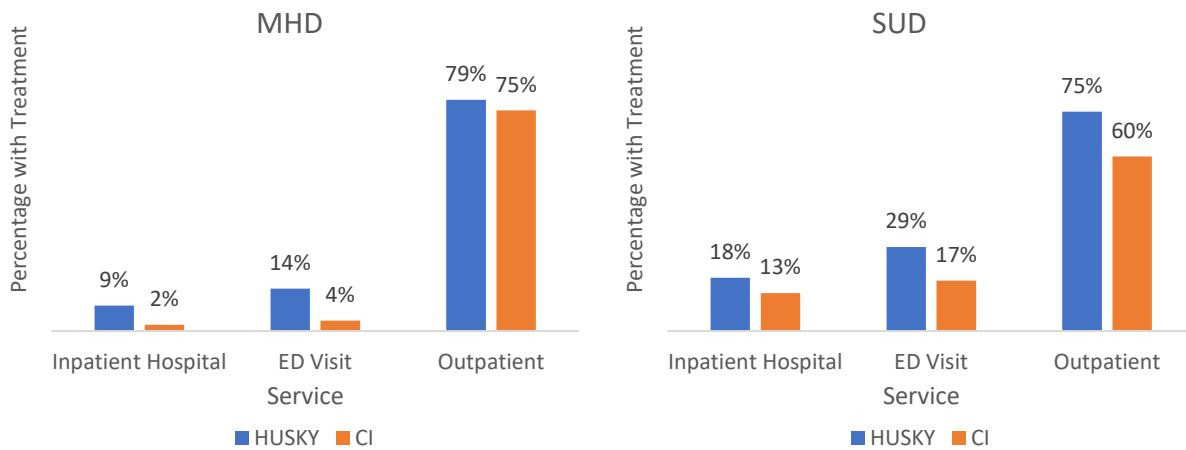
Enrollees ages 20 to 64 with SUD had the highest rates of outpatient utilization (HUSKY 78%; CI 64%) whereas those ages 65 and older with SUD had the lowest rates (HUSKY 55%; CI 42%) (Figure 3.4). Enrollees ages 65 and over generally had the lowest rates of utilization for both MHD and SUD across all three service types, with the exception of slightly higher HUSKY inpatient utilization for MHD compared to HUSKY enrollees ages birth to 19. SUD enrollees ages birth to 19 also had higher rates of ED utilization (HUSKY 34%; CI 39%) compared to other groups and those with MHD (Figure 3.5).

Figure 3.6 Percentage with Treatment for Enrollees with MHD and SUD, Female by Insurance Type



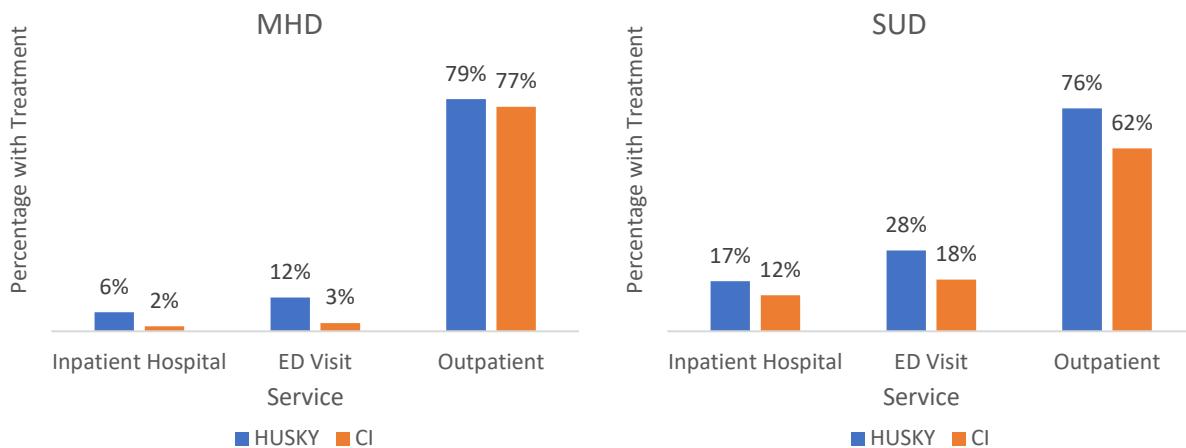
Inpatient hospital and ED utilization rates were lower for female enrollees with MHDs than those with SUDs regardless of insurance type, and HUSKY enrollees utilized both of these service types at higher rates than CI enrollees. Female HUSKY enrollees used outpatient services at similar rates (MHD 80%; SUD 79%), while female CI enrollees with SUD used outpatient services less often than CI enrollees with MHD (MHD 77%; SUD 67%) (Figure 3.6).

Figure 3.7 Percentage with Treatment for Enrollees with MHD and SUD, Male by Insurance Type



Rates of receiving outpatient treatment were similar for males and females with MHD. Males with MHD used inpatient hospital and ED care at higher rates than females. Both male and female HUSKY enrollees had higher rates of utilization than CI enrollees across all service types for both MHD and SUD. The greatest differences in utilization by sex were for CI enrollees with SUD where outpatient service use was 67% for females and 60% for males (Figure 3.7).

Figure 3.8 Percentage with Treatment for Enrollees with MHD and SUD, Urban by Insurance Type

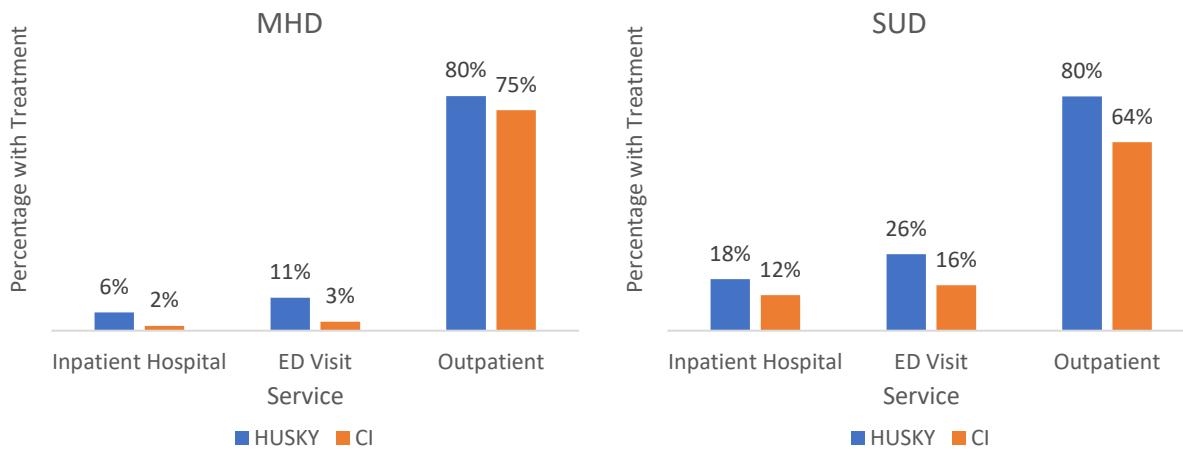


Comparing across Figures 3.8 and 3.9, rates of service use among enrollees with both MHD and SUD were very similar in urban and rural areas.³⁹ Enrollees with MHD in urban areas used inpatient hospital and ED services less often than those with SUD but had higher rates of

³⁹ Rural was defined as residing in either Litchfield or Windham County. All other counties are classified as urban.

outpatient service use. Urban HUSKY and CI enrollees with MHD also used outpatient services at similar rates (HUSKY 79%; CI 77%), while HUSKY enrollees with SUD had higher utilization than CI enrollees (HUSKY 76%; CI 62%) (Figure 3.8).

Figure 3.9 Percentage with Treatment for Enrollees with MHD and SUD, Rural by Insurance Type



3.2 Follow-up Treatment After ED Use and Inpatient Hospitalization

Receiving appropriate follow-up care after an inpatient hospitalization or ED visit is an essential component of comprehensive behavioral health treatment. Appropriate follow-up care has been associated with a lower probability of rehospitalization, lower risk of suicide, higher probability of taking medication, and increased engagement with long-term health care.^{40, 41} Demand for care has grown as a result of increases in the rates of hospitalizations and ED visits related to BHDs, particularly for children.^{42, 43, 44, 45} This increased demand for care, combined with health care provider shortages and other factors, including the high costs of care, make it

⁴⁰ Fontanella, C. A. et al. (2020). Association of Timely Outpatient Mental Health Services for Youths After Psychiatric Hospitalization With Risk of Death by Suicide. *JAMA Network Open*, 3(8), e2012887. <https://doi.org/10.1001/JAMANETWORKOPEN.2020.12887>

⁴¹ Hugunin, J. et al. (2023). Established Outpatient Care and Follow-Up After Acute Psychiatric Service Use Among Youths and Young Adults. *Psychiatric Services*, 74(1), 2–9. https://doi.org/10.1176/APPI.PS.202200047/SUPPL_FILE/APPI.PS.202200047.DS001.PDF

⁴² Child Health and Development Institute. (2018). *Issue Brief 65 - Mobile Crisis Services: An Effective Approach for Reducing Emergency Department Utilization*. <https://www.chdi.org/index.php/publications/issue-briefs/mobile-crisis-services-effective-approach-reducing-emergency-department-utilization-among-youth-behavioral-health-conditions>

⁴³ Laderman, M. et al. (2018). *Tackling the Mental Health Crisis in Emergency Departments: Look Upstream for Solutions*. Health Affairs Blog. <https://www.healthaffairs.org/content/forefront/tackling-mental-health-crisis-emergency-departments-look-upstream-solutions>

⁴⁴ SAMHSA. (2022). *2021 National Survey on Drug Use and Health: Model-Based Estimated Totals (in Thousands) (50 States and the District of Columbia.)* <https://www.samhsa.gov/data/sites/default/files/reports/rpt39466/2021NSDUHsaeTotals121522/2021NSDUHsaeTotals121522.pdf>

⁴⁵ Theberath, M. et al. (2022). Effects of COVID-19 pandemic on mental health of children and adolescents: A systematic review of survey studies. In *SAGE Open Medicine*. <https://doi.org/10.1177/20503121221086712>

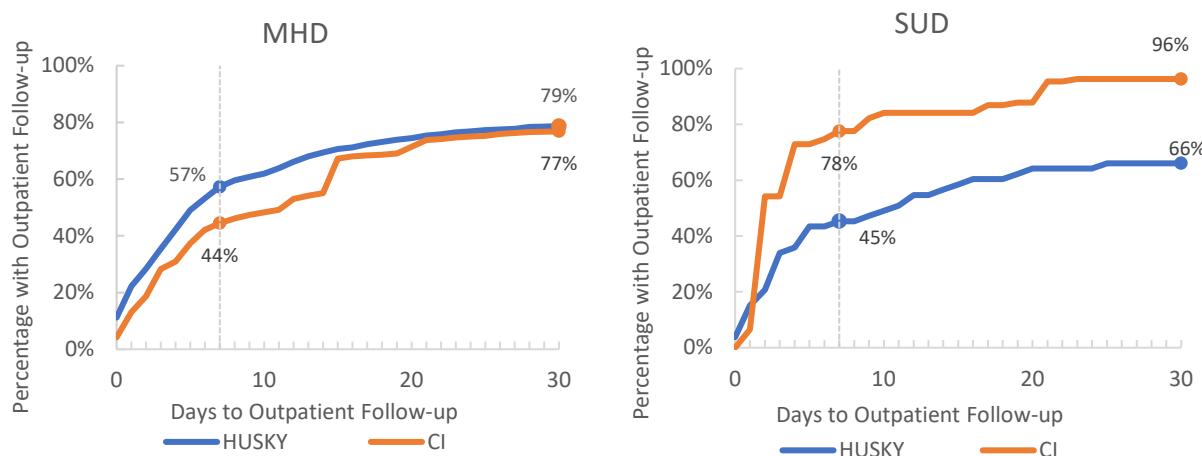
increasingly difficult to access care, and studies have found that a substantial proportion of individuals are not receiving adequate follow-up care.⁴⁶

A key indicator of access to care is the extent to which individuals using the ED or having an inpatient hospital stay are able to obtain follow-up care following discharge. Follow-up rates reflect the availability of outpatient care as well as how well the health care system is able to coordinate care for individuals who have used the ED or inpatient hospitalization. Being able to transition these individuals into outpatient care is an indicator of care quality. However, follow-up rates also can be influenced by other factors such as provider availability, patient choice, or the cost of care, which is discussed more in Section 4 of this report.

This analysis used the APCD to estimate the rates of receiving follow-up care for MHD- and SUD-related hospitalizations and ED visits, investigating how these rates varied across insurance types and demographic groups. Claims for individuals ages 6 and over were used to estimate the percentage of enrollees who followed up with a behavioral health provider within 7 to 30 days of discharge from a hospitalization⁴⁷ or an ED visit. Outpatient follow-up care included outpatient visits, IOP encounters, or PHs with any health care provider.

Figure 3.10 compares the rates of outpatient follow-up care after an inpatient hospitalization for an MHD and SUD by insurance type for enrollees ages 6 to 19.

Figure 3.10 Rate of Receiving Outpatient Follow-up Care after an Inpatient Hospitalization for an MHD and SUD, Ages 6 to 19



⁴⁶ Hugunin, J. et al. (2023). Established Outpatient Care and Follow-Up After Acute Psychiatric Service Use Among Youths and Young Adults. *Psychiatric Services*, 74(1), 2–9.

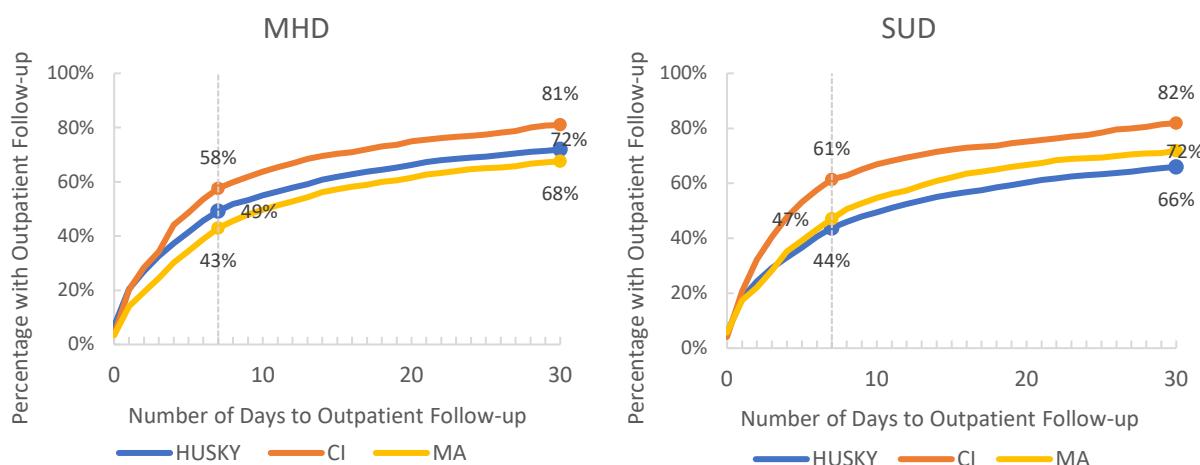
https://doi.org/10.1176/APPI.PS.202200047/SUPPL_FILE/APPI.PS.202200047.DS001.PDF

⁴⁷ This analysis excludes the following from the total number of enrollees with inpatient hospitalizations: 1) enrollees who had hospice services anytime during 2022, 2) the initial discharge and readmission or direct transfer discharge if the discharge occurred after December 1, 2022, and 3) discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for MHD or SUD.

Among individuals ages 6 to 19 who received inpatient hospitalization care for MHD, rates of outpatient follow-up after hospitalization were higher for HUSKY enrollees at 7 days (57%) compared to CI enrollees (44%), but were similar at 30 days (HUSKY 79%; CI 77%) (Figure 3.10). Differences in follow-up rates after inpatient hospitalization for SUD were more pronounced, with less than half (45%) of HUSKY enrollees receiving follow-up care by 7 days compared to over three-quarters (78%) of CI enrollees. Nearly all (96%) CI enrollees had outpatient follow-up for an SUD-related hospitalization by 30 days compared to two-thirds (66%) of HUSKY enrollees (Figure 3.10). Note that enrollees could have sought follow-up care from sources not paid through HUSKY or CI, and that care would not be reflected in these results.

Figure 3.11 compares the rates of outpatient follow-up care after an inpatient hospitalization for an MHD and SUD by insurance type for enrollees ages 20 and over.

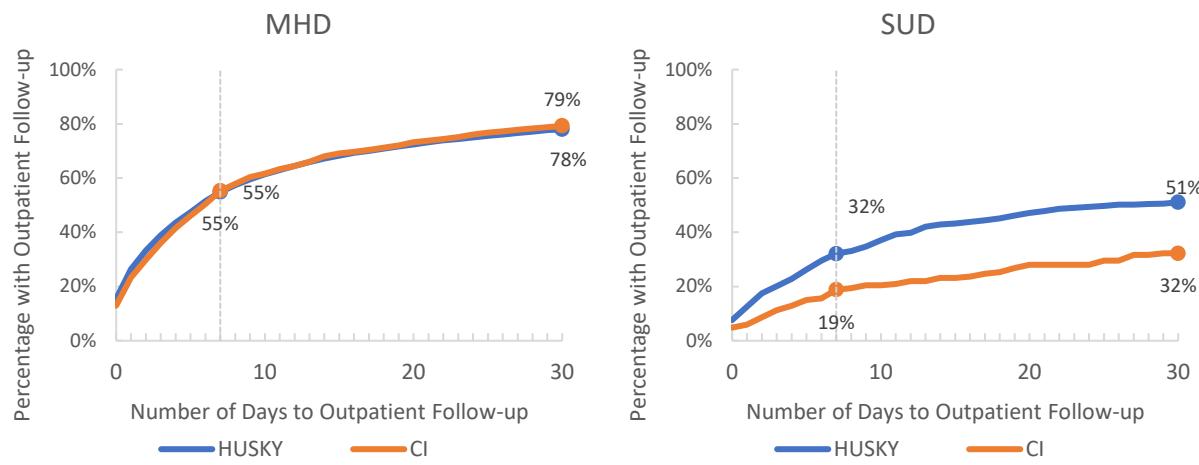
Figure 3.11 Rate of Receiving Outpatient Follow-up Care after an Inpatient Hospitalization for an MHD and SUD, Ages 20 and Over



For enrollees ages 20 years and older, rates of outpatient follow-up after inpatient hospitalization for MHD were higher for CI enrollees compared to both HUSKY and MA enrollees. Over half (58%) of those with CI received follow-up at 7 days, compared to those enrolled in HUSKY (49%) and MA (43%). These utilization rates followed the trend with those enrolled in CI having the greatest rate of follow-up (81%) at 30 days compared to HUSKY (72%) and MA (68%). These findings varied slightly from follow-up after an SUD-related inpatient hospitalization. While those with CI had similarly higher rates of follow-up at 7 days (61%) and 30 days (82%), MA rates of follow-up (47%) were higher than HUSKY follow-up rates (44%), though not substantially different at 7 days. CI enrollees had the highest rate of follow-up (82%) at 30 days compared to MA (72%) and HUSKY (66%) (Figure 3.11).

Figure 3.12 compares the rates of outpatient follow-up care after an ED visit for MHD and SUD by insurance type for enrollees ages 6 to 19.

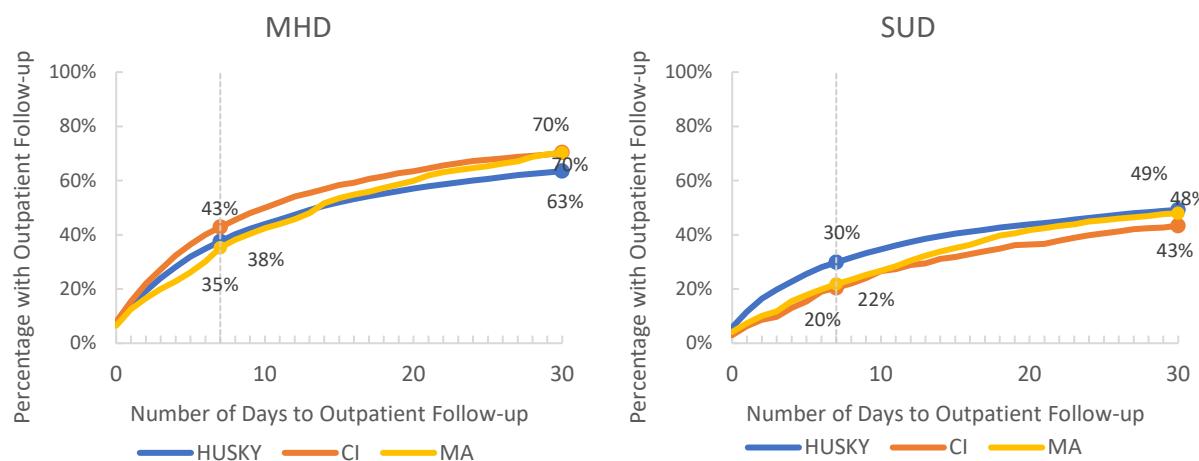
Figure 3.12 Rate of Receiving Outpatient Follow-up Care after an Emergency Department Visit for an MHD and SUD, Ages 6 to 19



For enrollees ages 6 to 19, rates of outpatient follow-up care after an ED visit for MHD were very similar for CI and HUSKY at 7 days and at 30 days. However, HUSKY enrollees had substantially higher rates of follow-up care for an SUD-related ED visit compared to CI enrollees (32% versus 19%) at 7 days and at 30 days (51% versus 32%). Overall, rates of follow-up care after an MHD-related ED visit were substantially higher than for an SUD-related visit. CI enrollees were more than twice as likely to receive follow-up care after an MHD-related ED visit than an SUD-related ED visit by 30 days. Follow-up rates in HUSKY were around 30 percentage points higher for those with an MHD-related ED visit than an SUD-related ED visit (Figure 3.12).

Figure 3.13 compares the rates of outpatient follow-up care after an ED visit for MHD and SUD by insurance type for enrollees ages 20 and over.

Figure 3.13 Rate of Receiving Outpatient Follow-up Care after an Emergency Department Visit for an MHD and SUD, Ages 20 and Over



For individuals ages 20 and over, CI enrollees had the highest rate of outpatient follow-up care after an ED visit for MHD (43%), compared to HUSKY (38%) and MA (35%) at 7 days, while 70% of enrollees with CI and MA received follow-up care by 30 days compared to 63% of HUSKY enrollees. Follow-up rates for SUD were much lower for all enrollees, with fewer than one-third of any enrollee group receiving follow-up care by 7 days and fewer than half of any group receiving follow-up care by 30 days. Rates of follow-up care for SUD were highest for HUSKY enrollees compared to the other insurance types. Overall, enrollees ages 20 and over with an SUD were less likely to receive follow-up care than those with an MHD, regardless of insurance type (Figure 3.13). Additionally, enrollees ages 6 to 19 in both CI and HUSKY were more likely to receive follow-up care for an MHD-related ED visit compared to adults (20 years and older) with CI and HUSKY.

While the type of insurance coverage an individual has may affect their ability to access follow-up care, there are likely several other factors that influence whether an enrollee receives appropriate follow-up care. Possible financial drivers of service use are further discussed in Section 4 to better understand the barriers to receiving care.

3.3 Provider Analysis – Number of Providers and Volume of Services Provided by Specialty Provider Type

The demand for behavioral health care exceeds the supply of providers, with an estimated 1.54 million people in Connecticut, around 40% of the population, living in mental health workforce shortage areas.⁴⁸ The supply of providers can vary across insurance types, which can make accessing care even more difficult depending on the type of insurance coverage an individual has. Nationally, supply shortages tend to be more pronounced in Medicaid, whose coverage is accepted by a lower share of providers than are other insurance types.⁴⁹ Additionally, providers may limit the number of patients they accept depending on their insurance coverage, even further restricting the provider supply and limiting access to care.^{50, 51, 52} Understanding the current supply of providers by insurance type as well as provider service volumes can give insight into the extent of provider shortages in the State and across insurance types.

⁴⁸ Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U. S. D. of H. and H. S. (2023). *Designated Health Professional Shortage Areas Statistics Third Quarter of Fiscal 2023 Designated HPSA Quarterly Summary as of June 30, 2023*.

⁴⁹ Bishop, T. F. et al. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry*. <https://doi.org/10.1001/jamapsychiatry.2013.2862>

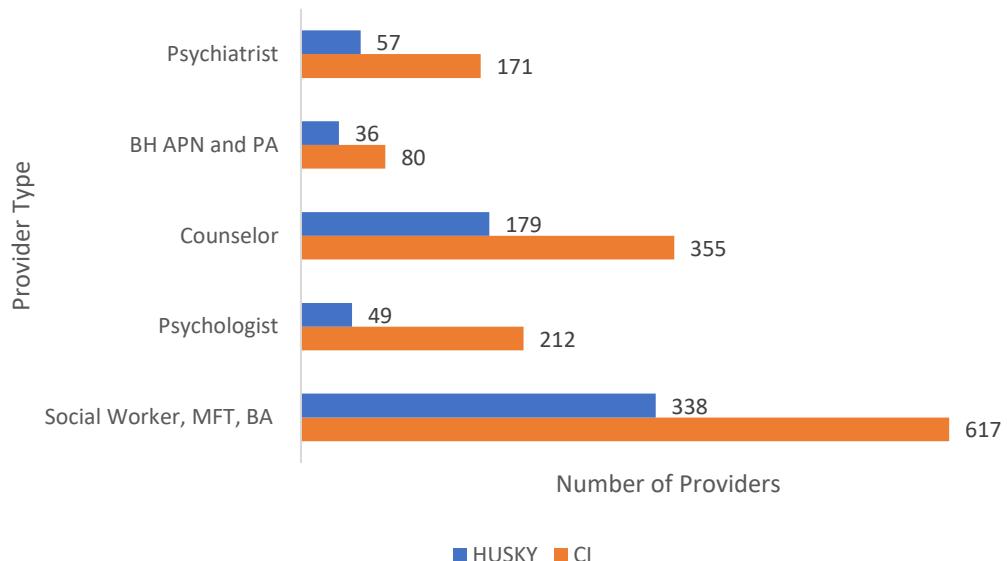
⁵⁰ Cunningham, P. J., & O’Malley, A. S. (2009). Do reimbursement delays discourage Medicaid participation by physicians? *Health Affairs*. <https://doi.org/10.1377/hlthaff.28.1.w17>

⁵¹ Long, S. K. (2013). Physicians may need more than higher reimbursements to expand Medicaid participation: Findings from Washington state. *Health Affairs*. <https://doi.org/10.1377/hlthaff.2012.1010>

⁵² Schoenman, J. A., & Feldman, J. J. (2002). *2002 Survey of Physicians About the Medicare Program*. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/contractor-reports/Mar03_02PhysSurvRpt2.pdf

This analysis used the 2022 APCD to compare the number of behavioral health providers in CI and HUSKY as well as provider service volumes for common behavioral health provider types. Note that some providers saw patients in both HUSKY and CI. Figure 3.14 compares the number of providers per 100,000 enrollees in CI and HUSKY.

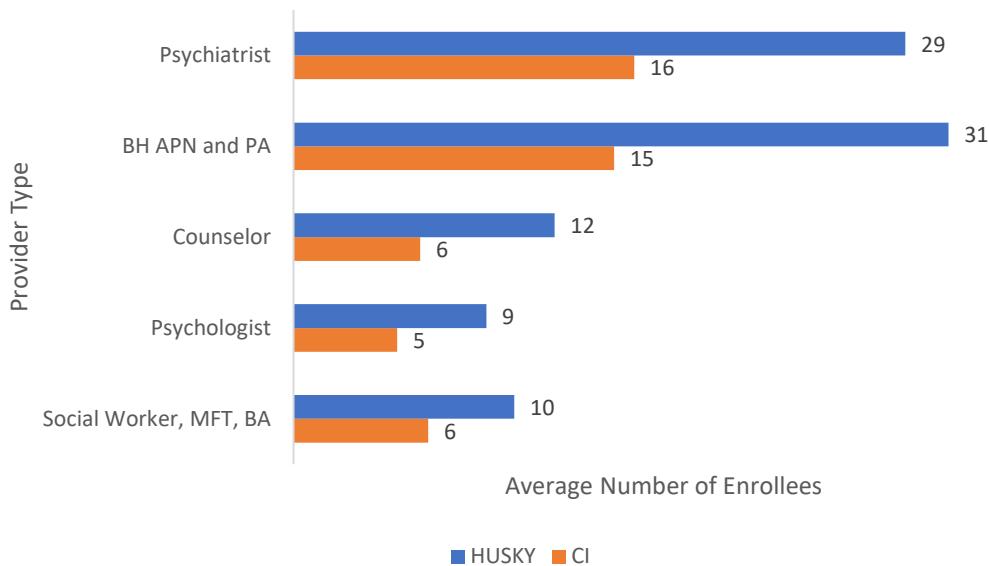
Figure 3.14 Number of Providers per 100,000 Enrollees in HUSKY and CI



There were substantially more providers per 100,000 enrollees in CI than in HUSKY for all provider types. Psychologists had the largest difference, with more than four times the number of psychologists seeing patients in CI than in HUSKY. SWs, MFTs, BAs, and counselors had the smallest difference with about half the number of providers accepting HUSKY than CI.

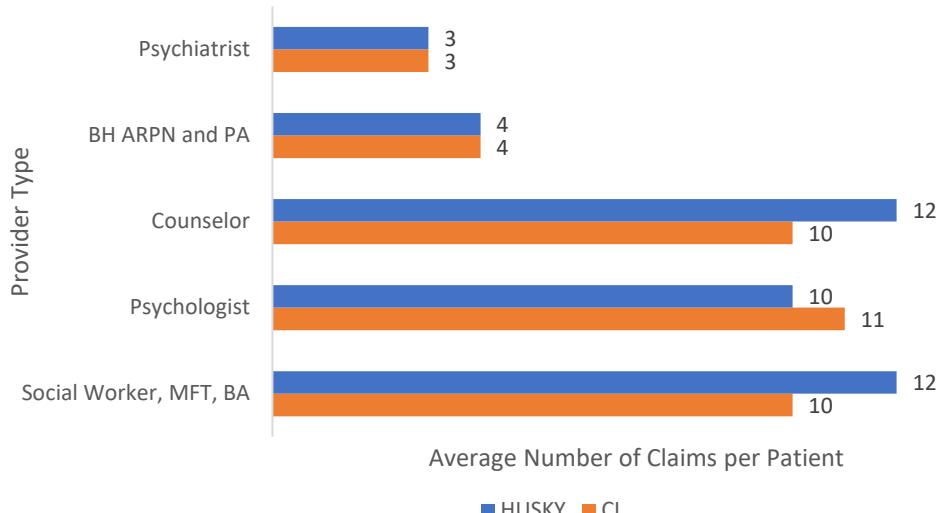
Figures 3.15 and 3.16 compare service volumes for providers accepting CI and HUSKY.

Figure 3.15 Average Number of Enrollees per Provider in HUSKY and CI



As seen in Figure 3.15 providers who saw HUSKY enrollees served almost twice as many individuals compared to providers who saw CI enrollees, though Figure 3.14 showed that substantially fewer providers saw HUSKY enrollees than saw CI enrollees.

Figure 3.16 Average Number of Claims per Patient in HUSKY and CI



As noted in Figure 3.16, providers who served HUSKY enrollees delivered a volume of services per enrollee comparable to that delivered by those who served CI enrollees, and this pattern was consistent across all types of behavioral health providers. These findings suggest that

while HUSKY enrollees receive a comparable volume of behavioral health services, their care is concentrated among fewer providers.

4 FINANCIAL DRIVERS OF SERVICE USE

Understanding the financial drivers of service use can assist Connecticut with determining which financial levers, if any, can be used to improve access to behavioral health care. Increasing reimbursement rates may incentivize provider participation in HUSKY and CI. Conversely, high out-of-pocket costs may deter enrollees from seeking care. HUSKY has no out-of-pocket costs for most programs; however, these costs may be a barrier to care for CI enrollees.

This section expands the analysis of reimbursement rates and service use in Sections 2 and 3 to investigate the association between reimbursement rates and out-of-pocket costs on outpatient service use. Specifically, the analyses examine (1) whether there is any indication that higher reimbursement rates are associated with greater outpatient behavioral health service use (Section 4.1), and (2) whether higher out-of-pocket costs are associated with lower service use in CI (Section 4.2).

4.1 Distribution of Psychotherapy Services in HUSKY and CI

As described in Section 2.1 (Table 2.1), HUSKY reimbursement rates for 60-minute psychotherapy were comparable to CI rates. However, the HUSKY rates for 30-minute and 45-minute psychotherapy were lower than CI reimbursement rates—in the range of 80% of CI rates for most behavioral health provider types. The analysis in this section examined if there were differences in the patterns of utilization for services where reimbursement rates were comparable in HUSKY and CI. Specifically, the analysis examined how often HUSKY enrollees used 60-minute psychotherapy (where reimbursement rates are comparable to CI rates), rather than 30- or 45-minute psychotherapy, and how this compares to how often these services are used in CI.

Table 4.1 shows the number of claims for 60-minute, 45-minute, and 30-minute psychotherapy and the distribution of claims across the three service types for the behavioral health provider types who provide psychotherapy services for HUSKY and CI. In HUSKY, 81.1% of all psychotherapy claims were for 60-minute psychotherapy, with fewer than 20% being for 30-minute and 45-minute psychotherapy combined. In contrast, 67.6% of all psychotherapy claims in CI were for 60-minute psychotherapy, with just over 30% of claims being for 30-minute and 45-minute psychotherapy. A similar pattern was seen for counselors, psychologists, and SW/BA/MFTs. There may be clinical or administrative reasons for greater use of 60-minute psychotherapy in HUSKY; however, it could also be a signal that the higher reimbursement rate for 60-minute psychotherapy is driving up utilization for this particular service, while utilization of 30- and 45-minute psychotherapy is less frequent due to low reimbursement for these services.

Table 4.1 Number and Percentage of 30-Minute, 45-Minute, and 60-Minute Psychotherapy Claims in HUSKY and CI

Provider Type	Service	HUSKY		CI	
		Number of Claims	Percentage of Total Psychotherapy Claims	Number of Claims	Percentage of Total Psychotherapy Claims
Counselors	Total psychotherapy claims	520,823	100%	350,820	100%
	60-minute psychotherapy	441,850	84.8%	266,346	75.9%
	45-minute psychotherapy	53,042	10.2%	70,995	20.2%
	30-minute psychotherapy	25,931	5.0%	13,479	3.8%
Psychologists	Total psychotherapy claims	71,696	100%	162,162	100%
	60-minute psychotherapy	48,599	67.8%	68,476	42.2%
	45-minute psychotherapy	15,527	21.7%	87,972	54.2%
	30-minute psychotherapy	7,570	10.6%	5,714	3.5%
SW/BA/MFTs	Total psychotherapy claims	759,702	100%	629,110	100%
	60-minute psychotherapy	605,945	79.8%	436,872	69.4%
	45-minute psychotherapy	101,064	13.3%	169,585	27.0%
	30-minute psychotherapy	52,693	6.9%	22,653	3.6%
All Provider Types Combined	Total psychotherapy claims	1,352,221	100.0%	1,142,092	100.0%
	60-minute psychotherapy	1,096,394	81.1%	771,694	67.6%
	45-minute psychotherapy	169,633	12.5%	328,552	28.8%
	30-minute psychotherapy	86,194	6.4%	41,846	3.7%

4.2 Association of Enrollee Out-of-Pocket Costs with Outpatient Behavioral Health Service Use

Out-of-pocket costs include the share of health care costs paid by patients. For the purposes of this report, they refer to copayments, coinsurance, and deductibles; they do not include health insurance premiums. Out-of-pocket costs are intended to reduce medically unnecessary care and reduce overall health care costs. In an early comprehensive study investigating how consumer behavior responded to varying out-of-pocket costs for medical care, the RAND Health Insurance Experiment randomized thousands of individuals across the U.S. to insurance plans with varying levels of out-of-pocket costs. The RAND experiment demonstrated that higher out-of-pocket costs led to (1) significant reductions in use of medical services, (2) lower total health care expenditures, and (3) no major changes in health outcomes or quality of

care. These findings, consistent with the findings from other researchers,^{53, 54, 55, 56, 57} suggested that higher out-of-pocket costs can help control overall health care costs. However, researchers have also documented some negative consequences of higher out-of-pocket costs. Specifically, they can cause patients to delay or forgo care and ultimately worsen health outcomes. The effects of out-of-pocket costs are especially pronounced among low-income populations that are more sensitive to financial barriers. Furthermore, for patients with BHD, forgoing treatment can lead to poorer management of their conditions, especially among patients with serious mental illness.^{58, 59}

This section reports the results of an exploratory analysis of the association between average out-of-pocket costs and outpatient behavioral health service use using the APCD to examine the average number of outpatient behavioral health visits for enrollees with different levels of out-of-pocket costs. With some minor exceptions, HUSKY enrollees do not incur out-of-pocket costs, so this analysis focused on CI.

As this investigation relies on claims data, there are several limitations to consider. First, claims data capture what services are billed and paid for but do not reflect patient-level factors (e.g., socio-demographic characteristics, patient preferences for care, or ability to pay) that may also influence health care utilization. Further, since claims data include only services that were billed and paid and not services that were denied or care that was avoided due to cost, claims may not always capture the full impact of out-of-pocket costs. Additionally, the APCD captures copay, coinsurance, and deductible amounts at the individual claim level for behavioral health services. This approach does not reflect the aggregate out-of-pocket costs across all health services or across an entire household, where deductibles accrue across all health services and potentially across all members of a health plan. Finally, there is an inherent circularity in how out-of-pocket costs and outpatient visits relate in this analysis: as enrollees meet their deductibles and their out-of-pocket costs are accounted for across visits, the average per-visit out-of-pocket cost across all visits will be lower. These limitations make it difficult to interpret the specific impact of out-of-pocket costs on behavioral health care. Nevertheless, while claims data may not capture all

⁵³ Baicker, K., & Goldman, D. (2011). Patient Cost-Sharing and Healthcare Spending Growth. *Journal of Economic Perspectives*, 25(2): 47–68.

⁵⁴ Chernew, M. et al. (2008). Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care. *Journal of General Internal Medicine*, 23, 1131–1136.

⁵⁵ Chandra, A. et al. (2014) The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts. *Journal of Health Economics*, 33, 57–66. <https://doi.org/10.1016/j.jhealeco.2013.10.008>

⁵⁶ Wharam, J. F. et al. (2018). High-Deductible Insurance and Delay in Care for the Macrovascular Complications of Diabetes. *Annals of Internal Medicine*, 169(12), 845–854. <https://doi.org/10.7326/M17-3365>

⁵⁷ Aron-Dine, A., et al. (2013). The RAND health insurance experiment, three decades later. *Journal of Economic Perspectives*, 27(1), 197–222.

⁵⁸ Islek, D. et al. (2018) Out-of-Pocket Health Expenditures in Patients with Bipolar Disorder, Anxiety, Schizophrenia and Other Psychotic Disorders: Findings from a Study in a Psychiatry Outpatient Clinic in Turkey. *Social Psychiatry and Psychiatric Epidemiology*, 53 (2018): 151–160.

⁵⁹ Rowan, K. et al. (2013). Access and Cost Barriers to Mental Health Care, by Insurance Status, 1999–2010.” *Health Affairs* 32, 1723–1730.

aspects of medical costs and service use, the standardized and detailed nature of claims data allows us to descriptively examine the association between out-of-pocket costs and behavioral health service use.

To conduct the analysis, we first computed the average out-of-pocket costs for CI enrollees with any outpatient behavioral health visits by averaging the out-of-pocket costs across all of their outpatient behavioral health visits.⁶⁰ As mentioned, out-of-pocket costs included costs for deductibles, copayments, and coinsurance as recorded in the claims data. After examining the distribution of average out-of-pocket costs across enrollees with BHD, we created the following categories of costs: \$0, \$1 to \$15, \$16 to \$40, and over \$40. These categories were created by grouping the positive dollar costs into roughly equal-size groups.

As shown in Table 4.2, 11.4% of enrollees with BHD who had at least one outpatient behavioral health visit had average out-of-pocket costs of \$0; 30.5% had out-of-pocket costs ranging from \$1 to \$15; 26.9% had out-of-pocket costs ranging from \$16 to \$40; and 31.2% had average out-of-pocket costs greater than \$40. When comparing out-of-pocket costs for enrollees with MHD versus SUD, out-of-pocket expenses ranging from \$16 to \$40 were greater for enrollees with SUD (33.1%) compared to individuals with MHD (26.9%), and over a third (36.4%) of SUD enrollees had out-of-pocket costs of greater than \$40 compared to enrollees with MHD (31.1%).

Table 4.2 Number and Percentage of CI Enrollees with Different Levels of Out-of-Pocket Costs for Outpatient Behavioral Health Visits for Enrollees with BHD, MHD, and SUD

Average Per-Enrollee, Per-Visit Out-of-Pocket Cost Range	BHD N=141,597		MHD N=140,009		SUD N=7,184	
	Number of Enrollees	Percentage of Enrollees	Number of Enrollees	Percentage of Enrollees	Number of Enrollees	Percentage of Enrollees
\$0	16,159	11.4%	15,865	11.3%	955	13.3%
\$1 to \$15	43,163	30.5%	42,965	30.7%	1,236	17.2%
\$16 to \$40	38,117	26.9%	37,599	26.9%	2,380	33.1%
> \$40	44,158	31.2%	43,580	31.1%	2,613	36.4%

Note: Summary statistic calculations were restricted to enrollees making one or more outpatient visits. MHD and SUD are not mutually exclusive, as some enrollees may have both.

Next, we calculated the average number of outpatient behavioral health visits among enrollees according to their level of out-of-pocket costs (Table 4.3). Overall, CI enrollees with BHD had an average of 12.6 outpatient visits (not shown in table). Among CI enrollees with average out-of-pocket costs of \$0, the average number of outpatient behavioral health visits was 8.1. For all other out-of-pocket cost categories, higher out-of-pocket costs were associated with a lower average number of outpatient behavioral health visits. Specifically, the average number of outpatient behavioral health visits was 16.0 for the \$1 to \$15 cost group, 13.2 for the \$16 to \$40,

⁶⁰ The average out-of-pocket cost was computed by dividing the enrollee's total out-of-pocket costs by their number of outpatient visits.

and 10.3 for the \$40+ out-of-pocket cost groups. As average per-visit out-of-pocket costs increased, the average number of visits was lower.

Table 4.3 Number of Outpatient Visits and Average Out-of-Pocket Cost per Outpatient Visit for CI Enrollees with BHD

	Category of Average Out-of-Pocket Costs							
	\$0		\$1 to \$15		\$16 to \$40		> \$40	
	Number of Enrollees	Average Visits	Number of Enrollees	Average Visits	Number of Enrollees	Average Visits	Number of Enrollees	Average Visits
Enrollees with BHD N=141,597	15,854	8.1	43,163	16.0	38,117	13.2	44,158	10.3

Note: Summary statistic calculations were restricted to enrollees making one or more outpatient visits.

Table 4.4 presents the results for MHD and SUD, extending the analysis to include results by age group. Among the out-of-pocket cost categories, the average number of MHD outpatient behavioral health visits was lowest (7.5) for the \$0 out-of-pocket cost group compared to the other categories. For enrollees with MHD, higher out-of-pocket costs for outpatient visits were associated with a lower average number of outpatient behavioral health visits, with the exception of the \$0 cost group. For example, among enrollees with MHD, the average number of outpatient behavioral health visits was 15.9 in the \$1 to \$15 out-of-pocket cost group and dropped to 13.2 and 10.3 visits for the \$16 to \$40 and \$40+ out-of-pocket cost groups, respectively.

Outpatient behavioral health visits for SUD showed a similar trend as for MHD, demonstrating a decline across out-of-pocket categories. In particular, the average number of outpatient visits for SUD treatment declined from 26.5 visits for the \$1 to \$15 out-of-pocket cost group to 13.2 for the \$40+ out-of-pocket cost group. With the exception of the \$0 cost group, the age group analysis for enrollees with MHD and SUD revealed that the average number of outpatient behavioral health visits was highest in the \$1 to \$15 out-of-pocket cost group and lowest in the \$40+ out-of-pocket cost group. It is notable that the average number of outpatient behavioral health visits was higher for enrollees with SUD compared to enrollees with MHD for all out-of-pocket cost levels. This may be due to billing for medication treatment for opioid use disorder, or for other high-frequency treatments. Furthermore, enrollees with SUD also reported the largest declining trend in visits across out-of-pocket cost groups.

Table 4.4. Average Number of Outpatient Visits and Average Out-of-Pocket Cost per Outpatient Visit for Enrollees with MHD and SUD

Enrollee Characteristics	Average Out-of-Pocket Cost Per Outpatient Behavioral Health Visit							
	\$0		\$1 to \$15		\$16 to \$40		> \$40	
	Number of Enrollees	Average Visits	Number of Enrollees	Average Visits	Number of Enrollees	Average Visits	Number of Enrollees	Average Visits
MHD								
All Enrollees n=140,009	15,865	7.5	42,965	15.9	37,599	13.2	43,580	10.3
Age Groups								
Birth to 19 n=28,830	3,489	12.9	9,139	18.6	7,051	16.7	9,151	11.6
20 to 64 n=107,898	11,759	6.1	32,785	15.2	29,744	12.4	33,610	9.9
65 and Over n=3,281	617	3.4	1,041	12.7	804	9.6	819	8.2
SUD								
All Enrollees n=7,184	955	21.1	1,236	26.5	2,380	15.7	2,613	13.2
Age Groups								
Birth to 19 n=418	47	11.0	77	24.8	134	16.5	160	17.8
20 to 64 n=6,540	859	22.2	1,110	26.9	2,184	15.7	2,387	13.1
65 and Over n=226	49	22.2	49	19.2	62	13.0	66	7.1

Note: Summary statistic calculations were restricted to enrollees making one or more outpatient BH visits. MHD and SUD are not mutually exclusive, as some enrollees may have both.

Overall, the results of this analysis suggest that when there is an out-of-pocket cost for behavioral health services, higher out-of-pocket costs are associated with lower service use, a finding that is well-documented in the mental health literature.^{61, 62, 63, 64} In addition to the limitations discussed in the introduction to this section, it is important to note the challenges of interpreting the \$0 out-of-pocket cost group results. According to the literature, when costs are lowest, utilization should be highest;⁶⁵ however, the analyses consistently showed that the \$0 cost group had the lowest service utilization. This seemingly contradictory finding is potentially attributable to several reasons. First, it could be the case that the claim was initially submitted and processed without showing a patient's cost sharing portion, or the cost sharing could have been waived or uncollectable, which would lead to the claim reflecting \$0 out-of-pocket costs. Second,

⁶¹ Ellis, R. P., & McGuire, T. G. (1984). Cost Sharing and the Demand for Ambulatory Mental Health Services. *American Psychologist*, 39(10), 1195–1197.

⁶² Keeler, E. B. et al. (1988). The Demand for Episodes of Mental Health Services. *Journal of Health Economics*, 7(4), 369–392. [https://doi.org/10.1016/0167-6296\(88\)90021-5](https://doi.org/10.1016/0167-6296(88)90021-5)

⁶³ Meyerhoefer, C. D., & Zuvekas, S. H. (2010). New Estimates of the Demand for Physical and Mental Health Treatment. *Health Economics*, 19(3), 297–315. <https://doi.org/10.1002/hec.1476>

⁶⁴ Golberstein, E., & Gonzales, G. (2015) The Effects of Medicaid Eligibility on Mental Health Services and Out-of-Pocket Spending for Mental Health Services. *Health Services Research* 50(6) (2015): 1734–1750.

⁶⁵ Aron-Dine, A. et al. (2013). “The RAND Health Insurance Experiment, Three Decades Later.” *Journal of Economic Perspectives*, 27(1), 197–222.

if a patient has multiple insurance policies, the primary claim may show \$0 out-of-pocket costs because the secondary payer covered the out-of-pocket costs. Since the claims data are annualized, the results could potentially reflect multiple plans. Another explanation is that as enrollees meet their deductibles or reach their out-of-pocket maximum, and their out-of-pocket costs are accounted for by non-behavioral health visits, the average per-visit out-of-pocket cost reflected for behavioral health visits could be zero. Last, it could also be the case that there are errors in the processed claim and that it incorrectly reflects a zero out-of-pocket cost. The relatively small size of the \$0 cost group relative to the other cost groups supports these potential explanations. For these reasons, the \$0 cost group results should be interpreted with caution.

5 FINANCIAL IMPACT OF BEHAVIORAL HEALTH TREATMENT

This section of the report considers the potential financial impact (Section 5.1) if HUSKY rates for behavioral health services were increased to align with the benchmark rates used in the Warning Signs payment parity analysis (presented in Appendix A) and investigates potential cost offsets of behavioral health treatment on ED costs (Section 5.2).

5.1 Estimated Cost of Increasing HUSKY Rates

As described in the Introduction, Connecticut is interested in understanding whether increasing HUSKY reimbursement rates for behavioral health services would increase treatment access by incentivizing greater provider participation in HUSKY. This section presents estimates of how much rate increases would potentially cost using rate and utilization data from the 2022 APCD. The estimates simulate the costs of increasing reimbursement rates under various assumptions about the size of rate increases and the impact that rate increases might have on service use. We calculated the potential cost of increasing the behavioral health services presented in Table 2.1 to equal the benchmark rates from Appendix A using the 2022 utilization profile of the behavioral health services. We estimated the cost of applying the full benchmark rates and also made a more conservative projection based on increasing the current rates to 90% of their respective benchmark rate, which would represent an incremental increase to the rates. An underlying assumption of the projections is that higher reimbursement rates drive higher service provision. Therefore, in addition to calculating the cost of rate increases based on current

utilization (based on the 2022 APCD), we calculated the cost assuming higher utilization using estimates found in the literature.^{66, 67, 68, 69, 70}

Table 5.1 summarizes the results of increasing rates for behavioral health services to 90% and 100% of the benchmark rates for all behavioral health services under assumptions of (1) no change in utilization and (2) an increase in utilization of 0.25% for every 1 percentage point increase in the reimbursement rate. Increasing behavioral health reimbursement rates to 90% of benchmark rates, assuming a modest increase in utilization, would cost \$11,567,535, which would be a 7.9% increase over current costs. Increasing the rates to 100% of the benchmark would cost an estimated \$17,843,823, which would be a 12.2% increase over current costs.

Table 5.1. Estimates of the Cost of Increasing Behavioral Health Reimbursement Rates in HUSKY for Eight Common Behavioral Health Services to 90% and 100% of Benchmark Rates

Financial Impact Estimate Baseline Inputs		
Number of claims for eight common behavioral health services		1,694,838
Estimated current cost (based on multiplying the number of claims by the reimbursement rate for each respective behavioral health service)*		\$ 146,846,404
Estimated Financial Impact of Increasing Reimbursement Rates for Behavioral Health Services		
Amount of rate increase	To 90% of Benchmark	To 100% of Benchmark
Total estimated annual cost assuming no change in utilization	\$ 156,100,432	\$ 161,121,462
Potential cost increase to the State (difference between current cost and estimated cost)	\$ 9,254,028	\$ 14,275,058
Percent increase over current costs	6.3%	9.7%
Total estimated annual cost, assuming a 0.25% increase in utilization for every \$1 increase reimbursement rate	\$ 158,413,939	\$ 164,690,227
Potential cost increase to the State (difference between current cost and estimated cost)	\$ 11,567,535	\$ 17,843,823
Percent increase over current costs	7.9%	12.2%

*The actual amount paid based on the claims was \$150,707,286.

Note: The estimates presented here include total costs and do not account for the federal versus state share of HUSKY spending.

As described in Section 2.1 (Table 2.1), the largest discrepancies between HUSKY and CI reimbursement rates are for office visits by psychiatrists, BH APRNs, and BH PAs. To supplement the estimates of adjusting rates for the common services, Table 5.2 provides estimates

⁶⁶ Baker, L. C., & Beeson, A. (2000). Medicaid Policy, Physician Behavior, and Health Care for the Low-Income Population. *Journal of Human Resources*, 35(3), 480–502. <https://doi.org/10.2307/146389>

⁶⁷ Callison, K., & Nguyen, B. T. (2018). The Effect of Medicaid Physician Fee Increases on Health Care Access, Utilization, and Expenditures. *Health Services Research*. <https://doi.org/10.1111/1475-6773.12698>

⁶⁸ Horny, M. et al. (2015). Using Medical Claims for Policy Effectiveness Surveillance: Reimbursement and Utilization of Abdomen/Pelvis Computed Tomography Scans. *Health Services Research*, 50(6), 1910–1926. <https://doi.org/10.1111/1475-6773.12293>

⁶⁹ Schnell, M., & Alexander, D. (2024). The Impacts of Physician Payments on Patient Access, Use, and Health. *American Economic Journal: Applied Economics*, 16(3), 142–177. <https://doi.org/10.1257/app.20210227>

⁷⁰ Shen, Y. C., & Zuckerman, S. (2005). The Effect of Medicaid Payment Generosity on Access and Use Among Beneficiaries. *Health Services Research*, 40(3), 723–744. <https://doi.org/10.1111/j.1475-6773.2005.00382.x>

of the costs of increasing only these services. Because these services have the largest discrepancies in rates, increasing them to align more closely with the benchmark rates has a significant financial impact in terms of the percent change over the current costs for these services. Increasing the rates for these services to 90% of the benchmark rates, assuming a modest increase in utilization, would cost an estimated \$7,568,712, which would be a 94.6% increase over current costs (Table 5.2). Increasing these rates to match the benchmark rates would more than double the current expenditures for these services.

Table 5.2 Estimates of the Costs of Increasing Reimbursement Rates in HUSKY for Established Patient Office Visits by Psychiatrists, BH APRNs, and BH PAs to 90% and 100% of Benchmark Rates

Financial Impact Estimate Baseline Inputs		
Number of claims for office visits for psychiatrists, APRNs, and PAs		150,266
Estimated current cost (based on multiplying the number of claims by the reimbursement rate for each respective behavioral health service)*		\$ 8,003,217
Financial Impact of Increasing Reimbursement Rates for Behavioral Health Office Visits		
Amount of rate increase	90% of Benchmark	100% of Benchmark
Total estimated annual cost assuming no change in utilization	\$ 14,058,186	\$ 15,620,207
Potential cost increase to the State (difference between current cost and estimated cost)	\$ 6,054,969	\$ 7,616,990
Percent increase over current costs	75.7%	95.2%
Total estimated annual cost, assuming a 0.25% increase in utilization for every \$1 increase reimbursement rate	\$ 15,571,928	\$ 17,524,454
Potential cost increase to HUSKY (difference between current cost and estimated cost)	\$ 7,568,712	\$ 9,521,237
Percent increase over current costs (for office visits)	94.6%	119.0%
Percent increase over costs for all eight common behavioral health services (from Table 5.3)	5.2%	6.5%

*The actual amount paid based on the claims was \$10,109,413.

Note: The estimates presented here include total costs and do not account for the federal versus state share of HUSKY spending.

Note: The Connecticut Department of Social Services increased reimbursement for select behavioral health services for HUSKY Health (Medicaid) members age 20 years and under pursuant to [Public Act 23-204 §1](#) through a [state plan amendment](#) effective July 1, 2024. Affected behavioral health services, inclusive of family therapy, include behavioral health clinics, psychologists, physician office and outpatient; medical clinics, inclusive of school-based health clinics, and rehabilitation clinics. These increases represent an estimated additional aggregate expenditure of \$13.8 million in state fiscal year 2025 and \$15.5 million in state fiscal year 2026.

5.2 Potential Cost Offsets of Treatment

The State is interested in increasing access to outpatient behavioral health care while simultaneously decreasing avoidable ED care. ED care is necessary in some instances to address

mental health crises or drug overdose. However, access to outpatient care may reduce reliance on the ED and avoid the high costs of ED care. This section of the report examines ED use for BHD and associated costs in relation to outpatient service use to see whether HUSKY and CI enrollees who use outpatient behavioral health treatment have lower behavioral health-related ED use and costs. Specifically, the analysis examined whether enrollees with outpatient behavioral health service use in the first half of the year (2022) were less likely to have an ED visit for a behavioral health condition during the second half of the year, and whether there were any associated cost savings related to reduced ED use. Section 5.2.1 presents the results of the association between outpatient behavioral treatment and ED use. Section 5.2.2 presents the costs associated with ED use and behavioral health treatment.

5.2.1 Association of Outpatient Behavioral Health Treatment with ED Use

Enrollees were grouped by their pattern of outpatient behavioral health treatment in the first half of the year (January through June) into the following categories: 0 visits, 1 to 4 visits, 5 to 17 visits, and 18 or more visits.⁷¹ Table 5.3 summarizes the number and percentage of enrollees with BHD who had at least one ED visit in the second half of the year (July through December) for each of the categories of outpatient behavioral health service use.

Consistent with the findings from Section 3.1, HUSKY enrollees had higher rates of behavioral health ED use than CI enrollees across all outpatient visit categories. However, HUSKY and CI enrollees had similar patterns of ED use in relation to the number of outpatient behavioral visits. HUSKY and CI enrollees with no behavioral health visits had ED visit rates of 6.9% and 1.4%, respectively. For enrollees making one or more behavioral health visit, enrollees in the middle two visit groups (1 to 4 visits; 5 to 17 visits) had ED rates of approximately 4.5% in HUSKY and 0.9% in CI. The group with the highest number of outpatient visits had relatively high ED visit rates at 6.5% in HUSKY and 2.0% in CI. Enrollees with 18 or more visits may represent individuals with more serious or complex behavioral health conditions who are more likely to seek ED care. That is to say that enrollees in the highest outpatient visit group (18 or more visits) may represent enrollees with more serious or complex MHD and SUD, while the middle categories of number of visits may indicate individuals with less severe conditions and patterns of outpatient visits more typical to manage their behavioral health conditions.

⁷¹ These categories were established based on grouping the number of visits in quartiles.

Table 5.3 ED Use in the Second Half of Year by the Average Number of Outpatient Behavioral Health Visits in the First Half of Year for HUSKY and CI Enrollees with BHD

Number of Outpatient Behavioral Health Visits in First Half of Year	HUSKY (n=258,905)		CI (n=188,454)	
	Number of Enrollees	Percentage with an ED Visit in Second Half of Year	Number of Enrollees	Percentage with an ED Visit in Second Half of Year
0 Visits	91,038	6.9%	75,343	1.4%
1 to 4 Visits	57,804	4.4%	55,372	0.9%
5 to 17 Visits	65,051	4.6%	43,620	0.9%
18+ Visits	45,012	6.5%	14,119	2.0%

Table 5.4 presents findings separately for MHD and SUD for HUSKY enrollees by age group, providing additional insights into the association between outpatient behavioral treatment and ED use. Because a high proportion of individuals with BHD have MHD, the findings for MHD parallel those reported above for BHD. HUSKY enrollees with MHD with no behavioral health visits had ED visit rates of 5.9%. For enrollees making one or more behavioral health visit, enrollees had ED visit rates of 4.3% and 4.6% for the 1 to 4 and 5 to 17 visit categories, respectively, and 7.3% for the 18+ visit category. A similar pattern was seen for adults ages 20 to 64. However, the results were different for individuals ages birth to 19 with MHD; those who had 5 to 17 visits had the lowest ED rate (3.2%) while those with the highest number of visits (18+), had the highest rate of ED (6.8%). Among enrollees ages 65 and older, the ED visit rate was higher with increasing number of visits—those with 18+ visits had the highest ED visit rate (7.7%) and those with no outpatient visits had the lowest ED visit rate (1.2%).

Table 5.4 ED Use in the Second Half of Year by the Number of Outpatient Behavioral Health Visits in the First Half of Year for HUSKY Enrollees with MHD or SUD

Number of Outpatient Behavioral Health Visits in First Half of Year	All Enrollees		Ages Birth to 19		Ages 20 to 64		Ages 65 and Over	
	Number of Enrollees	% With ED Visit in Second Half of Year	Number of Enrollees	% With ED Visit in Second Half of Year	Number of Enrollees	% With ED Visit in Second Half of Year	Number of Enrollees	% With ED Visit in Second Half of Year
HUSKY Enrollees with MHD								
0 Visits	78,293	5.9%	22,499	4.2%	48,704	7.4%	7,090	1.2%
1 to 4 Visits	55,039	4.3%	15,232	5.1%	37,896	5.1%	1,911	2.7%
5 to 17 Visits	62,398	4.6%	19,692	3.2%	41,476	5.3%	1,230	2.9%
18+ Visits	37,350	7.3%	11,504	6.8%	25,441	7.5%	405	7.7%
HUSKY Enrollees with SUD								
0 Visits	24,014	17.2%	2,041	15.7%	20,846	17.9%	1127	7.0%
1 to 4 Visits	12,328	14.4%	637	15.1%	11,250	14.6%	441	9.3%
5 to 17 Visits	16,632	12.2%	883	17.4%	15,428	11.9%	321	8.1%
18+ Visits	20,717	9.9%	639	28.3%	19,679	9.4%	399	6.8%

A different pattern was observed for SUD in HUSKY. Among adults ages 20 to 64, there was a clear trend of lower ED use associated with higher outpatient service use. Among this

group, the ED use rate was 17.9% for those who received no outpatient visits, and steadily decreased with more visits: 14.6% for the 1 to 4 group; 11.9% for the 5 to 17 group, and 9.4% for the 18+ group. However, individuals ages birth to 19 with SUD had a different experience—those with the most outpatient visits had the highest percentage of ED visits (28.3%), compared to 5 to 17 visits (17.4%), 1 to 4 visits (15.1%), and no outpatient visits (15.7%). Notably, enrollees ages 65+ who had either no visits or 18+ visits had similar ED rates (7.0% and 6.8%, respectively). ED utilization rates among this group were higher among those with 1 to 4 outpatient visits (9.3%) and 5 to 17 outpatient visits (8.1%). It is unclear why such variations exist in ED usage after outpatient visits.

Table 5.5 reports results for CI enrollees with MHD and SUD by age group. For CI enrollees, the overall ED visit rate for enrollees with MHD is relatively low, particularly for adults. Across the age categories, ED visit rates for enrollees with MHD are highest among enrollees with 18+ outpatient behavioral health visits.

For enrollees ages 20 to 64 with SUD, ED visit rates were lowest in the higher outpatient visit groups (5.8% for enrollees with 5 to 17 visits; 7.1% for enrollees with 18+ visits). This pattern was similar to that seen for adults in HUSKY, but was not as pronounced. There were only 704 individuals ages birth to 19 identified with SUD in CI. ED use was high among these enrollees, but there was no clear pattern of association with ED visit rates.

Table 5.5 ED Use in the Second Half of Year by the Number of Outpatient Behavioral Health Visits in the First Half of Year for CI Enrollees with MHD or SUD

Number of Outpatient Behavioral Health Visits in First Half of Year	All Enrollees		Ages Birth to 19		Ages 20 to 64		Ages 65 and Over	
	Number of Enrollees	% With ED Visit in Second Half of Year	Number of Enrollees	% With ED Visit in Second Half of Year	Number of Enrollees	% With ED Visit in Second Half of Year	Number of Enrollees	% With ED Visit in Second Half of Year
CI Enrollees with MHD								
0 Visits	71,594	1.2%	11,935	1.5%	55,790	1.1%	3,869	0.4%
1 to 4 Visits	54,879	0.9%	10,044	1.2%	43,283	0.8%	1,552	0.5%
5 to 17 Visits	43,220	0.9%	9,350	1.7%	33,095	0.7%	775	0.6%
18+ Visits	13,858	2.0%	3,775	3.6%	9,842	1.4%	241	1.2%
CI Enrollees with SUD								
0 Visits	5905	8.7%	343	19.2%	5183	8.3%	379	4.5%
1 to 4 Visits	2535	8.6%	122	23.8%	2324	8.0%	89	3.4%
5 to 17 Visits	2263	6.8%	168	20.2%	2041	5.8%	54	1.9%
18+ Visits	996	8.1%	71	23.9%	902	7.1%	23	0.0%

These results provide some evidence that use of outpatient services is associated with lower ED use among HUSKY and CI enrollees, particularly those with SUD. These trends are consistent with the literature that higher numbers of outpatient visits are associated with lower ED

use for patients with MHD and SUD, with the exception of patients with more serious conditions.⁷²

5.2.2 Costs of ED and Outpatient Care

The literature examining the association between outpatient behavioral health service use and overall cost of care finds there are cost savings from behavioral health treatment; however, such savings vary substantially over time and by diagnosis. A literature review prepared by the Washington State Department of Social and Health Services (DSHS) Mental Health Division⁷³ found that individuals with serious mental illness did not create medical cost offsets because medical costs increased as patient symptoms stabilized and they accessed needed medical care. A randomized control trial of Medicaid enrollees with chronic medical conditions in Oahu found that patients who received a mental health intervention reported a 10% to 20% decline in total medical costs after 3.5 years, largely driven by fewer hospital days, fewer ED visits, and fewer prescription drugs. A more recent study found cost offsets for Medicaid and CI enrollees with SUD, but not for individuals with serious mental illness after three years.⁷⁴ Other researchers examining the incremental impacts of outpatient behavioral health treatment found that individuals newly diagnosed with a behavioral health condition who used outpatient treatment reported lower medical and prescription drug expenditures over 15 and 27 months. For example, a study found that having one or more outpatient behavioral health visits was associated with a 20% reduction in medical and pharmaceutical costs over 12 months and an 18% reduction in medical and pharmaceutical costs over 27 months.⁷⁵

This section extends the analysis presented in Section 5.2.1 and reports the results of an exploratory analysis of the costs associated with outpatient behavioral health visits and ED use to investigate potential short-term cost offsets of outpatient behavioral health services. Unlike the literature that focuses on long-term effects of outpatient behavioral health visits, this analysis for different patterns of outpatient behavioral service use (0 visits, 1 to 4 visits, 5 to 17 visits, and 18+ visits) in the first half of the year, examines the total per-enrollee costs for behavioral health ED

⁷² Lavergne, M. R., et al. (2022). The Relationship Between Outpatient Service Use and Emergency Department Visits Among People Treated for Mental and Substance Use Disorders: Analysis of Population-Based Administrative Data in British Columbia, Canada. *BMC Health Services Research*, 22(1), 1–12. <https://doi.org/10.1186/s12913-022-07759-z>

⁷³ Anderson, N., & Estee, S. (2002). *Medical Cost Offsets Associated With Mental Health Care: A Brief Review* (Issue December). <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-3-28.pdf>

⁷⁴ Henke, R. M. et al. (2021). Cost Offsets of Treatment for Serious Mental Illness and Substance Use Disorder. *Psychiatric Services*, 72(9), 1006–1011. <https://doi.org/10.1176/appi.ps.201900445>

⁷⁵ Bellon, J. et al. (2022). Association of Outpatient Behavioral Health Treatment With Medical and Pharmacy Costs in the First 27 Months Following a New Behavioral Health Diagnosis in the US. *JAMA Network Open*, 5(12). <https://doi.org/10.1001/jamanetworkopen.2022.44644>

visits, total per-enrollee costs for any ED (all-cause) visits, and total per-enrollee costs for outpatient behavioral health visits are reported in the second half of the year.

Table 5.6 presents the results of the visit-expenditure associations for HUSKY enrollees with MHD or SUD by age group, where the columns include total behavioral health ED costs, total all-cause ED costs, and total outpatient behavioral health treatment costs in the second half of the year for increasing patterns of outpatient behavioral health visits in the first half of the year. For HUSKY enrollees with MHD, total behavioral health ED costs were, on average, \$83 for the six-month period for the group with no outpatient behavioral health visits and \$151 for the group with most outpatient visits. HUSKY enrollees with SUD had behavioral health ED costs of \$236 and \$181 for the no outpatient visit and 18+ outpatient visit groups. Among HUSKY enrollees with MHD, higher use of outpatient care in the first half of the year was associated with lower all-cause ED costs in the second half of the year for the group with 5 to 17 outpatient visits (\$314) compared to the group with no outpatient visits (\$362); however, all-cause ED costs were higher at 18+ outpatient visits (\$404). For HUSKY enrollees with SUD, higher use of outpatient care in the first half of the year was associated with lower all-cause ED costs in the second half of the year (\$505 for the 18+ outpatient visit group versus \$721 for the no outpatient visit group).

Table 5.6 Expenditures for ED and Outpatient Behavioral Health Services in the Second Half of the Year by the Number of Outpatient Behavioral Health Visits in the First Half of the Year for HUSKY enrollees with MHD or SUD

Number of Outpatient Behavioral Health Visits in the First Half of Year	Number of Enrollees	ED and Outpatient Behavioral Health Costs in the Second Half of the Year		
		Total Behavioral Health ED Costs Per Enrollee	Total All-Cause ED Costs Per Enrollee	Total Outpatient Behavioral Health Costs Per Enrollee
Costs per HUSKY Enrollee with MHD (N=233,080)				
0 Visits	78,293	\$83	\$362	\$0
1 to 4 Visits	55,039	\$84	\$323	\$270
5 to 17 Visits	62,398	\$88	\$314	\$1,283
18+ Visits	37,350	\$151	\$404	\$3,792
Costs per HUSKY Enrollee with SUD (N=73,691)				
0 Visits	24,014	\$236	\$721	\$0
1 to 4 Visits	12,328	\$290	\$749	\$304
5 to 17 Visits	16,632	\$225	\$602	\$1,348
18+ Visits	20,717	\$181	\$505	\$3,119

Table 5.7 presents the visit-expenditure association results for CI enrollees with MHD and SUD by age categories. The table shows that higher use of outpatient services in the first half of the year was not associated with meaningful reductions in behavioral health ED expenditures in the second half of the year; however, among enrollees with MHD, higher use of outpatient care in the first half of the year was associated with lower all-cause ED costs in the second half of the year (\$372 for the 0 outpatient behavioral health visit group versus \$266 for the 5 to 17 outpatient

visit group). However, all-cause ED costs were higher at 18+ outpatient visits compared to 1 to 4 and 5 to 17 outpatient visits. Among enrollees with SUD, higher use of outpatient care in the first half of the year was associated with lower all-cause ED costs in the second half of the year (\$930 for the 0 outpatient visit group versus \$799 for the 18+ outpatient visit group).

Table 5.7. Total Expenditures for ED and Outpatient Behavioral Health Services in the Second Half of the Year by the Number of Outpatient Behavioral Health Visits in the First Half of the Year for CI Enrollees with MHD and SUD

Number of Outpatient Behavioral Health Visits in the First Half of Year	Number of Enrollees	ED and Outpatient Behavioral Health Costs in the Second Half of the Year		
		Total Behavioral Health ED Costs Per Enrollee	Total All Cause ED Costs Per Enrollee	Total Outpatient Behavioral Health Costs Per Enrollee
Costs per CI Enrollee with MHD (N=183,551)				
0 Visits	71,594	\$27	\$372	\$0
1 to 4 Visits	54,879	\$23	\$271	\$273
5 to 17 Visits	43,220	\$29	\$266	\$1,152
18+ Visits	13,858	\$72	\$343	\$4,141
Costs per CI Enrollee with SUD (N=11,699)				
0 Visits	5,905	\$189	\$930	\$0
1 to 4 Visits	2,535	\$221	\$765	\$389
5 to 17 Visits	2,263	\$206	\$673	\$1,668
18+ Visits	996	\$253	\$799	\$6,341

This cost-offset analysis focused on total per-enrollee ED costs found that a higher number of outpatient behavioral health visits was associated with lower behavioral health ED costs for HUSKY enrollees with SUD and all-cause ED costs for HUSKY and CI enrollees with SUD; however, although the lower costs were observed for all-cause ED expenditures in the six-month analysis, any overall cost savings were offset by the cost of the outpatient behavioral health care. The lack of an observed finding of a cost offset from higher outpatient service use is potentially attributable to the short timeline. This finding is supported by the cost-offset literature that shows cost savings from behavioral health treatment can take up to three years to achieve and may not extend to individuals with serious mental illness.^{76, 77, 78} While examining potential cost-offsets over a six-month period limits us from identifying cost savings, the short-run analysis did demonstrate that outpatient visits have immediate on service use across different care settings.

⁷⁶ Anderson, N., & Estee, S. (2002). *Medical Cost Offsets Associated With Mental Health Care: A Brief Review* (Issue December). <https://www.dshs.wa.gov/sites/default/files/rda/reports/research-3-28.pdf>

⁷⁷ Henke, R. M. et al. (2021). Cost Offsets of Treatment for Serious Mental Illness and Substance Use Disorder. *Psychiatric Services*, 72(9), 1006–1011. <https://doi.org/10.1176/appi.ps.201900445>

⁷⁸ Bellon, J. et al. (2022). Association of Outpatient Behavioral Health Treatment With Medical and Pharmacy Costs in the First 27 Months Following a New Behavioral Health Diagnosis in the US. *JAMA Network Open*, 5(12). <https://doi.org/10.1001/jamanetworkopen.2022.44644>

APPENDIX A: WARNING SIGNS BEHAVIORAL HEALTH PAYMENT PARITY ANALYSIS

The United States Department of Labor (U.S. DOL) Payment Parity Warning Signs Analysis methodology evaluates behavioral health payment parity for health insurance issuers. The analysis compares reimbursement rates for behavioral health and other medical services against benchmark rates and evaluates whether behavioral health rates are systematically lower than their corresponding benchmark rates as compared to how close reimbursement rates for other medical services are to their respective benchmark rates.⁷⁹ This analysis used the U.S. DOL warning sign analysis methodology to compare HUSKY, MA, and CI issuer rates to benchmark rates to identify issuers with potentially problematic patterns of reimbursement rates. The analysis uses the following steps:

1) Calculate reimbursement rates for a set of behavioral health and other medical services for a given issuer.

The methodology described in Section 2.1 was used to establish reimbursement rates for behavioral health services in Step 1. Psychotherapy and psychiatric diagnostic evaluation services provided by any specialty and office-based services provided by a BH APRN or PA, BH RN, counselor, psychiatrist, psychologist, SW, MFT, or BA are classified as behavioral health services. Reimbursement rates for other medical services were calculated based on CPT codes for office visits by non-behavioral health providers and physical and occupational therapy evaluation by rehabilitative providers. The CPT codes used for calculating reimbursement rates and their descriptions are listed in Table A.1. below.

⁷⁹ US Department of Labor. (2020). *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MPHAEA)*. <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

Table A.1. Warning Signs Analysis CPT Codes and Classification

CPT Code	Description	Classification
90791	Psychiatric diagnostic evaluation	BH service
90832	Psychotherapy, 30 minutes	BH service
90834	Psychotherapy, 45 minutes	BH service
90837	Psychotherapy, 1 hour	BH service
97161	Evaluation of physical therapy, 20 minutes	Other medical service
97163	Evaluation of physical therapy, 45 minutes	Other medical service
97165	Evaluation of occupational therapy, 30 minutes	Other medical service
99203	New patient office or other outpatient visit, 30-44 minutes	Depends on provider type*
99213	Established patient office or other outpatient visit, 20-29 minutes	Depends on provider type*
99214	Established patient office or other outpatient visit, 30-39 minutes	Depends on provider type*

*Classified as a BH service if provided by a behavioral health specialist, i.e., by a BH APRN or PA, BH RN, counselor, psychiatrist, psychologist, SW, MFT, or BA.

2) Create benchmark rates to use as comparison rates for each calculated reimbursement rate.

The benchmark rates for physician-provided services were based on the 2022 Medicare Physician Fee Schedule and the benchmark rates for non-physician practitioners were calculated by computing the median reimbursement rates for each CPT code, for each provider type across the CI issuers represented in the APCD.

3) Compute the ratio of each reimbursement rate (from Step 1) to its respective benchmark rate (from Step 2).

The ratios of HUSKY, MA, and CI issuer reimbursement rates to their respective benchmark rates are listed in Tables A.2 to A.4 as percentages of the benchmark rate. Medicare is not subject to federal parity requirements, but results for MA are included in this analysis for comparison purposes.

4) Review the ratios to see if they are consistent across behavioral health services and other medical services.

The ratios were compared across behavioral health and other medical services for HUSKY, MA, and each CI issuer to see whether a preponderance of ratios for behavioral health services were lower than the ratios for other medical services. Higher ratios (above 100) indicate that the issuer pays a higher rate relative to the benchmark; lower ratios (below 100) indicate rates that are lower than the benchmark. The DOL specifies that outcomes of this analysis are not determinative of a MHPAEA violation, but rather serve as red flags or “Warning Signs” to alert the plan or issuer that provider reimbursement rates warrant further review.

Summary of Results

HUSKY. The analysis, shown in Table A2, showed that HUSKY reimbursement rates were lower than the benchmark rates across all behavioral health and other medical services and all provider types included in the analysis. However, HUSKY reimbursement rates for other medical services were lower relative to their respective benchmark rates than HUSKY rates for behavioral health services. While the lower reimbursement rates across all services may be cause for concern, there is no specific concern regarding behavioral health payment parity in HUSKY.

MA. Several ratios for MA psychiatrists were lower than the ratios for the other physician specialties, including 20-29-minute office visits, psychiatric diagnostic evaluation, and 60-minute psychotherapy. These findings suggest that physician-provided behavioral health services are not in parity with other physician-provided services in MA (Table A2).

CI. The CI analysis included seven issuers that were represented in the 2022 APCD. Three of the seven issuers in the State had rates that were near their benchmark or higher for nearly all behavioral health and other medical services. The behavioral health services from these issuers had ratios that were in a similar range as the ratios for other medical services. There are no parity concerns for these issuers. These issuers included Aetna, Harvard Pilgrim Health Care, and Tufts Health Plan (Table A3). Four issuers had a preponderance of ratios for behavioral health services that were lower than the benchmark, including several that were less than 90 percent of the benchmark. In contrast, most ratios for other medical services were near or above the benchmark. These four issuers included Anthem, Cigna, ConnectiCare, and United HealthCare (Table A4).

Table A.2. Comparison of HUSKY and MA Reimbursement Rates to Benchmark Reimbursement Rates for Common Behavioral Health and Other Medical Services, 2022

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate	
			HUSKY	MA
20-29-minute office visit	Allergy & Immunology	\$98	76%	99%
	General APRN and PA	\$82	61%	101%
	Colon & Rectal Surgery	\$98	44%	99%
	Dermatology	\$98	44%	99%
	Obstetrics & Gynecology	\$98	44%	99%
	Orthopaedic Surgery	\$98	44%	99%
	Otolaryngology	\$98	44%	99%
	Pediatrics	\$98	84%	99%
	Physical Medicine & Rehab	\$98	44%	99%
	Primary Care	\$98	76%	99%
	General RN	\$71	74%	137%
	BH APRN and PA	\$58	67%	104%

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate	
			HUSKY	MA
Counselor		\$91	90%	94%
	Psychiatrist	\$98	44%	80%
30-39-minute office visit	Allergy & Immunology	\$139	58%	99%
	General APRN and PA	\$121	82%	96%
	Colon & Rectal Surgery	\$139	47%	99%
	Dermatology	\$139	47%	99%
	Obstetrics & Gynecology	\$139	47%	99%
	Orthopaedic Surgery	\$139	47%	99%
	Otolaryngology	\$139	47%	99%
	Pediatrics	\$139	88%	99%
	Physical Medicine & Rehab	\$139	47%	99%
	Primary Care	\$139	80%	99%
	General RN	\$105	69%	112%
	BH APRN and PA	\$105	56%	61%
	Counselor	\$129	89%	106%
	Psychiatrist	\$139	47%	98%
30-minute evaluation of occupational therapy	BH RN	\$81	142%	100%
	SW, MFT, BA	\$120	95%	46%
	Rehabilitative Providers	\$65	123%	145%
	Rehabilitative Providers	\$68	123%	126%
	Rehabilitative Providers	\$80	104%	106%
30-44-minute new patient office visit	General APRN and PA	\$123	56%	83%
Psychiatric diagnostic evaluation	BH APRN and PA	\$148	90%	75%
	Counselor	\$125	86%	95%
	Psychiatrist	\$188	74%	81%
	Psychologist	\$134	97%	90%
	SW, MFT, BA	\$125	86%	90%
30-minute psychotherapy	BH APRN and PA	\$67	71%	56%
	Counselor	\$55	81%	112%
	Psychiatrist	\$82	86%	80%
	Psychologist	\$65	83%	77%
	SW, MFT, BA	\$55	81%	90%
45-minute psychotherapy	BH APRN and PA	\$84	97%	95%
	Counselor	\$81	81%	91%
	Primary Care	\$108	83%	71%
	Psychiatrist	\$108	83%	93%
	Psychologist	\$95	84%	88%

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate	
			HUSKY	MA
	Rehabilitative Providers	\$170		44%
	SW, MFT, BA	\$81	81%	91%
60-minute psychotherapy	General APRN and PA	\$100	122%	120%
	BH APRN and PA	\$104	117%	121%
	Counselor	\$98	101%	119%
	Psychiatrist	\$159	85%	79%
	Psychologist	\$107	112%	127%
	Rehabilitative Providers	\$125	79%	72%
	SW, MFT, BA	\$98	101%	102%

1. *Psychiatric diagnostic evaluation and psychotherapy services are categorized as behavioral health services, regardless of the specialty provider type. Office visits are categorized as behavioral health services when they are provided by a behavioral health specialty provider. In the table, behavioral health services are indicated by red font, and other medical services are indicated by black font.*
2. *Higher ratios (above 100) indicate that the issuer pays a higher rate relative to the benchmark, and lower ratios (below 100) indicate rates that are lower than the benchmark.*
3. *Gray cells indicate that there were too few claims (<50) to compute a reliable rate.*
4. *Light-orange-shaded cells highlight issuer-to-benchmark ratios that are between 90% and 100%; dark orange cells highlight ratios that are lower than 90%.*

Table A.3. Comparison of CI Reimbursement Rates to Benchmark Reimbursement Rates for Common Behavioral Health and Other Medical Services, 2022

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate		
			Tufts	Aetna	Harvard Pilgrim Health Care
20-29-minute office visit	Allergy & Immunology	\$98		113%	120%
	General APRN and PA	\$82	101%	101%	126%
	Colon & Rectal Surgery	\$98		100%	
	Dermatology	\$98	99%	99%	118%
	Obstetrics & Gynecology	\$98	100%	106%	136%
	Orthopaedic Surgery	\$98	99%	100%	127%
	Otolaryngology	\$98	99%	99%	118%
	Pediatrics	\$98	110%	118%	127%
	Physical Medicine & Rehab	\$98	99%	99%	115%
	Primary Care	\$98	99%	99%	118%
	General RN	\$71		116%	
	BH APRN and PA	\$58	141%	135%	157%
	Counselor	\$91		93%	
	Psychiatrist	\$98	99%	99%	108%
30-39-minute office visit	Allergy & Immunology	\$139		119%	131%
	General APRN and PA	\$121	96%	96%	125%
	Colon & Rectal Surgery	\$139		100%	
	Dermatology	\$139	99%	99%	125%
	Obstetrics & Gynecology	\$139	100%	111%	141%
	Orthopaedic Surgery	\$139	99%	100%	131%
	Otolaryngology	\$139	99%	99%	125%
	Pediatrics	\$139	120%	128%	137%
	Physical Medicine & Rehab	\$139	99%	99%	116%
	Primary Care	\$139	99%	99%	128%
	General RN	\$105		112%	
	BH APRN and PA	\$105	105%	111%	123%
	Counselor	\$129		106%	
	Psychiatrist	\$139	99%	99%	109%
30-minute evaluation of occupational therapy	BH RN	\$81		100%	
	SW, MFT, BA	\$120			
20-minute Evaluation of physical therapy	Rehabilitative Providers	\$65		166%	
	Rehabilitative Providers	\$68	118%	159%	177%

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate		
			Tufts	Aetna	Harvard Pilgrim Health Care
45-minute evaluation of physical therapy	Rehabilitative Providers	\$80		168%	
30-44-minute new patient office visit	General APRN and PA	\$123	83%	89%	123%
Psychiatric diagnostic evaluation	BH APRN and PA	\$148			
	Counselor	\$125		91%	125%
	Psychiatrist	\$188		85%	
	Psychologist	\$134		120%	132%
	SW, MFT, BA	\$125	124%	97%	125%
30-minute psychotherapy	BH APRN and PA	\$67			
	Counselor	\$55		116%	123%
	Psychiatrist	\$82		100%	
	Psychologist	\$65		126%	117%
	SW, MFT, BA	\$55	147%	115%	123%
45-minute psychotherapy	BH APRN and PA	\$84		126%	
	Counselor	\$81	109%	117%	110%
	Primary Care	\$108		110%	
	Psychiatrist	\$108		114%	110%
	Psychologist	\$95	103%	130%	107%
	Rehabilitative Providers	\$170		101%	
	SW, MFT, BA	\$81	109%	117%	110%
60-minute psychotherapy	General APRN and PA	\$100		130%	
	BH APRN and PA	\$104		127%	
	Counselor	\$98	131%	114%	135%
	Psychiatrist	\$159		105%	111%
	Psychologist	\$107	135%	139%	140%
	Rehabilitative Providers	\$125		100%	
	SW, MFT, BA	\$98	121%	114%	135%

1. Psychiatric diagnostic evaluation and psychotherapy services are categorized as behavioral health services, regardless of the specialty provider type. Office visits are categorized as behavioral health services when they are provided by a behavioral health specialty provider. In the table, behavioral health services are indicated by red font, and other medical services are indicated by black font.

2. Higher ratios (above 100) indicate that the issuer pays a higher rate relative to the benchmark, and lower ratios (below 100) indicate rates that are lower than the benchmark.

3. Gray cells indicate that there were too few claims (<50) to compute a reliable rate.

4. Light-orange-shaded cells highlight issuer-to-benchmark ratios that are between 90% and 100%; dark orange cells highlight ratios that are lower than 90%.

Table A.4. Comparison of CI Reimbursement Rates to Benchmark Reimbursement Rates for Common Behavioral Health and Other Medical Services, 2022

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate			
			ConnectiCare	Cigna	United Healthcare	Anthem
20-29-minute office visit	Allergy & Immunology	\$98	100%	95%	99%	95%
	General APRN and PA	\$82	102%	115%	102%	96%
	Colon & Rectal Surgery	\$98	111%	125%	99%	98%
	Dermatology	\$98	99%	95%	99%	87%
	Obstetrics & Gynecology	\$98	114%	134%	99%	111%
	Orthopaedic Surgery	\$98	100%	95%	99%	87%
	Otolaryngology	\$98	99%	95%	99%	92%
	Pediatrics	\$98	102%	95%	99%	95%
	Physical Medicine & Rehab	\$98	98%	86%	99%	84%
	Primary Care	\$98	99%	106%	99%	94%
	General RN	\$71	117%	97%	137%	100%
	BH APRN and PA	\$58	157%	100%	116%	100%
	Counselor	\$91				99%
	Psychiatrist	\$98	100%	78%	87%	76%
30-39-minute office visit	Allergy & Immunology	\$139	111%	100%	100%	99%
	General APRN and PA	\$121	97%	117%	97%	95%
	Colon & Rectal Surgery	\$139	116%	113%	99%	103%
	Dermatology	\$139	100%	100%	99%	91%
	Obstetrics & Gynecology	\$139	115%	138%	99%	103%
	Orthopaedic Surgery	\$139	103%	100%	99%	95%
	Otolaryngology	\$139	103%	102%	99%	99%
	Pediatrics	\$139	111%	100%	115%	100%
	Physical Medicine & Rehab	\$139	99%	97%	99%	89%
	Primary Care	\$139	99%	116%	99%	99%
	General RN	\$105	113%	141%	113%	100%
	BH APRN and PA	\$105	123%	96%	100%	61%
	Counselor	\$129				
	Psychiatrist	\$139	99%	91%	98%	84%
30-minute evaluation of occupational therapy	BH RN	\$81		112%	127%	79%
	SW, MFT, BA	\$120			46%	100%
20-minute evaluation of physical therapy	Rehabilitative Providers	\$65	135%	144%	141%	100%
	Rehabilitative Providers	\$68	121%	119%	126%	100%

Service	Specialty Provider Type	Benchmark Rate	Ratio of Issuer Rate to Benchmark Rate			
			ConnectiCare	Cigna	United Healthcare	Anthem
45-minute evaluation of physical therapy	Rehabilitative Providers	\$80	100%	101%	106%	85%
30-44-minute new patient office visit	General APRN and PA	\$123	100%	126%	91%	95%
Psychiatric diagnostic evaluation	BH APRN and PA	\$148	75%		119%	89%
	Counselor	\$125	125%	86%	125%	100%
	Psychiatrist	\$188	83%	87%	84%	89%
	Psychologist	\$134	100%	93%	92%	99%
	SW, MFT, BA	\$125	125%	86%	94%	100%
30-minute psychotherapy	BH APRN and PA	\$67	52%		58%	82%
	Counselor	\$55	123%	95%	120%	100%
	Psychiatrist	\$82	82%	86%	80%	134%
	Psychologist	\$65	60%	90%	60%	93%
	SW, MFT, BA	\$55	64%	95%	64%	100%
45-minute psychotherapy	BH APRN and PA	\$84	121%	126%	111%	100%
	Counselor	\$81	110%	85%	110%	100%
	Primary Care	\$108	70%	83%	77%	88%
	Psychiatrist	\$108	83%	82%	93%	107%
	Psychologist	\$95	107%	86%	99%	94%
	Rehabilitative Providers	\$170		118%	54%	57%
	SW, MFT, BA	\$81	110%	85%	105%	100%
60-minute psychotherapy	General APRN and PA	\$100	132%	157%	147%	100%
	BH APRN and PA	\$104	144%	152%	127%	96%
	Counselor	\$98	135%	105%	135%	100%
	Psychiatrist	\$159	83%	99%	95%	87%
	Psychologist	\$107	122%	108%	128%	100%
	Rehabilitative Providers	\$125		84%	89%	100%
	SW, MFT, BA	\$98	135%	105%	135%	100%

1. Psychiatric diagnostic evaluation and psychotherapy services are categorized as behavioral health services, regardless of the specialty provider type. Office visits are categorized as behavioral health services when they are provided by a behavioral health specialty provider. In the table, behavioral health services are indicated by red font, and other medical services are indicated by black font.

2. Higher ratios (above 100) indicate that the issuer pays a higher rate relative to the benchmark, and lower ratios (below 100) indicate rates that are lower than the benchmark.

3. Gray cells indicate that there were too few claims (<50) to compute a reliable rate.

4. Light-orange-shaded cells highlight issuer-to-benchmark ratios that are between 90% and 100%; dark orange cells highlight ratios that are lower than 90%.