Testimony before the Insurance Committee, 3/5/19
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In support of Raised HB 5270 AN ACT CONCERNING PEER SUPPORT SPECIALISTS AND REQUIRING HEALTH INSURANCE COVERAGE FOR OUTPATIENT PEER SUPPORT SERVICES PROVIDED BY CERTIFIED PEER SUPPORT SPECIALISTS.

In support of HB 7125 AN ACT CONCERNING PARITY FOR MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS, NONQUANTITATIVE TREATMENT LIMITATIONS, DRUGS PRESCRIBED FOR THE TREATMENT OF SUBSTANCE USE DISORDERS, AND SUBSTANCE ABUSE SERVICES.

In support of HB 7261 AN ACT PROHIBITING REQUIREMENTS FOR PRESCRIBING CLINICALLY INAPPROPRIATE QUANTITIES OF OUTPATIENT PSYCHOTROPIC DRUGS

Representative Scanlon, Senator Lesser, and respected members of the Insurance Committee:

I am the Co-Director of the Regional Behavioral Health Action Organization (RBHAO) for Southwestern CT, also known as The Hub. I am here in support of HB 5270 regarding peer support services. I also support HB 7125 (parity) and HB 7261 (psychotropic drugs); please refer to my written testimony on those.

HB5270: AAC Peer Support Specialists

Eliza is a 23 year old who works for me. She has experienced family dysfunction, trauma, foster care, mental illness, substance abuse, and homelessness. She has received all kinds of treatment, and now she works as a peer specialist on our TurningPointCT.org project. She is able to make connections with young people who aren't connected with anyone else. Through her willingness to share her personal lived experience, coupled with her training as a certified Recovery Support Specialist, certified Recovery Coach, and SMART Recovery® facilitator, she helps young people open up about their struggles, acknowledge when they need help, and feel empowered to make changes in their lives. I have watched her connect with her peers and heard how she helps even when just answering the phone. What she provides is every bit as valuable as the therapy that some—but only some—of the teens in her support group also receive. Fortunately we have grants from DCF and DMHAS that fund this work, because otherwise those teens wouldn't have their support group and Eliza might not have a job.

Nicole is a young woman in recovery from alcohol who has dealt with depression and anxiety. Her peer training is as a Recovery Coach; she works at a local hospital, not in the ER as in the CCAR program you may have heard about, but on the Community Care Team, where she does mobile outreach with people in the community. When a local church group came to me about a parishioner who had been couch-surfing with church families for more than a year, who was refusing to seek help despite increasing symptoms such as hearing voices, I knew that Nicole could help. The church group had tried to get the woman to every treatment program in town, but Nicole was the one who met her for coffee, offered her support, and got her connected with services. And she did it in less than 2 days. Most communities lack anyone to do this kind of mobile outreach at all, and especially not a peer support specialist.

These are just two examples of how effective peer support can be. In both cases, these women have tremendous personal qualities and extensive training, along with support and structure for their work. Research has found that peer programs have **outcomes** such as:[1]

▪ Increased life expectancy	▪ Reduced use of emergency services
▪ Improved quality of life	▪ Increased awareness of condition
▪ Reduced isolation	▪ Improved self-efficacy

• Heightened empathic response	• Decreased depression
• Increased self-esteem	• Improved self-care skills, including medication adherence

Peer support has a **record of success in reducing healthcare costs** by providing alternatives to hospitalization, reducing the length of hospital stay, and preventing rehospitalizations, all of which improve quality of care. Examples:

- Certified Peer Specialists in Pierce County, Washington provided respite services as an alternative to immediately hospitalizing people in crisis. Involuntary hospitalizations were reduced by 32%, saving an estimated $1.99 million per year.[3]
- A study in New York found that clients who worked with a "Peer Bridger" reduced their average length of hospitalization from 6 days to 2.3 days.[4]
- According to a major health care provider in Arizona, the addition of peer support staff at two major psychiatric hospitals has resulted in a 36% reduction in the use of seclusion, a 48% reduction in the use of restraints, and a 56% reduction in hospital readmission rates.[5]
- A Connecticut study of patients with a history of multiple admissions for inpatient services revealed that patients who worked with a "Peer Mentor" had 42% fewer admissions and 48% fewer total hospital days of service after nine months, compared to the control group.[6]
- In Clackamas County, Oregon, the provision of peer services to some 5000 adults, youth, and families was estimated to have saved ~$2.3 million: $1.289 million in jail costs, $720,400 in welfare costs, and $283,000 from system savings through a peer warmline. In one example, a woman who had been visiting the Emergency Department weekly met with a peer instead, for a cost savings of ~$55,600. This program operates on a budget of $1.7 million. (2016 Peer Link webinar)
- A 2014 Medicare & Medicaid Research Review did a retrospective analysis of 2003-04 data from Georgia's then-new peer program (the first nationally) and found that participants sought more professional care, filled more drug prescriptions, and used acute-care facilities less. Higher levels of peer support were associated with lower psychiatric hospitalization costs.
- A 2006 Georgia study found that clients who had Certified Peer Specialists involved in their care experienced reduced symptoms, increased skills and abilities, and increased access to needed resources. These improvements led to an average savings of $5,494 per year per person.[2]

However, in Connecticut, the majority of state residents cannot access peer support since services are primarily available to those served through the DMHAS system. Making certified peer support a covered service would provide access to this valuable and cost-effective service to the 80% of CT residents who have commercial insurance. It would also increase employment opportunities for people in recovery: there are currently ~950 certified Recovery Support Specialists in the state who are not able to find employment in this field since their service is not billable. Peers can also help ease the national shortage of mental health workers.

Some specific comments about the components of the Committee's bill:

(1) The first part of the Committee's bill proposes to have DPH develop regulations around the certification and education of peer support specialists. In developing regulations, DPH should evaluate the current training and certification programs in CT and the US:
   - Currently, peers in CT are trained through one of two agencies: Advocacy Unlimited trains Recovery Support Specialists (RSS's), who are people with lived experience with mental illness, while the CT Community for Addiction Recovery (CCAR) trains Recovery Coaches, who are usually (but not exclusively) people with lived experience with addiction.
   - *Recommendations:*

- It will be important to determine whether the peer support that is ultimately covered by insurance would include those (relatively few) Recovery Coaches who are not people with lived experience. (Most peers would say no.)
- Reviewing these training programs for DPH regulation will offer the opportunity to look at how each curriculum addresses the very common *co-occurrence* of mental illness with addiction. Whether ultimately DPH chooses one, both, or an adaptation or combination of these training programs to serve as the basis for the state certification, it will be critical to ensure that anyone certified as a peer specialist meet minimum standards for the knowledge, attitudes, and skills needed to help clients who have both mental health and substance use issues.

- Currently, certification of peer support specialists is offered upon completion of the training and an exam offered either through Advocacy Unlimited or the CT Certification Board. There is now also a National Certified Peer Specialist (NCPS) Certification that has been developed by Mental Health America to offer a uniform national standard for peer support with high levels of skills and experience. Its standards were developed by peers from all parts of the country working in conjunction with healthcare provider organizations, in order to meet workforce needs.
- *Recommendation:*
  - The national certification is currently considered as an advanced level of training on top of existing state certifications. Adopting the NCPS as the standard for DPH regulation may be a way to provide a career pathway for current peer support specialists to attain a higher level of certification enabling them to apply for new, billable job opportunities in commercial healthcare organizations.
  - It will still be important to evaluate whether the NCPS certification addresses addiction or is focused primarily on mental health, since it was developed by Mental Health America. It may be that DPH will want to create separate certifications for mental health and substance use, although in that case both should have minimum skills related to each of these areas and their co-occurrence.

(2) The Committee's bill further proposes that DPH identify the types of services for which peer support would be offered and covered by health insurance. A starting place could be to focus on services that prevent hospitalization or rehospitalization:

- The research mentioned above highlights the efficacy of peer support in stabilizing people who are in crisis in community settings rather than hospital settings. Currently many people who are experiencing suicidal ideation, hallucinating, having a panic attack, extremely intoxicated, or recovering from an overdose end up in hospital emergency rooms at great expense to our healthcare system and little value to them as patients. In some cases, they may end up being admitted at even greater expense, but the hospital is simply a place for them to stay safe while they are being stabilized. Alternatives such as peer-run respites, "living rooms," and sobering centers can offer the safety and stabilization along with the warmth of the peer support and the connection to community resources. I have had two Board members who were hospitalized in the past year when suicidal tell me they knew they didn't need hospital-level care since they were already in treatment; they just didn't have anywhere else to go. They would have preferred a peer respite.
- Over the past 2 years, CCAR Recovery Coaches have been hired to work with a number of hospital Emergency Rooms in the state. They are on call for individuals who come in as a result of an overdose. The peers introduce themselves, make a connection, and give the patient a message of hope and support for accessing recovery resources. This service has been very valuable, although again it is based in hospitals, which means that the ER expenses are incurred in addition to the recovery coaching.
- We have spoken with representatives of the CT Hospital Association who were interested in exploring peers as an alternative program that can provide a less traumatic, more empowering experience than hospitalization.

(3) The final component of the Committee's bill relates to insurance coverage. I would like to direct you to a webinar provided just last week by Mental Health America on Peer Support in Alternative Payment Models (APMs). It includes examples of how peers are used and discussion of alternative payment models, such as bundled payment for psychiatric hospitalization (care including Peer Bridgers) and data from pilot tests. The webinar (just under an hour) can be viewed at https://youtu.be/rAdlSr7s1wE or the slideshow (25 slides) can be seen at http://www.mentalhealthamerica.net/sites/default/files/Peers%20in%20APMS%20Webinar.pdf

[1] http://peersforprogress.org/science-behind-peer-support/
[2] Fricks, L. (Presenter). (2007). PowerPoint presented at SAMHSA National Mental Health Block Grant and Data
[3,4] New York Association of Psychiatrict Rehabilitation Services, www.nyaprs.org/e-news-bulletins/2011/2011-02-02-Bergeson-Cost-Effectiveness-of-Using-Peers-as-Providers.cfm
[5] http://www.recoveryinnovations.org/pdf/RIA%20Programs%20and%20Outcomes.pdf
[6] Sledge, W., Lawless, M., Sells, D., Wieland, M., O'Connell, M., & Davidson, L. (2011) Effectiveness of Peer Support in Reducing Readmission of Persons With Multiple Psychiatric Hospitalizations. Psychiatric Services, (62)5, 541-544.

HB7125: AAC Parity

I am a member of the CT Parity Coalition, which has been working actively with organizations statewide and with legislators to find ways to ensure that CT residents benefit from equal insurance coverage for their physical, mental health, and substance use treatment needs.

Officially, Connecticut already has parity in place, since we are subject to the federal parity law. However, just over a year ago, the December 2017 Milliman report, "Addiction and Mental Health vs Physical Health: Analyzing Disparities in Network Use and Provider Reimbursement Rates," identified CT as the state with *the highest disparity* between physical and behavioral healthcare in terms of the proportion of office visits that are out-of-network. Significant disparities were also identified in inpatient care and payments to behavioral health providers compared with primary care providers.

These apparent disparities hinted at possible larger problems lying below the tip of the iceberg. What CT lacks is adequate data reporting to allow either the state or consumers to determine where the issues lie and how great the disparities are. When people are struggling with a mental illness or addiction, the last thing they need at an extremely vulnerable moment in their life is to have to go through repeated processes to try to get coverage for the treatment they need. We don't make people suffering with cancer or diabetes jump through hoops until they're exhausted or give up, and we don't make it hard for them to access specialists or prescribers when they need them. We need to be able to analyze the ways coverage is provided to individuals with behavioral health treatment needs in comparison with coverage for individuals with medical needs in order to identify the next steps needed to protect patients with mental health and substance use challenges.

Our coalition has been able to connect with similar "Parity 2.0" efforts in other states, and we are confident that the language we have shared with the Committee represents a workable solution. I want to note that this is still only a next step. Once this bill becomes law and we start to have access to usable reports, we may end up back here in a year or two asking for Parity 3.0 to correct system issues that may be identified. On the other hand, the analyses that we're asking for may lead the insurance industry to self-correct, as has happened in other states. Looking at the data in new ways should be eye opening for everybody.

We are very grateful to Rep. Kupchick, Senator Osten, and Rep. McCarthy Vahey for putting forward this bill, as well as to the many legislators who also proposed parity bills this session, showing an understanding of the issue and support for resolving it. Last year the bill almost passed; this year, let's get it done!

In support of HB7261: Prohibiting Requirements for Prescribing Outpatient Psychotropic Drugs

Over the past couple of years, following advocacy by the substance use prevention community, the General Assembly has passed bills limiting the supply of opioids able to be prescribed. These laws represent a laudable effort to prevent people who are prescribed narcotics from becoming dependent as well as to limit the diversion of prescribed drugs.

Ironically, at the same time that opioids are being restricted, prescribers note that they are often *required* by insurance panels to prescribe 90-day supplies of certain psychotropic drugs even against their clinical judgment. These quantities can lead to accidental overdoses and suicides.

Psychotropic drugs include a variety of types of drugs, including benzodiazepines. Benzos are drugs (such as Xanax) that are commonly and increasingly prescribed for anxiety. When taken for that purpose, they are intended for relatively short-term use (e.g., 2-4 weeks); however, patients often become dependent on these drugs and take them for years despite negative health effects. These patients may be getting 90-day supplies, but it is in not in their interest.

Not only do benzos create dependence, they are often involved in overdose deaths. In Connecticut, 26% of the overdose deaths from opioids between 2012 and 2017 involved a combination of opioids + benzos. It is quite inconsistent to restrict opioid prescriptions but not benzodiazepines (or other psychotropics) when the two types of drugs are often used in combination.

Prescribers have expressed concern that in an attempt to prevent suicides, overdoses, or drug abuse, they should have the right to prescribe less than a 90-day supply of a psychotropic when they feel it appropriate.

While insurance companies and patients have an interest in using bulk purchases to keep costs low, prescribers should not be forced to give large quantities when they feel it may endanger their patient. Similarly, the difference in the per-unit cost of a larger supply compared with a smaller supply should not be so great that patients and families demand more than necessary. A solution could be to adapt prescribing guidelines to help clinicians identify patients at increased risk and trigger the ability to prescribe a smaller quantity at lower cost per unit.