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

I. Barriers:

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

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

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

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

   <u>Proposed Solutions</u>:

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

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

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

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

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

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

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

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

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