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

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Acknowledgements

This study was undertaken by Acumen, LLC on behalf of the Connecticut Office of Health Strategy

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Background
Authorizing Legislation

In accordance with Public Act 22-47 §§ 57-58, An Act Concerning Children's Mental Health, the Connecticut Office of Health Strategy (OHS) commissioned two coordinated studies:

- The Behavioral Health Coverage by Private Insurers Study (Behavioral Health Coverage Study)
  - A study of the rates at which health carriers delivering, issuing for delivery, renewing, amending, or continuing individual and group health insurance policies in the state and third-party administrators … reimburse health care providers for covered physical, mental, and substance use disorder benefits (Subsection 57)
- The Payment Parity Study
  - A study of whether payment parity exists between providers of mental health and substance use disorder services and providers of other medical services in the private insurance market, such providers within the HUSKY Health program and HUSKY Health program mental health and substance use disorder providers, and their counterparts in the private insurance market (Subsection 58)

Background

Presentation Contents

- Behavioral Health Workforce Literature Review and Environmental Scan
- Behavioral Health Reimbursement Rates and Payment Parity in HUSKY; Private, or Commercial Insurance (CI); and Medicare Advantage (MA)
- Behavioral Health Service Use
- Financial Drivers of Behavioral Health Service Use
- Financial Impact of Behavioral Health Treatment

Background

Methodological Notes and Study Limitations

The analyses used claims data from the 2022 Connecticut All-Payer Claims Database (APCD).

- Other sources of State funding that supplement public and private insurance payments—for example, grant funds provided through DMHAS—are not represented in the analyses.

The CI data include claims for all fully insured commercial lives (employer-sponsored small and large groups plans and individual plans purchased on the insurance exchange) 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.

Because of the complex funding for facility-based behavioral health services, the analyses focused on claims billed by individual physicians or other practitioners (professional medical claims). Therefore, the analyses are relevant to professional claim payments to practitioners.

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

The payment parity analysis highlights reimbursement patterns that warrant further scrutiny; the results, on their own, do not constitute mental health parity non-compliance.

Study Conclusions

Recommendations for Consideration

- Examine HUSKY reimbursement rates for behavioral health services in relation to Medicare fee-for-service rates and median commercial insurance rates, prioritizing the services with the largest discrepancies between HUSKY and commercial insurance (established patient office visits by psychiatrists, behavioral health advanced practice nurses, and behavioral health physician assistants).
- 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 Medicare Advantage 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.

Behavioral Health Workforce Literature Review and Environmental Scan

Behavioral Health Workforce Literature Review

Behavioral Health Provider Participation in Medicaid

- Behavioral health provider participation in insurance declined across all insurance types in recent years and one of the most commonly discussed reasons for these declines, especially in Medicaid, has been low levels of provider reimbursement.
- Studies analyzing the impact of temporary Medicaid fee increases for primary care mandated by the Affordable Care Act (ACA) found a positive association between fee increases and appointment availability for Medicaid enrollees. Physicians already participating in Medicaid increased the number of Medicaid patients they accepted, but there was no evidence that more providers enrolled in Medicaid as a result.
- Other studies on Medicaid fee increases found that changes in fees contributed to increased healthcare utilization and improved the ability of beneficiaries to find providers accepting Medicaid.

**Note that these are general findings from the academic literature and are not specific to Connecticut; the references and full citations are included in the full Environmental Scan Report and are available upon request.*

Behavioral Health Workforce Literature Review

Approaches to Expand the Behavioral Health Workforce

- *Peer Support Services* – Certify individuals who have recovered from a mental health or substance use disorder to provide support to those experiencing similar conditions.
- *Inter-State Licensing* – Allow qualifying providers to practice in participating states without having to obtain additional licensure.
- *School-Based Health Care* – Expand school-based care to expand access and reduce emergency department visits.
- *Crisis Care* – Enhance crisis care networks and services for individuals experiencing psychiatric or substance abuse related emergencies who require immediate care.

**Note that these are general findings from the academic literature and are not specific to Connecticut; the references and full citations are included in the full Environmental Scan Report and are available upon request.*

Behavioral Health Workforce Literature Review

Approaches to Attract and Retain New Workers and Incentivize Providers to Work in Mental Health Shortage Areas

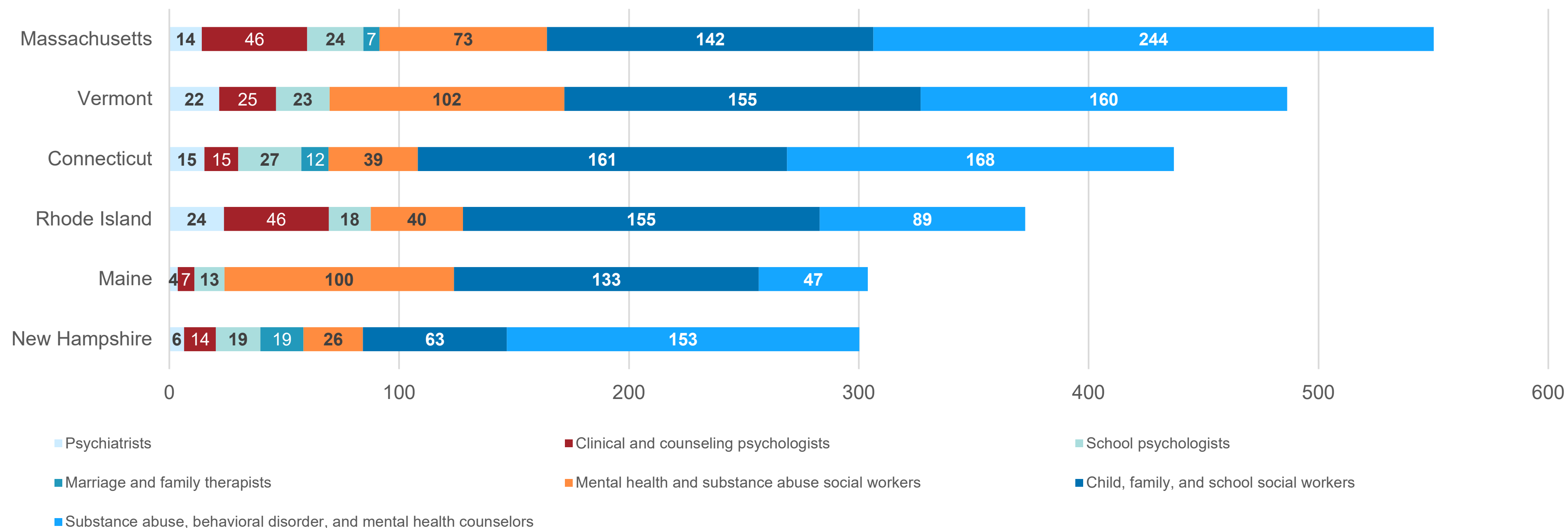
- Increase psychiatrist residency spots.
- Implement loan forgiveness and scholarship programs.
- Provide other financial incentives for providers in underserved areas.
- Establish professional outreach and mentorship programs to promote behavioral health opportunities.

**Note that these are general findings from the academic literature and are not specific to Connecticut; the references and full citations are included in the full Environmental Scan Report and are available upon request.*

Behavioral Health Workforce Environmental Scan

Number of Behavioral Health Providers per 100,000 Total Population in New England States

- Connecticut has the third highest number of behavioral health providers per 100,000 total state population in the New England region, behind Massachusetts and Vermont.
- Connecticut is fourth in the per capita number of more highly trained providers, specifically psychologists (combined school and counseling/clinical) and social workers (combined behavioral health and child/family social workers).

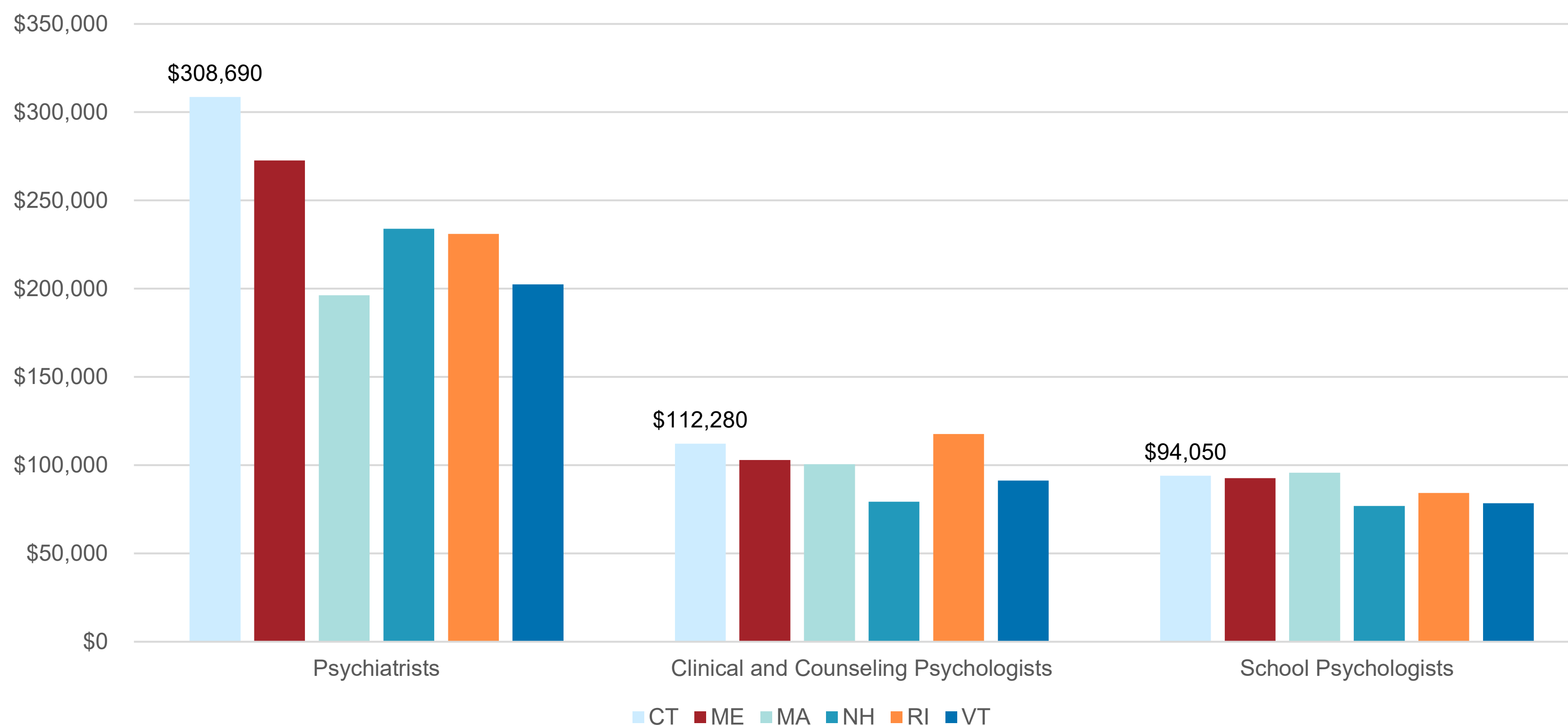


Source: U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates; based on surveys of employers who pay unemployment insurance, may under-represent self-employed individuals.

Behavioral Health Workforce Environmental Scan

Average Salaries for Behavioral Health Professions in New England States (1 of 2)

- Connecticut has the highest average salary for psychiatrists in the New England region, and the second highest for clinical and counseling psychologists and school psychologists.

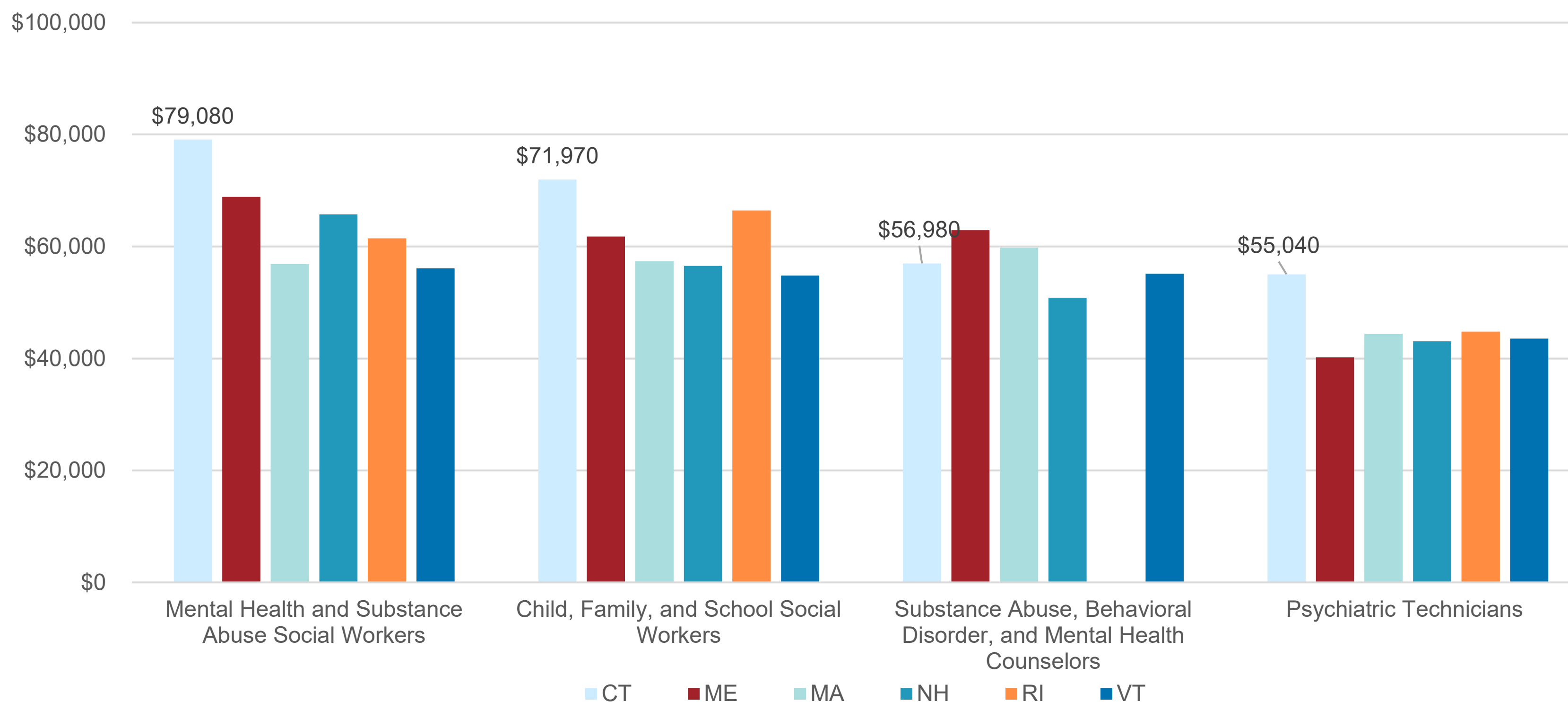


Source: U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates; based on surveys of employers who pay unemployment insurance, may under-represent self-employed individuals.

Behavioral Health Workforce Environmental Scan

Average Salaries for Behavioral Health Professions in New England States (2 of 2)

- Connecticut has the highest average salary for mental health and substance abuse social workers; child, family, and school social workers; and psychiatric technicians in New England.



Source: U.S. Bureau of Labor Statistics, May 2022 State Occupational Employment and Wage Estimates; based on surveys of employers who pay unemployment insurance, may under-represent self-employed individuals.

Behavioral Health Reimbursement Rates and Payment Parity

Behavioral Health Reimbursement Rates

Behavioral Health Reimbursement Rates in HUSKY, CI, and MA

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

Behavioral Health Payment Parity

Behavioral Health Payment Parity in HUSKY, MA, and CI

HUSKY

- Reimbursement rates in HUSKY were lower than established benchmark comparison rates across all behavioral health and other medical services included in the parity analysis.
- There were no disparities between the rates for behavioral health and other medical services; HUSKY paid comparably low rates for both behavioral health and other medical services.

Medicare Advantage (MA)

- Physician-provided behavioral health services were not in parity with other physician-provided services in MA.

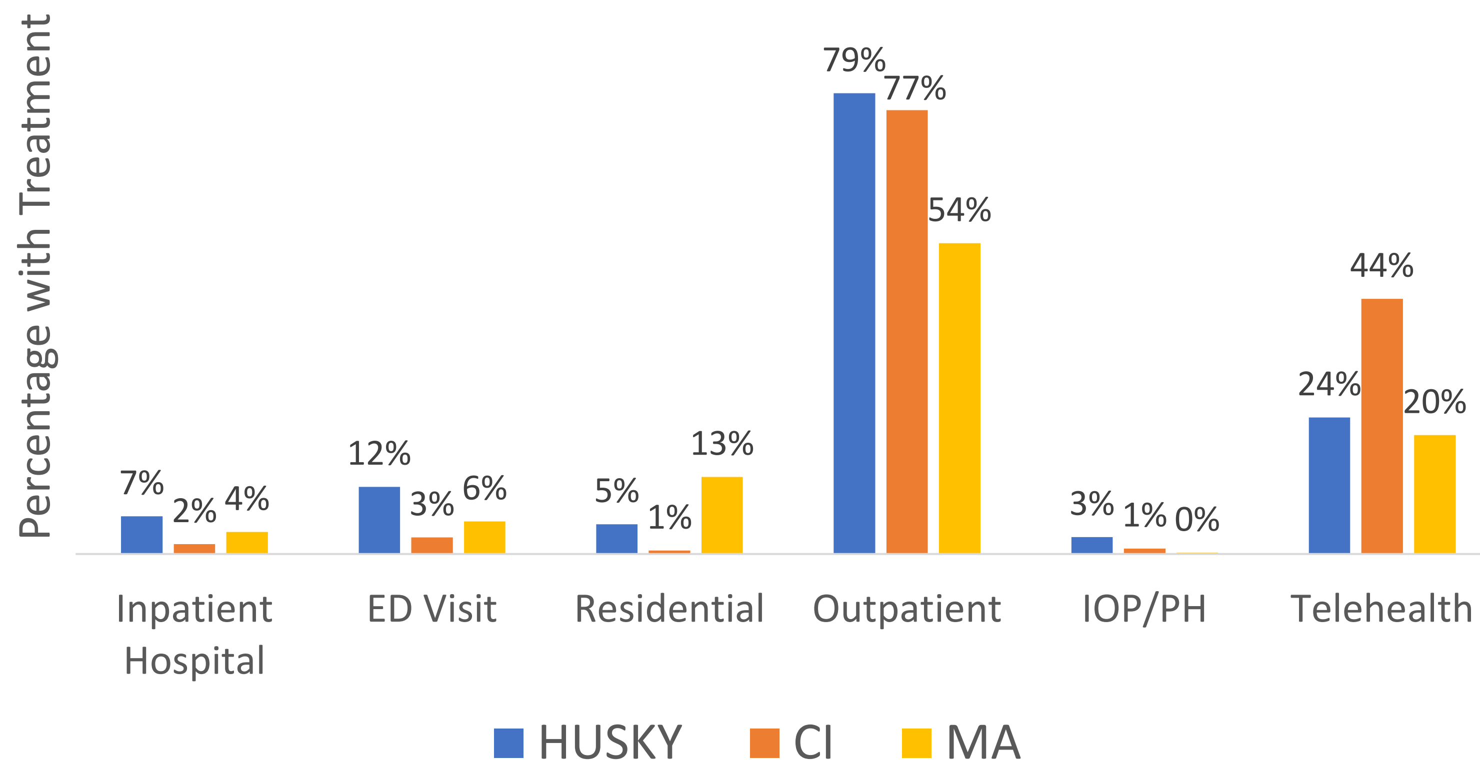
Commercial Insurance (CI)

- Four of seven CI issuers represented in the APCD had evidence of disparities between their behavioral health and other medical service rates.

Behavioral Health Service Use

Behavioral Health Service Use

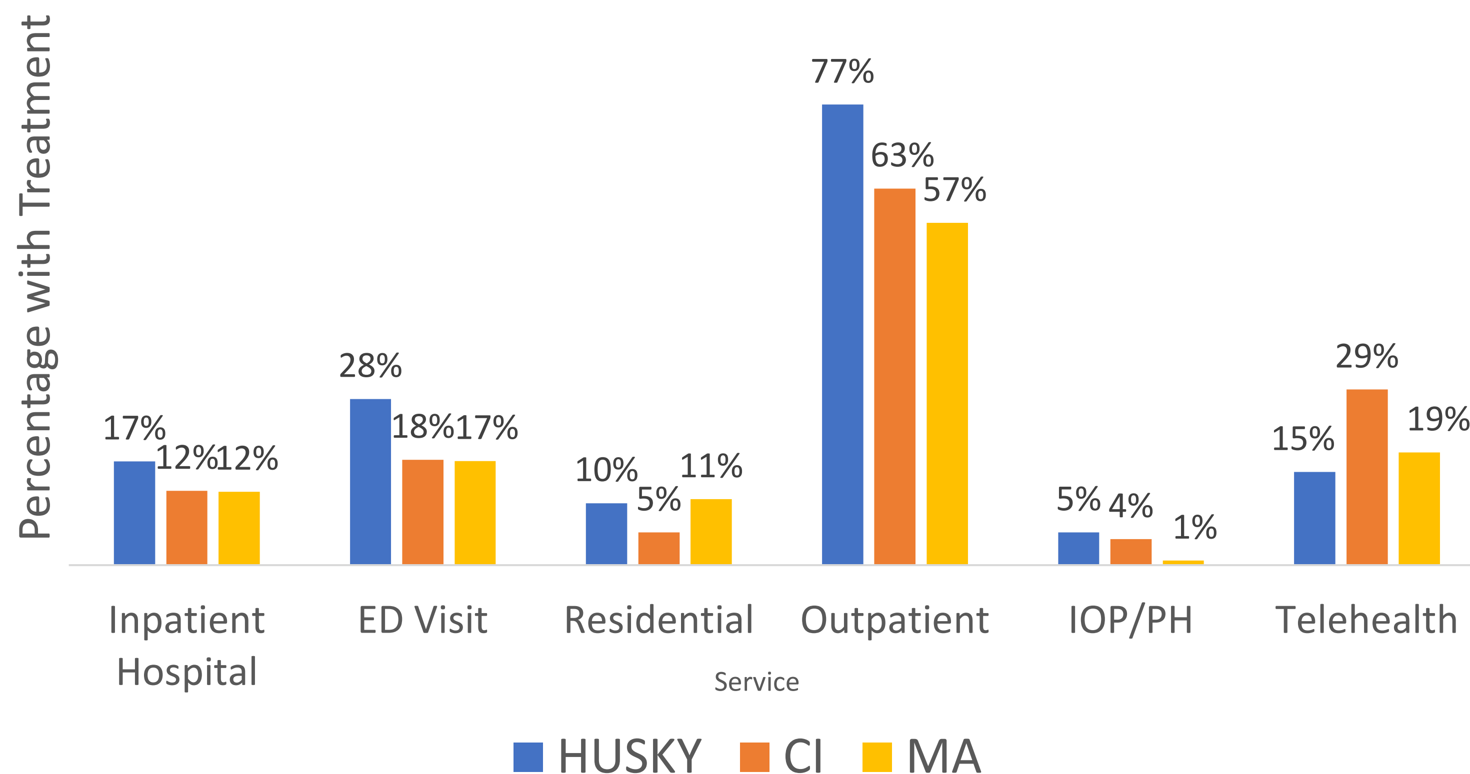
Behavioral Health Service Use Among Enrollees with Mental Health Disorder (MHD)



- Outpatient behavioral health service use among persons 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.

Behavioral Health Service Use

Behavioral Health Service Use Among Enrollees with a Substance Use Disorder (SUD)



- Over one-quarter (28%) of HUSKY enrollees with an SUD had a behavioral health-related ED visit compared to 18% of CI enrollees and 17% of MA enrollees with SUD.
- HUSKY enrollees with SUD had the highest rate of outpatient treatment.

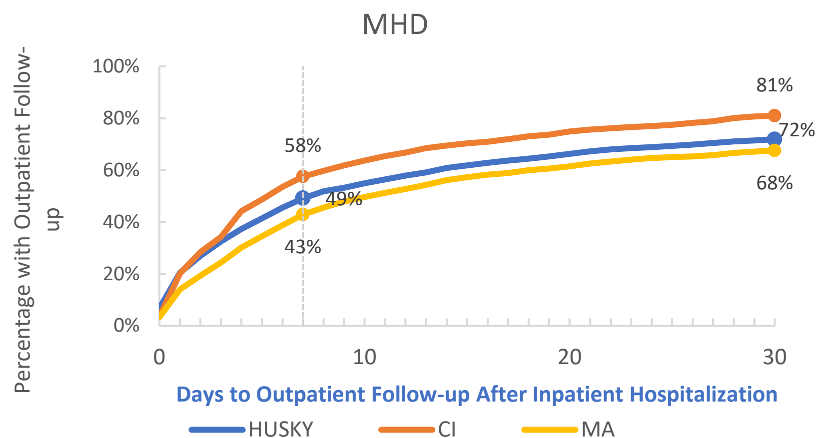
Behavioral Health Service Use

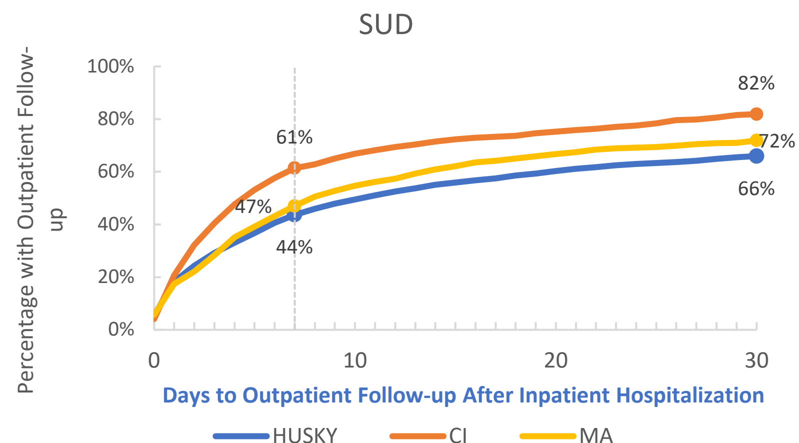
Behavioral Health Service Use by Age, Sex, and Geography

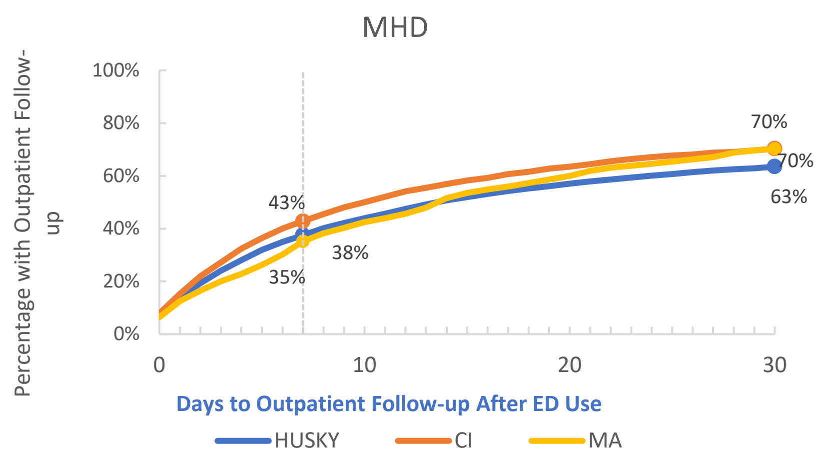
- Youth ages birth to 19 with an MHD in both HUSKY (83%) and CI (82%) had high rates of outpatient service use.
- Just over half of youth with an SUD in HUSKY and CI (59% in both groups) had outpatient service use, as represented in the claims. However, they might have received SUD services paid through 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.

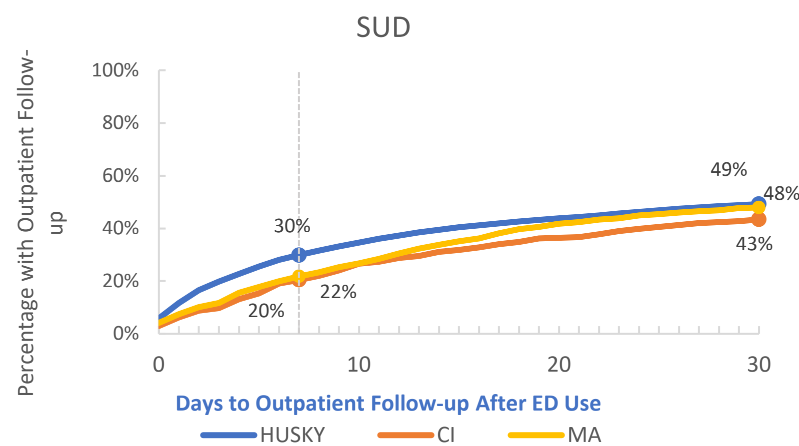
Behavioral Health Service Use

Follow-up After Inpatient Hospitalization and ED Use, **Ages 20 and Over**









- Among those ages 20 and over, follow-up rates after an inpatient hospitalization for MHD were higher in CI compared to HUSKY and MA after both 7 and 30 days.
- This trend was similar for follow-up after hospitalization for SUD.
- Follow-up rates after an ED visit for MHD were higher in CI (70%) compared to HUSKY (63%) and the same for MA (70%).
- However, follow-up rates after an ED visit for SUD were higher in HUSKY (49%) compared to CI (43%) and MA (48%).

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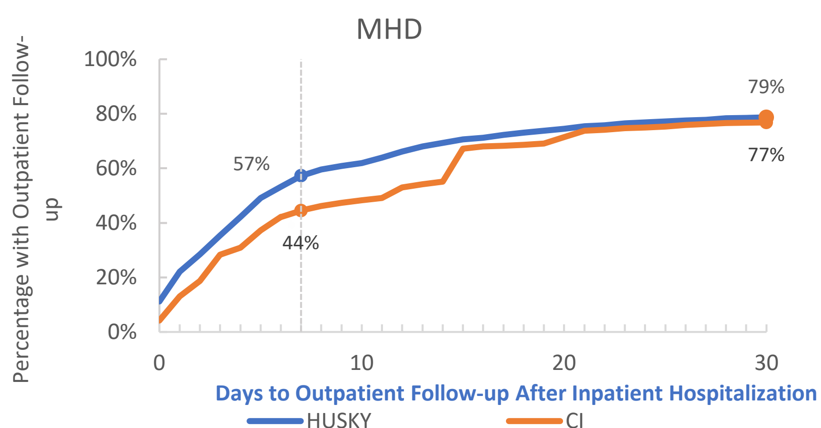
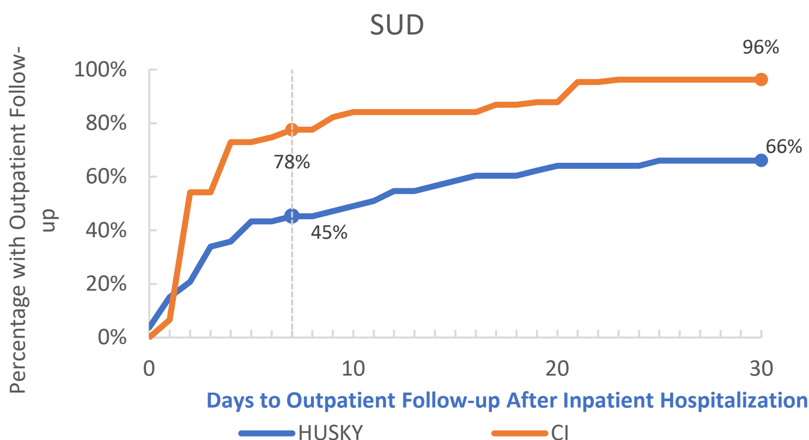
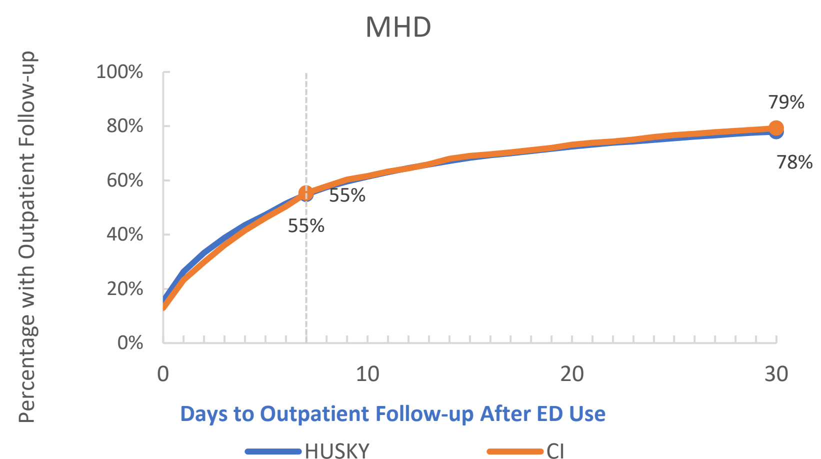
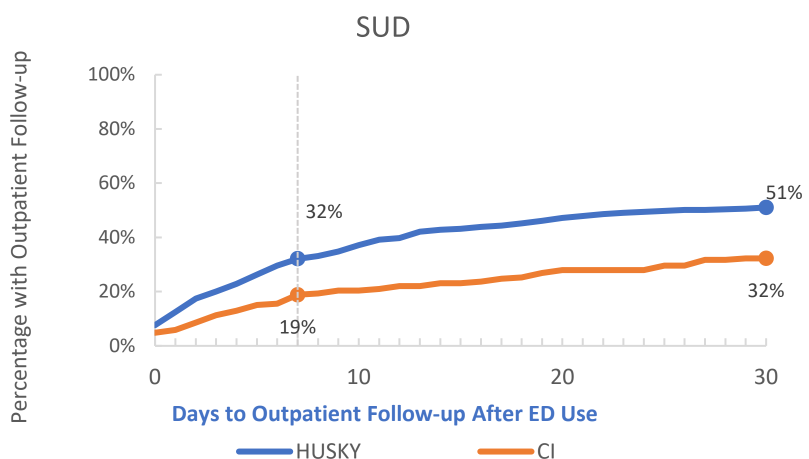
Behavioral Health Service Use

Follow-up After Inpatient Hospitalization and ED Use, **Ages 6 to 19**







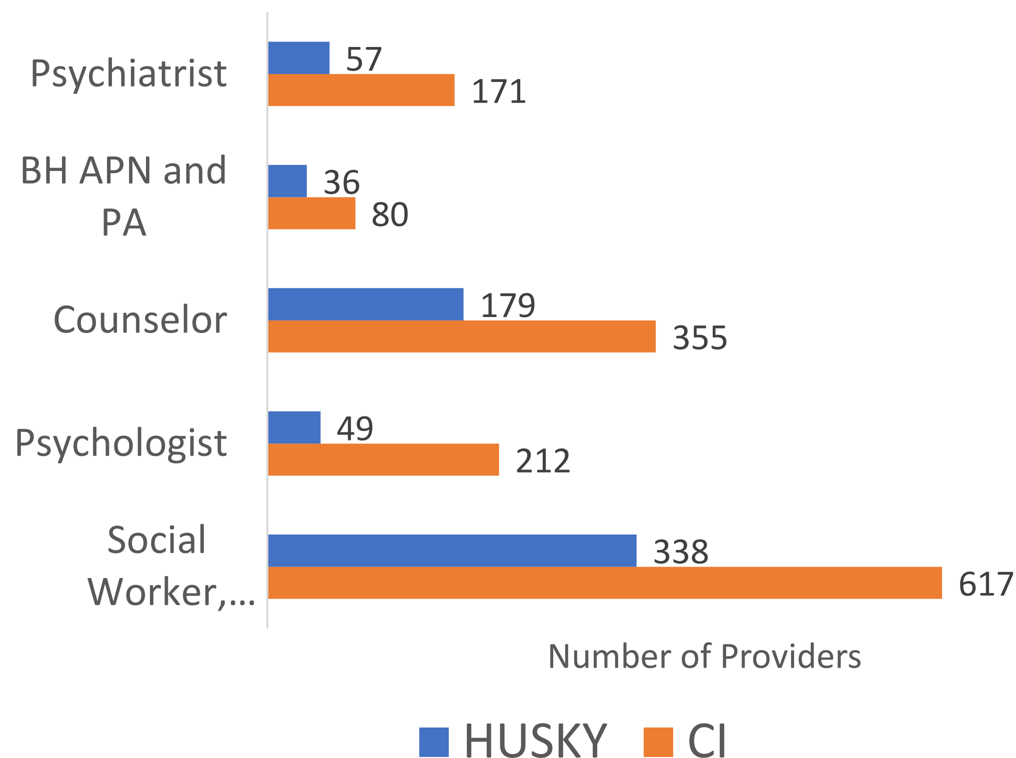


- Among youth ages 6 to 19, 30-day follow-up rates after both inpatient hospitalizations and ED visits for MHD were similarly high in HUSKY and CI, at around 80%.
- In CI, nearly all youth (96%) received a follow-up visit after hospitalization for SUD, whereas approximately one-third (32%) received a 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.

*Includes office-based care and outpatient care, intensive outpatient treatment, partial hospitalization, and residential treatment

Behavioral Health Service Use

Behavioral Health Provider Supply

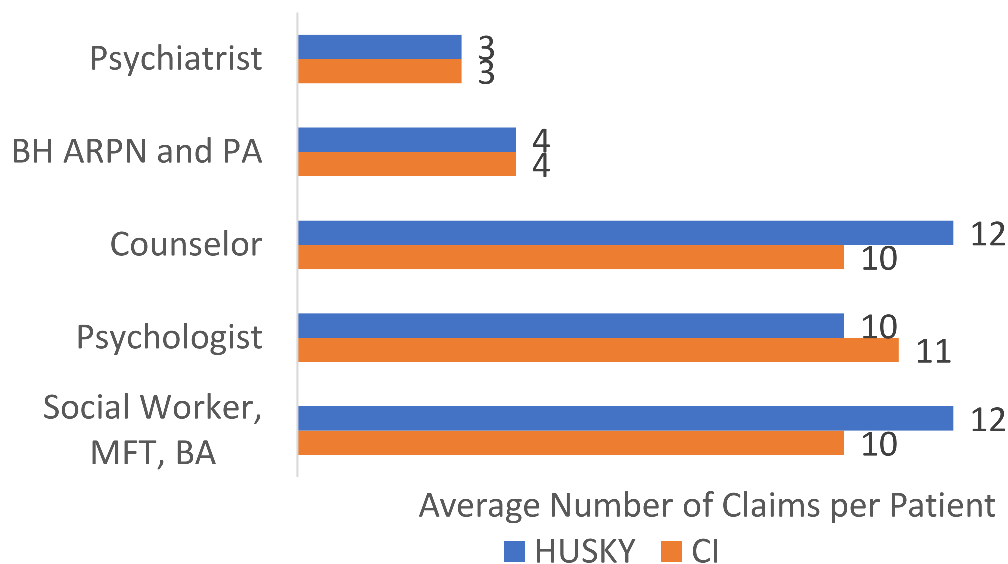


- There were significantly fewer behavioral health providers who saw HUSKY enrollees compared to the number who saw CI enrollees, particularly psychiatrists and psychologists.

Behavioral Health Service Use

Volume of Services Provided to Enrollees with an MHD or SUD

Average Number of Behavioral Health Services per Enrollee with a Behavioral Health Disorder (either an MHD or SUD) in HUSKY and CI



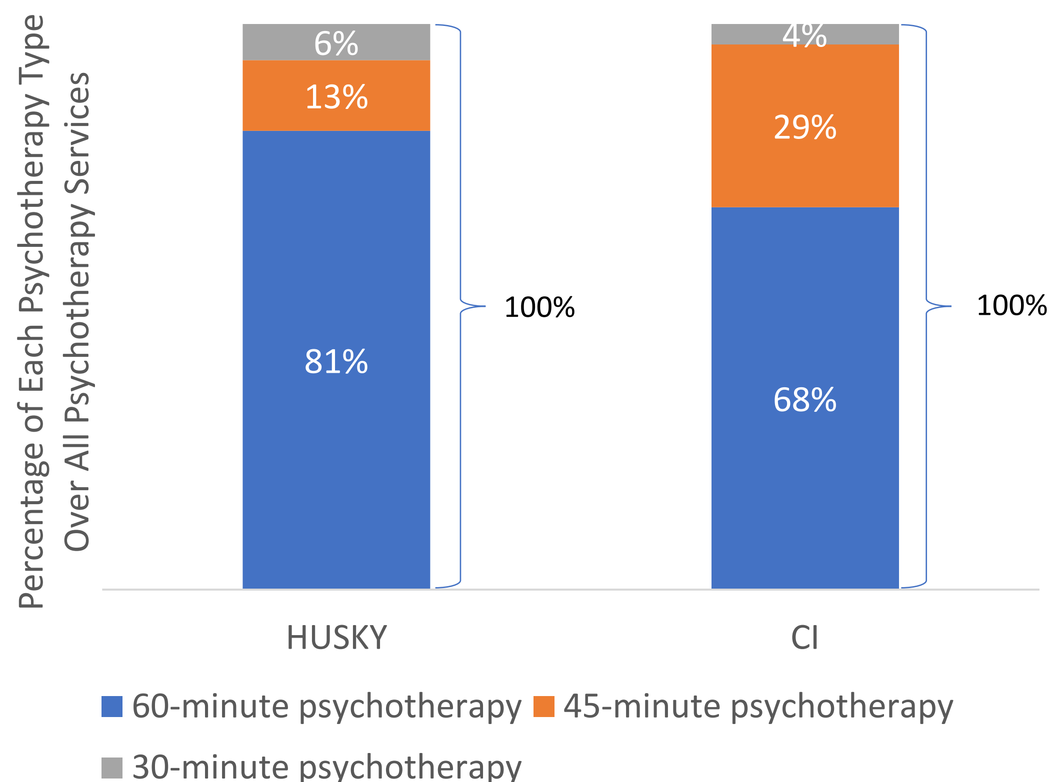
- Despite there being fewer available providers, HUSKY enrollees with a behavioral health disorder received a comparable volume of behavioral health services compared to CI enrollees.
- However, their care was concentrated among fewer providers.

Financial Drivers of Behavioral Health Services

Financial Drivers of Behavioral Health Services

Use of Psychotherapy Services in HUSKY and CI

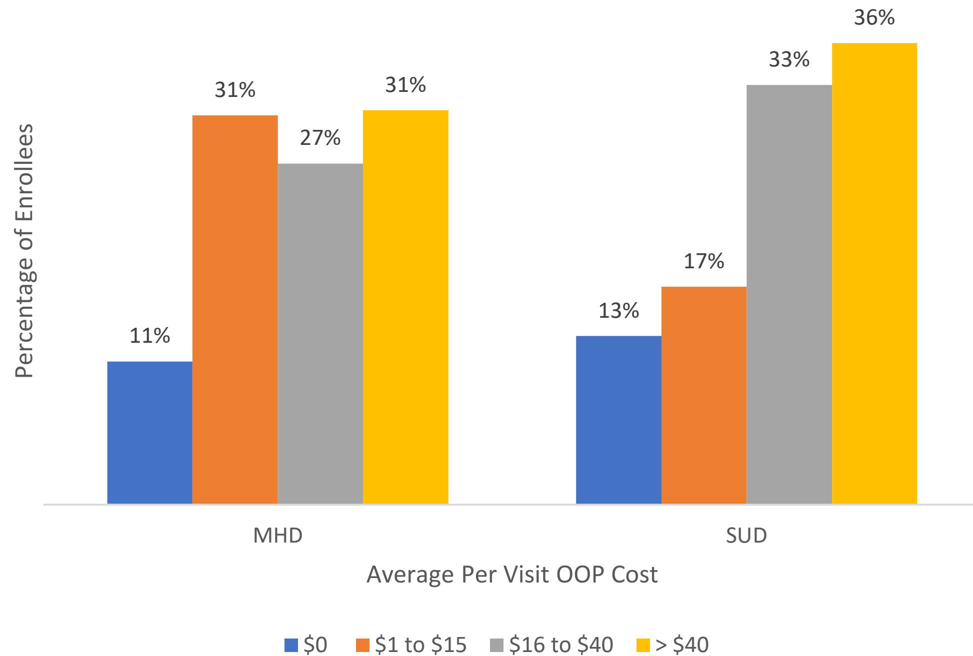
Distribution of Types of Psychotherapy Services in HUSKY and CI



- Reimbursement rates for 60-minute psychotherapy were similar in HUSKY and CI, whereas rates for 30-minute and 45-minute psychotherapy were considerably lower in HUSKY.
- Use of 60-minute psychotherapy in HUSKY—where reimbursement rates were similar to CI—was higher than the use of 30-minute and 45-minute psychotherapy—where rates were lower than CI.
- Higher use of 60-minute psychotherapy in HUSKY may signal that the more competitive rates for 60-minute psychotherapy may be driving up use of this service.

Financial Drivers of Behavioral Health Services

Out-of-Pocket (OOP) Costs in Commercial Insurance (CI)

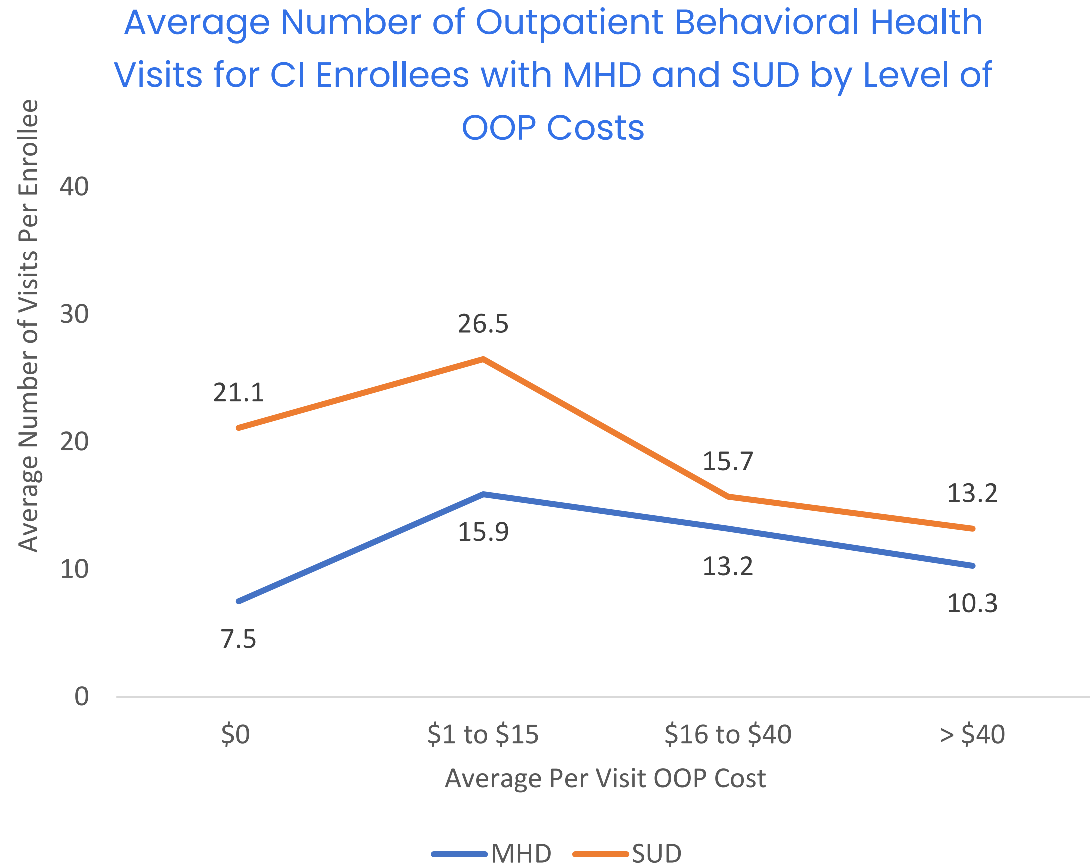


- CI enrollees paid significant OOP costs for outpatient behavioral health services: Nearly a third (31%) of enrollees with MHD paid more than $40 per visit on average.

- CI enrollees with SUD paid higher OOP costs for outpatient behavioral health treatment compared to CI enrollees with MHD: Among CI enrollees with SUD, 33% paid $16 to $40 and 36% of enrollees paid more than $40 on average for outpatient visits.

Financial Drivers of Behavioral Health Services

Out-of-Pocket (OOP) Costs in Commercial Insurance (CI)



- Among enrollees with MHD, the average number of outpatient behavioral health visits was 15.9 in the $1 to $15 OOP cost group and dropped to 13.2 and 10.3 visits for the $16 to $40 and $40+ OOP cost groups, respectively.
- Among enrollees with SUD, the average number of outpatient behavioral health visits declined from 26.5 visits for the $1 to $15 OOP cost group to 13.2 for the $40+ OOP cost group.
- The unexpected findings for the $0 OOP cost group may be explained by the cost sharing being waived or uncollectable, enrollees meeting their deductible or OOP maximum, and having their OOP costs accounted for by non-behavioral health visits, or a secondary payer covering the OOP costs.

Financial Impact of Behavioral Health Treatment

Financial Impact of Behavioral Health Treatment

Financial Impact of Increasing HUSKY Rates

Estimated Cost of Increasing HUSKY Rates for Common Behavioral Health Services

Estimated current total cost of common behavioral health services	$ 146,846,404
Estimated cost of increasing rates to 90% of benchmark rates for office visits, assuming a modest increase in utilization (0.25% for every $1 increase)	$ 11,567,535
Total estimated annual cost of increasing rates for common services	$ 158,413,939
Percent increase over current costs	7.9%

- Increasing rates for common behavioral health services to 90% of benchmark rates would cost an estimated additional $11,567,535.
- This represents a 7.9% increase in total 2022 spending for behavioral health services.

Financial Impact of Behavioral Health Treatment

Financial Impact of Increasing HUSKY Rates

Estimated Cost of Increasing HUSKY Rates for Behavioral Health Office Visits with Psychiatrists, BH APRNs, and PAs

Estimated current total cost of common behavioral health services	**$ 146,846,404**
Estimated cost of increasing rates for behavioral health office visits to 90% of benchmark rates for office visits, assuming a modest increase in utilization (0.25% for every $1 increase)	$ 7,568,712
Total estimated annual cost of increasing rates for select services	$ 15,571,928
Percent increase over costs for common behavioral health services	5.2%

- The largest discrepancies in reimbursement rates between HUSKY and CI were for office visits by psychiatrists, APRNs, and PAs.
- Increasing rates for these services to 90% of benchmark rates would cost an estimated additional $7,568,712.
- This represents a 5.2% increase in total 2022 spending for behavioral health services.

Financial Impact of Behavioral Health Treatment

Increased reimbursement for select behavioral health services

- 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.

Estimated aggregate cost of increasing HUSKY Rates for select behavioral health services

State Fiscal Year 2025	$ 13,798,100
State Fiscal Year 2026	$ 15,504,047

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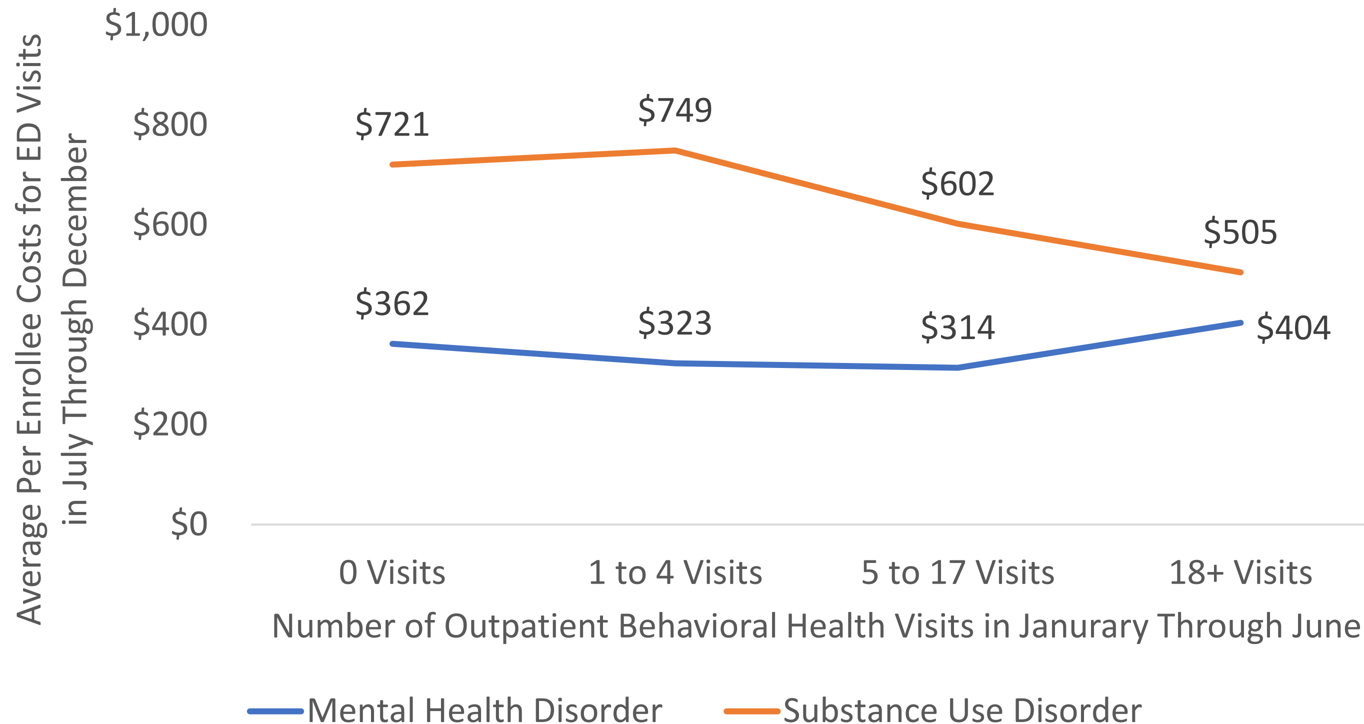
Financial Impact of Behavioral Health Treatment

Financial Impact of Outpatient Behavioral Health Treatment on ED Use



- Among HUSKY and CI enrollees with SUD, those with a higher number of outpatient behavioral health visits had lower total all cause ED costs.
- However, any overall cost savings were offset by the cost of the outpatient behavioral health care.
- The 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.

Methodology

Methodology
Reimbursement Rate Analysis (1 of 2)

- Reimbursement rates were constructed for common behavioral health services for HUSKY, Commercial Insurance, and Medicare Advantage using 2022 claims data from the CT APCD professional claims, i.e., claims for services billed by individual doctors or other practitioners.
- The analysis may not include all 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 the Department of Mental Health and Addiction Services or Department of Child and Family Service) are not included.

Methodology
Reimbursement Rate Analysis (2 of 2)

- Behavioral health services were identified in the claims data using Common Procedure Terminology (CPT) codes for office visits, psychiatric diagnostic evaluation, and psychotherapy.

- The rates were constructed for each CPT code for different behavioral health provider types, including:
  - Physicians: psychiatrists and neurologists
  - Non-physician providers: advanced practice nurses (APRNs), physician assistants (PAs), social workers, counselors, and psychologists

- The reimbursement rates represent the median amount paid to the provider for the service from all parties, which includes the amount paid by the insurance company, deductible, copay, and coinsurance, if applicable.

Methodology
Payment Parity Analysis

- Payment parity was evaluated using methodology adapted from the Department of Labor Provider Reimbursement Rate Warning Signs Analysis* which entails the following steps:
    1. Calculate reimbursement rates for behavioral health and other medical services for a given issuer.
    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).
    4. Review 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.
- The 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 analysis. The results are intended to highlight potential patterns of reimbursement rates that may be problematic and warrant further scrutiny.

*https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf

Methodology

Behavioral Health Service Use

- The APCD 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 below.
  - 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.
  - BHD refers to having either an MHD or SUD.
- The diagnoses were 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.
- Outpatient services included: office-base care, psychotherapy, care coordination, evaluation, home-based care, intensive outpatient (IOP)/partial hospitalization (PH), SUD treatment including medication treatment for alcohol or opioid use disorder, telehealth, hypnotherapy, and electric shock therapy.

Conditions Used to Identify Mental Health and Substance Use Disorders

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; Suicide
SUD	Alcohol Use Disorder, Drug Use Disorder

Study Reports

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

Behavioral Health Insurance Coverage and Payment Parity in HUSKY, Private Insurance, and Medicare Advantage: Behavioral Health Workforce Environmental Scan