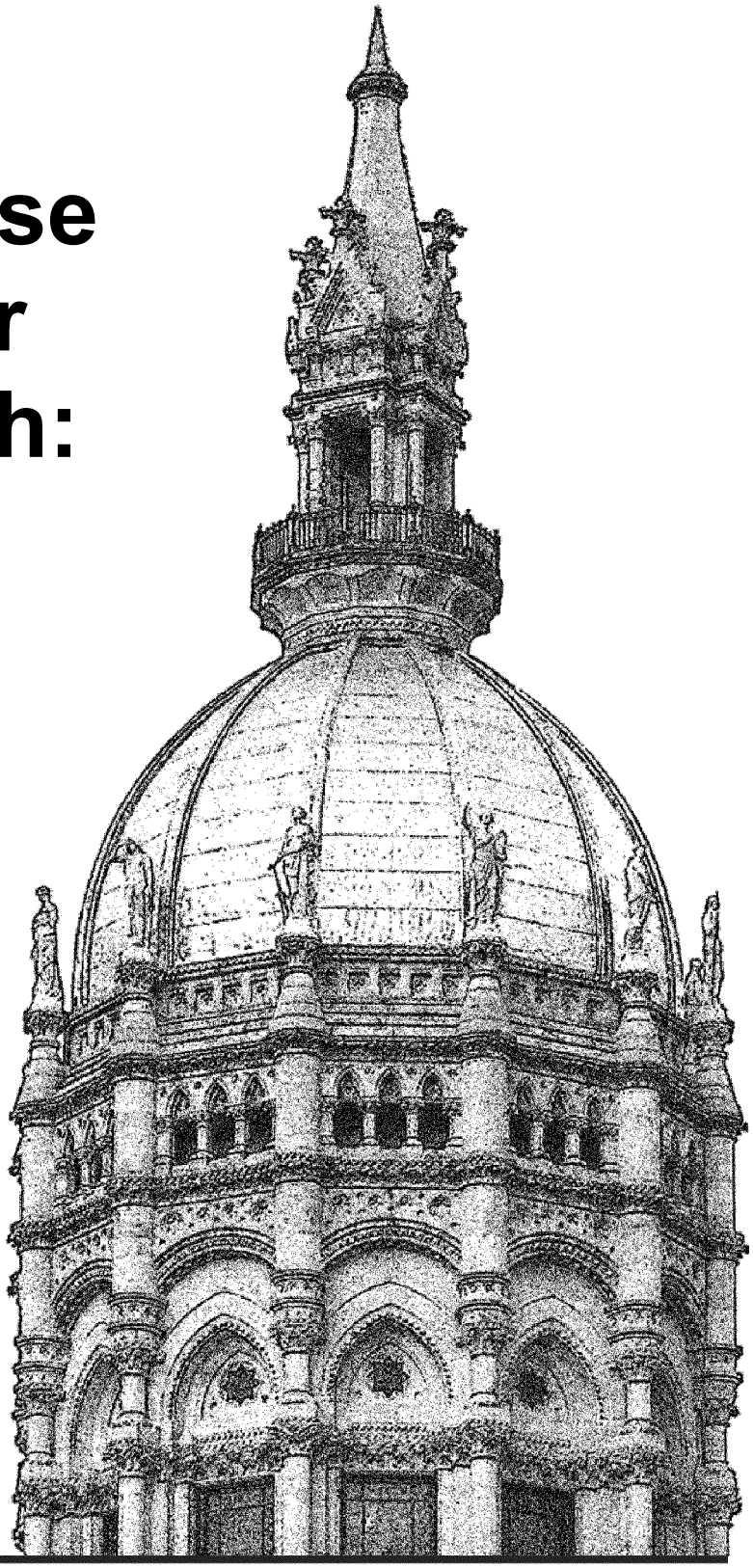
Access to Substance Use Treatment for Insured Youth: Phase II

June 2013



PRI

Legislative Program Review and Investigations Committee

Connecticut General Assembly

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

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LEGISLATIVE PROGRAM REVIEW
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Access to Substance Use Treatment For Insured Youth: Phase II

JUNE 2013

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PRI Study Highlights June 2013

Access to Substance Use Treatment for Insured Youth: Phase II

Background

In April 2012, the program review committee (PRI) authorized a study to assess insurer coverage and enrollee utilization of substance use treatment. In addition, the project aimed to examine availability of those treatment services. The study was limited to youth ages 12-25 who have private (i.e., commercial) or Medicaid insurance.

In Connecticut, about 7% of youth ages 12-17 and 21% of those ages 18-25 have met the clinical criteria for abuse or dependence on alcohol or an illicit drug within the past year, according to a recent federal survey. Research estimates indicate a substantial portion of those needing treatment do not receive it, perhaps partly due to insurance coverage and capacity issues.

Commercial health plans that are fully insured generally are regulated by the state, while self-insured plans (in which the employer assumes the financial risk of coverage) and Medicaid are subject to federal oversight. Plan coverage of substance use treatment is affected by both federal and state mental health parity laws.

A Connecticut resident with a health plan coverage complaint may seek assistance from the state's insurance department, Office of the Healthcare Advocate, and/or Office of the Attorney General. If the plan is self-insured or a government plan, certain federal or state agencies may be more appropriate venues for grievances.

This Phase II report, which focuses on treatment services capacity and overarching issues, was based on: interviews with staff from multiple state agencies and offices, advocates, treatment providers, and researchers; review of state and federal laws, as well as literature on substance use treatment; and treatment provider and college counseling center survey results.

An earlier Phase I report, approved by PRI in December 2012, involved utilization review, mental health parity laws, and state oversight and consumer assistance.

Main Findings

There has been little lasting attention to improving access to substance use treatment for people outside the state service system. A cross-agency council has focused mainly on policies affecting state clients, and there have not been strong laws regarding commercial insurers' behavioral health (substance use and mental health) provider network adequacy.

Screening youth for behavioral health problems by medical providers appears to be done on a limited basis, for multiple reasons. Screening can help connect people to needed treatment early on.

Several substance use treatment locators exist, but they are sub-optimal. There are some inconsistencies, and more problematically, there is no information on availability and insufficient detail on insurance acceptance.

Multiple evaluations have found substantial waits for inpatient, residential, in-home, and outpatient counseling behavioral health treatment. Hospitals are burdened by an increasing volume of behavioral health (substance use and mental health) needs, and the wait for adolescent in-home evidence-based models is especially long. Substance use treatment should be available promptly.

Age-appropriate services appear to be lacking. Some data indicate the youth who do receive treatment are not served by age-specific services. Recovery supports could help sustain treatment gains but there are few available to Connecticut youth. Age appropriateness helps treatment be maximally effective.

PRI Recommendations

Several recommendations are made with the overall goal of improving insured youth's access to appropriate treatment. This is a critical goal because substance use has tremendous costs to society, families, and individuals. It can and does result in direct and indirect cost-shifting from the private to public sector. This report's recommendations aim to:

1. **Improve people's ability to find treatment**, by directing people to a single useful treatment locator, easing capacity problems (see below), and taking steps to develop a behavioral health urgent care center
2. **Ensure youth receive and benefit from needed, appropriate treatment**, by asking state agencies to work with all youth treatment providers, establishing a behavioral health consultation phone line for primary care providers - in part to encourage screening, and moving forward with an initiative to establish youth-specific recovery supports
3. **Increase attention to substance use treatment access**, by requiring commercial insurers to submit an access plan and assigning general oversight of access to care to a cross-agency entity that includes treatment providers and people in recovery

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Acronyms

ACA	Patient Protection and Affordable Care Act of 2010
ADPC	Alcohol and Drug Policy Council
BHP	Behavioral Health Partnership
CBT	Cognitive Behavioral Therapy
CID	Connecticut Insurance Department
DCF	Department of Children & Families
DMHAS	Department of Mental Health and Addiction Services
DPH	Department of Public Health
FFT	Functional Family Therapy
HMO	Health Maintenance Organization
IICAPS	Intensive In-Home Child and Adolescent Psychiatric Services
MCO	Managed Care Organization
MDFT	Multidimensional Family Therapy
MST	Multisystemic Family Therapy
NAIC	National Association of Insurance Commissioners
N-SSATS	National Survey of Substance Abuse Treatment Services
NCQA	National Committee for Quality Assurance
NSDUH	National Survey on Drug Use and Health
OHA	Office of the Healthcare Advocate
SAMHSA	Substance Abuse and Mental Health Services Administration
URAC	Formerly known as the Utilization Review Accreditation Commission

Recommendations

Chapter I: State Government's Roles

1. The Alcohol and Drug Policy Council should include as one of its main missions the goal of ensuring access to appropriate substance use treatment for the entire state's population, including adolescents and young adults. The group should explore, develop, and advance comprehensive strategies for improving access to treatment for all Connecticut residents. (p. 10)

2. C.G.S. Sec. 38a-478c shall be amended to require health carriers to annually report on:

   a. By county, for inclusion in the Consumer Report Card:

   i. The estimated prevalence of substance use disorders among child, young adult, and other adult enrollees;

   ii. The number and percent of child, young adult, and other adult enrollees who received covered substance use treatment, by level of care;

   iii. The median length of substance use treatment for child, young adult, and other adult enrollees, by level of care;

   iv. The per member per month child, young adult, and other adult claim expenses for substance use treatment;

   v. The number of in-network substance use treatment providers, by level of care, showing the percentage of in-network providers that are taking new clients with that insurance;

   b. For the entire state:

   i. The number, by licensure type, of behavioral health practitioners and, by level of care provided, facilities that have applied for in-network status, and for each, the percent that were accepted; and

   ii. The number and percentage of behavioral health practitioners by licensure type and, by level of care, facilities that have halted participation in the network.

   c. Identification and explanation of factors that may be impacting access to substance use care, including but not limited to screening, statewide supply of certain practitioner types, provider capacity limitations, and reimbursement rates.

   d. Plans and ongoing or completed activities to address the identified factors that may be negatively impacting access to care.

   The health carrier may request the commissioner to deem any of the information in (b), (c), or (d) above proprietary and unavailable to the public. The commissioner may approve or deny such request. If any information is deemed proprietary, the insurance department and the Office of the Healthcare Advocate may view the information but not make it public. (pp. 13-14)

3. The Connecticut Insurance Department should, for the Consumer Report Card, request fully-insured health carriers to submit behavioral health utilization review (including coverage requests and adverse determinations) data:
    a. according to specific levels of care (for example, inpatient, residential, partial hospitalization, et cetera);
    b. separately for mental health treatment, substance use treatment, and co-occurring disorders;
    c. separately for children, young adults, and other adults; and
    d. including, separately, internal appeals and external appeals information. (p. 14)

Chapter II: Substance Use Treatment Services for Insured Youth

4. *The State of Connecticut should have a comprehensive pediatric behavioral health consultation program. The consultation line's screening, training, consultation, and referral activities should include both mental health and substance use. The program should work with commercial insurers to explore how those insurers can play a role in the project. (p. 18) *[Note: Public Act 13-3, signed into law on April 4, requires a substantially similar program. This recommendation was proposed, along with the others, in March 2013; the committee endorsed the recommendation in June in support of the now-mandated program.]*

5. The Alcohol and Drug Policy Council should assess whether Connecticut's physician, nurse, and physician assistant preparation programs include training on behavioral health screening, administering a brief intervention for substance use, and referring to treatment. The council then should encourage and assist the preparation programs not offering the training, to do so, on at least a voluntary basis. (p. 19)

6. The Alcohol and Drug Policy Council should assess the various substance use treatment locators maintained at the state level. The assessment should be used to select one of the locators to be Connecticut's primary source of information on substance use treatment options. The relevant state agencies should publicize this locator online and encourage private nonprofits to do the same.

    The locator should contain information on whether each treatment program is accepting new clients – updated at least daily – and what insurance plans, if any, are accepted. An effort should be made, working through the healthcare practitioner associations, to include in the locator private behavioral healthcare practices. (p. 20)

7. The Departments of Mental Health and Addiction Services, Public Health, and Children and Families should develop a proposal to launch an urgent care center for behavioral health, bringing in both public and private partners. (p. 26)

8. The Department of Children and Families should instruct its funded providers to keep data, for a short period (e.g., three to six months), on:
    a. the name of the insurance carrier (if any) of each child whose parent(s) seeks treatment in an in-home behavioral healthcare model, including the employer if the plan is self-insured;

b.whether the child was accepted into the program;

And for those children accepted:

a. whether the insurance carrier agreed to cover the treatment;
b. for those parents whose commercial insurance agreed to cover the treatment,
   i. voluntary reporting on the terms of the cost-sharing, and
   ii. whether the child did in fact then participate in the program; and
c. for those children who had commercial insurance that did not agree to cover the treatment, the per-child cost of the treatment and voluntary reporting by the parent on whether the coverage denial was due to exceeding insurance spending limits.

The Department of Children and Families should use this information to assess the accessibility of these models to commercially insured youth and the extent of cost-shifting to the state and its contracted nonprofit providers. If the department finds extensive cost-shifting, it should propose ways to alleviate the burden on the state and its providers. (pp. 26-27)

9. The Department of Children and Families and the Department of Mental Health and Addiction Services should offer training and/or other resources to substance use treatment providers – including those who are not state-contracted – to ensure that adolescents and young adults receive developmentally appropriate substance use treatment. (p. 28)

10. The Department of Children and Families and the Department of Mental Health and Addiction Services, as well as other state agencies, should continue the effort to develop youth recovery supports that are reasonably accessible statewide to adolescents and young adults both in and out of state agency systems.

    The interagency group should set a date by which it will complete a plan describing:

    a. the supports to be built (including using existing advocacy or mutual support groups as a foundation);
    b. how the supports will be found by and accessible to youth; and
    c. options for implementation, including but not limited to funding. (p. 30)

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Introduction

Access to Substance Use Treatment for Insured Youth: Phase II

In Connecticut, about one in 13 adolescents (ages 12 through 17) and one in five young adults (18 through 25) have abused or become dependent on alcohol or an illicit drug within the past year, according to a recent estimate. These youth, who are said to have a substance use disorder, can enter into a range of treatments and settings. However, less than 13 percent of youth needing treatment for a substance use disorder have received care from a licensed treatment provider – and only four percent of those needing treatment for a substance use disorder involving alcohol have received it.[1]

There are many potential reasons for this treatment gap, including a person's denial that a problem exists, under-detection of the disorder by healthcare professionals, the social stigma surrounding substance use, and difficulty accessing care even when someone is seeking treatment. [2]

Study focus. The Legislative Program Review and Investigations Committee (PRI) sought to examine access to substance use care, focusing on accessibility for youth with either private (i.e., commercial) or public insurance, through a study authorized in April 2012. The public insurance component of the study was limited to the state's Medicaid program for mental health and substance use services (the Behavioral Health Partnership), while the commercial insurance aspect is restricted to fully-insured plans.[3] (Self-insured health plans are not governed by state law.)[4] The study was conducted in two phases.

Treatment accessibility is strongly influenced by two factors: ability to pay, which for many people is impacted by insurance coverage; and availability of appropriate services. Phase I of this study, completed and approved by the program review committee in December 2012, focused on the first factor. In that report, the committee recommended changes concerning Connecticut's agencies and laws involved in regulating or contesting health insurance plan offerings and decisions.

Phase II of the study, which is the subject of this report, focused on the second factor: the availability of appropriate treatment services for Connecticut youth. In undertaking the assessment, it became clear that capacity is affected by a variety of features, ranging, for example, from how easily treatment can be located to how closely health insurance network

[1] National Survey on Drug Use and Health (NSDUH) 2010-2011 State Estimates. See Appendix A for more information on youth and adolescent substance use disorder prevalence and treatment received.

[2] "Access to Treatment for Adolescents with Substance Use and Co-Occurring Disorders: Challenges and Opportunities," Stacy Sterling, Constance Weisner, Agatha Hinman, and Sujaya Parthasarathy, *Journal of the American Academy of Child & Adolescent Psychiatry 49*(7): 637-646, July 2010.

[3] A fully-insured plan is one whose financial risk is borne by a health insurer (instead of by the employer).

[4] The U.S. Department of Labor, the U.S. Department of Health and Human Services (HHS), and the Internal Revenue Service have oversight of self-insured and government plans. The labor department receives complaints and inquiries, conducts investigations when necessary, and has enforcement authority for self-insured plans. The Centers for Medicare and Medicaid Services (CMS), which is part of HHS, has the same role for government plans.

sufficiency is monitored. This report addresses those aspects as well as capacity by evaluating the ability of Connecticut youth to access available, appropriate treatment at an early stage of problematic substance use. In addition, the roles of various state agencies and councils that can influence access to substance use treatment were examined.

Key findings. There has been little prolonged attention to improving access to substance use treatment for people outside the state service system. The Alcohol and Drug Policy Council is statutorily charged with formulating and improving state substance use-related policies, but the group's work has focused mainly on state agency clients, much like the state agencies themselves. Within the insurance department, additional health insurance carrier reporting and planning requirements could be instituted to better assess and ensure access to covered treatment for enrollees of fully-insured commercial health plans.

Screening. Medical health provider screening for substance use is one way in which problems can be discovered early. Substance use screening in a primary care setting makes sense because behavioral health is a part of overall health, many youth have periodic check-ups, and substance use disorders have physical health manifestations and implications. In Connecticut, however, behavioral health screening appears to be done for youth on a limited basis, for multiple reasons.

Locating treatment. When someone needs treatment, it is important to be able to quickly find feasible treatment options at the appropriate level of care. Multiple Connecticut-specific treatment locators can aid in finding treatment, but these are inconsistent. The locators also lack crucial information on payment methods and ability to take new clients.

Treating promptly. Although the precise capacity of substance use treatment in Connecticut is unknown, it is probable that a person would have difficulty promptly accessing inpatient, detoxification, residential, in-home evidence-based models, and regular outpatient counseling treatments, according to various assessments. The wait to receive in-home care is especially long.

Treating appropriately. Treatment received should be appropriate to the person's circumstances and characteristics. There is some indication, however, that a portion of the adolescents and young adults who do receive treatment might not be getting services appropriate to their developmental and life stage.

Supporting recovery. When intensive treatment has been completed, ongoing care or case management as well as recovery supports help maintain gains and facilitate a return to more intensive treatment when relapse occurs. Generally, there is little availability in Connecticut of youth-specific recovery supports, which could help sustain treatment gains and, for people of any age, are not covered by insurance. Care management is available to a portion of commercially insured people with substance use disorders, and for the most part is of limited duration.

Recommendations: Rationale and goals. This report, like the committee's Phase I report, makes several recommendations with the overall goal of improving insured youth's access to early and appropriate substance use treatment.

As noted in the previous report, this is a critical goal from a fiscal policy perspective because substance use has tremendous costs to society, families, and individuals – and especially government. The financial burden of substance use treatment falls to government in a unique way. State and local governments are the biggest payor of these services, accounting for 36 percent of substance use treatment expenditures (excluding Medicaid) but only six percent of all healthcare spending.[5] In contrast, commercial (i.e., private) insurance pays for 37 percent of all healthcare spending but only 12 percent of substance use treatment expenditures.[6]

There are many potential reasons for the substantially lighter treatment cost load carried by commercial insurance, including some that have little to do with the terms or management of insurance coverage. While acknowledging that, it is important to recognize and attempt to remedy the difficulties some Connecticut residents have experienced in promptly getting covered behavioral health treatment. The recommendations from both study phases aim to ensure that insured enrollees who attempt to obtain appropriate substance use treatment coverage are able to do so.

This report's recommendations, taken together, more broadly intend to boost access to needed substance use treatment by:

1. increasing detection of substance use problems at routine medical appointments;
2. improving practitioners' and the general public's ability to quickly and easily locate treatment;
3. ensuring youth in particular receive and benefit from appropriate treatment; and
4. calling for efforts to oversee and work to improve, at the state level, access to substance use treatment, focusing on but not limited to treatment for insured youth.

Report structure. Various ways in which state agencies and councils can affect access to care are explained in Chapter I. How youth become connected to substance use treatment is described briefly and then followed by an assessment of Connecticut's system for helping youth access and benefit from care, in Chapter II. Recommendations are found in both chapters. Appendix B contains an overview of the study's methods. Other appendices provide material supporting the main body of the report.

Agency response. It is the policy of the Legislative Program Review and Investigations Committee to provide agencies subject to a study with an opportunity to review and comment on committee findings and recommendations prior to publication of the final report. Written responses were solicited and received from the state Departments of Children and Families, Insurance, Mental Health and Addiction Services, Public Health, and Social Services; and the

[5] When all types of government funding are included, 80 percent of treatment expenditures are borne by the state, local, and/or federal governments.

[6] 2005 data. From: "Mental Health Financing in the United States: A Primer," Rachel L. Garfield, The Kaiser Commission on Medicaid and the Uninsured, April 2011. Accessed February 6, 2013 at: http://www.kff.org/medicaid/upload/8182.pdf.

Office of the Healthcare Advocate (OHA). These are presented in the final appendix (I). The Department of Social Services and the Office of the Attorney General chose not to provide formal comments.

Chapter I

State Government's Roles

Various state agencies and councils play roles that can influence treatment capacity. As described in this chapter, this influence can be exerted through licensure requirements, funding, and oversight responsibility, including for health insurance carrier network adequacy. The entities involved and their roles are conveyed in the figure on the next page. No single body, however, is in charge of overseeing access to substance use treatment for the entire state's adolescents and young adults.

The committee recommends later in this chapter that oversight be given to an existing cross-agency council that is focused on substance use. Two other recommendations would result in greater information and attention to substance use treatment access for people insured by commercial health plans.

Provider Licensure

The supply of facilities, clinics, and individual healthcare practitioners – all referred to as providers unless otherwise noted – can be influenced by licensure requirements. In Connecticut, the Department of Children and Families (DCF) and the Department of Public Health (DPH) each license one or more types of behavioral health (substance use and mental health) care providers, as shown in the table below. The purpose of licensure is to ensure a minimum level of health and safety.

The Department of Public Health licenses practitioners and nearly all types of substance use treatment facilities. Children's residential facilities are licensed by DCF. Multiple licenses are required for facilities delivering both substance use and mental health treatment.

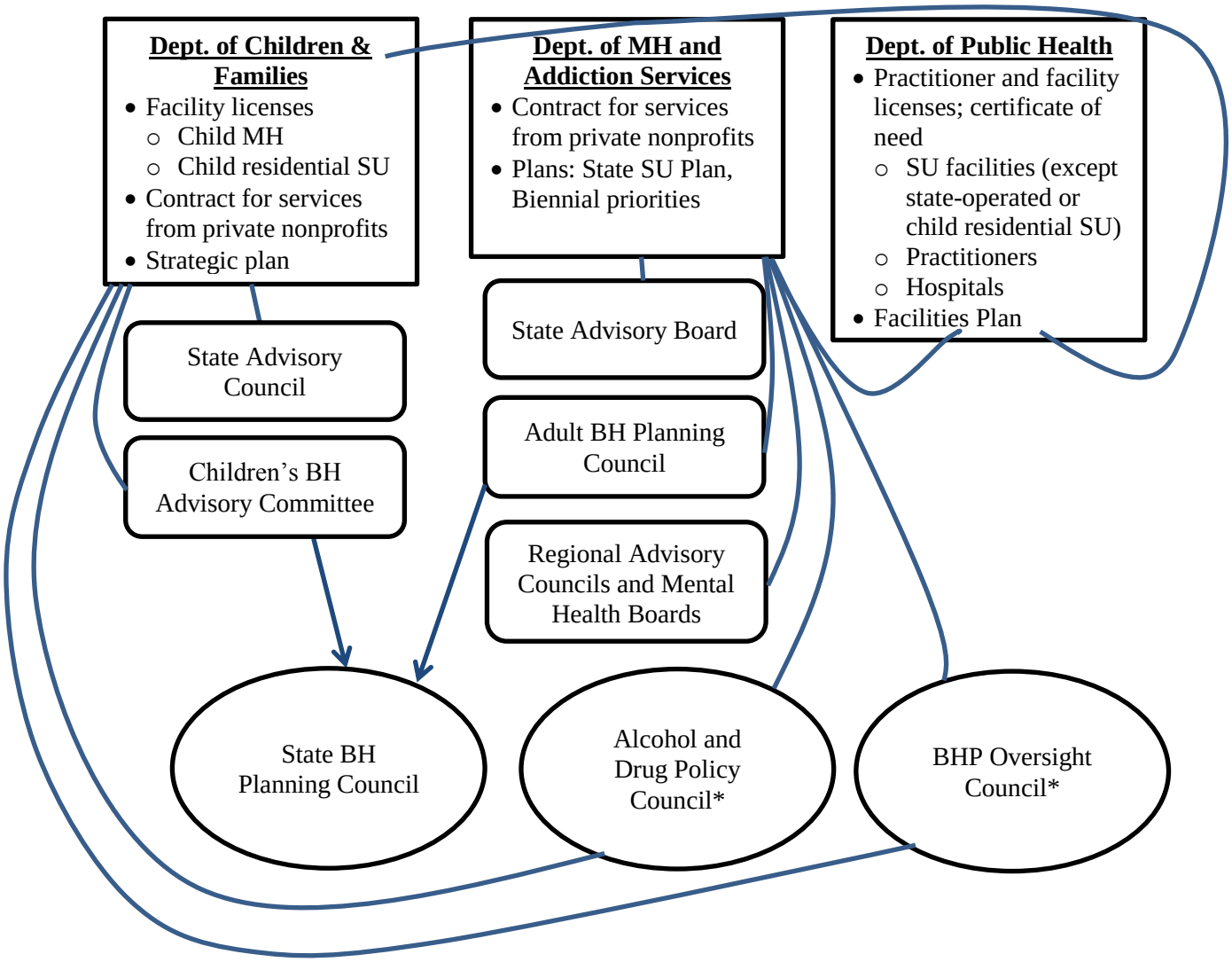
The Department of Mental Health and Addiction Services (DMHAS) does not conduct licensing but all its contracted facility providers giving clinical services are DPH-licensed.

Table I-1. Licensure of Connecticut Behavioral Health Treatment Providers

Agency	***Provider Types Licensed***	
	Substance Use	***Mental Health***
DCF	Residential facility: Child	Residential facility: Child Outpatient facility: Child – *optional**
DPH**	Inpatient facility: Child and adult Residential facility: Adult Outpatient facility: Child and adult	Inpatient facility: Child and adult Residential facility: Adult Outpatient facility: Adult
	Individual behavioral and physical healthcare practitioners General and children's hospitals	

*Optional, unless receiving DCF funding.
**State-operated facilities are not licensed by DPH.
Source: PRI staff analysis of information provided by DCF and DPH.

Figure I-1. State Agencies, Offices, and Councils With Potential Roles in Influencing Access to Treatment for Insured Youth



CT Insurance Dept.
- Insurer regulation, e.g., network adequacy (fully-insured plans)
- Insurance consumer

Office of Healthcare Advocate
- Insurance consumer assistance
- Policy recommendations to improve access to covered care

Office of the Attorney General
- Insurance consumer assistance
- General watchdog

Office of the Child Advocate
- General watchdog

BH = Behavioral health
MH = Mental health
SU = Substance use
*Includes other state agencies.
Source: PRI staff.

DPH has for several years been in the process of developing regulations that would no longer require facility providers that treat both mental health and substance use under certain licenses to hold multiple licenses.[7] An existing law, passed in 2009, requires this dual licensure to have been implemented by January 1, 2011 – more than two years ago.[8] DPH personnel stated in a fall 2012 conversation with program review committee staff that it likely will be another 12 to 18 months until the regulations can successfully proceed through the review and adoption process. They indicated the process would not be sped up through further legislative mandate. There simultaneously are other efforts being considered within the executive branch that would ease licensure's administrative burden on the state's contracted nonprofit providers without compromising standards.

Funding

DMHAS and DCF both fund contracted private nonprofits that provide substance use treatment services to the departments' clients, people with insurance, and those who are uninsured. The payments are meant to cover state agency clients who are unentitled or uninsured, and defray part of the cost for uninsured people who are not state agency clients.

Due to the timeframe of this study, data on this funding was not examined;[9] however, generally it is acknowledged that state-supported nonprofits are experiencing deteriorating financial conditions.[10] Financially stretched providers would be unable, at current resource levels, to help better meet service demand through expansion.

Coordination & Oversight of Treatment

Several state agencies, offices, and councils play a role in overseeing access to substance use treatment for adolescents and/or young adults, described below.

Alcohol & Drug Policy Council (ADPC). The 29-member council, formed in 1996 via executive order and then established in statute in 1997, is responsible for reviewing policies and practices of individual agencies and the Judicial Department regarding:

- substance use treatment programs and prevention services;
- the referral of people to these programs and services; and
- criminal justice sanctions and programs.

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[7] The following facility licenses would be combined into a single license: Mental Health Day Treatment, Community Residence, and Residential Living Center; Psychiatric Outpatient Clinics for Adults; and Private Freestanding Facilities for the Care or the Treatment of Substance Abusive or Dependent Persons.

[8] Required by C.G.S. Sec. 19a-902, per Public Act 09-149, An Act Implementing the Recommendations of the Legislative Program Review and Investigations Committee Concerning Substance Abuse Treatment for Adults.

[9] Part of DMHAS and DCF substance use-related funding comes from federal sources. For example, Connecticut received $16,883,413 from the Substance Abuse Prevention and Treatment Block Grant and $4,464,764 from the Community Mental Health Block Grant. (As of February 14, 2013, there was no final FFY 2013 appropriation.) Historically – and continuing through the current grant cycle – none of the substance use treatment grant has been used for adolescent services.

[10] See, for example: "Governor's Cabinet on Nonprofit Health and Human Services Report to Governor Dannel P. Malloy," October 1, 2012. Accessed February 6, 2012 at: http://www.ct.gov/opm/lib/opm/assets/temp/governors_np_cabinet_annual_report_final_2012-10-01.pdf

The council is also charged with developing and coordinating a statewide, interagency, integrated plan, and then annually reporting its evaluation of the plan and any recommended changes to it. The authorizing statute specifically focuses on state agency programs and policies.[11] Its members include nonprofit providers, healthcare practitioners, state personnel from all three branches of government,[12] and persons in recovery. The council is co-chaired by the DMHAS and DCF commissioners, and the Office of Policy and Management is to provide staff within available appropriations.

The council has not been very active recently, due in part to turnover among key state agency personnel. There were four meetings across 2011 and 2012, with no annual report issued in either year. In earlier years, the council's reports have extensively discussed adolescent substance use (especially in 2007), largely in terms of how state agencies could improve services to their clients. State agency personnel reported that the council had been useful most recently in the effort to address prescription drug misuse. The future direction of the ADPC is under consideration by DMHAS and DCF.

State Behavioral Health Planning Council. Begun in 1992, the council was formed to provide overall advice and direction for the state's mental health efforts but has since been expanded to also include substance use. The children's representatives to the council are DCF's Children's Behavioral Health Advisory Committee, while the adult segment is DMHAS's Adult Behavioral Health Planning Council. The adult council concerned only mental health until it was expanded in fall 2012 to include substance use stakeholder representation (e.g., people in recovery, advocates, providers). Consequently the joint child-adult council was re-named to reflect its broadened mission.

The entire council meets quarterly. In 2012, its meetings involved updates on DCF and DMHAS initiatives, as well as on the federal mental health and substance use block grants.[13]

Behavioral Health Partnership (BHP) Oversight Council. The council oversees the state's Medicaid behavioral health program, the BHP. The group is statutorily required and includes providers of substance use and mental health treatment, people in recovery from behavioral health disorders, and representatives of numerous state agencies.[14] The council meets monthly and has been active in trying to improve access to behavioral health services for BHP enrollees.

Department of Mental Health & Addiction Services (DMHAS). The department – the behavioral health state agency for adults – assumed a key role in coordination and oversight with the enactment of Public Act (P.A.) 09-149, which was based on recommendations from a 2008 program review committee study. The law, found at C.G.S. Sec. 17a-451(j), makes the department responsible for creating and implementing a state substance abuse plan. The plan, to

[11] C.G.S. Sec. 17a-667
[12] These officials or their designees: Secretary of Office and Policy and Management; Commissioners of Children and Families, Consumer Protection, Correction, Education, Higher Education, Mental Health and Addiction Services, Motor Vehicles, Public Health, Public Safety, Social Services, Transportation, and Insurance; Chief Court Administrator; Chief State's Attorney; Chief Public Defender; and chair of Board of Pardons and Parole.
[13] Based on program review committee staff review of meeting minutes.
[14] C.G.S. Sec. 17a-22j

be updated periodically, is to include prevention and treatment, but due to the agency's jurisdiction, is limited to adults (including young adults 18 through 25, who are part of this study's focus). Issued in September 2010, the plan's major strategies generally address state agency services, although one involved making the Connecticut Clearinghouse website's treatment locator function more consumer-friendly.

The department is advised by multiple councils and boards. Pertinent to substance use, there are: the Behavioral Health Planning Council, the State Board of Mental Health and Addiction Services, Regional Action Councils, and Regional Mental Health Boards.

DMHAS oversees services given by the private nonprofits it funds, through contracting requirements, but not those of other treatment providers.

Department of Children and Families (DCF). The Department of Children and Families is the behavioral health state agency for children[15] and has other roles regarding child protection, juvenile justice, and prevention. As such, DCF participates in ADPC and works with DMHAS; furthermore, its mandated strategic plan must include behavioral health services (both mental health and substance use). It is advised by the State Advisory Council on Children and Families and by the Children's Behavioral Health Advisory Committee.

DCF oversees the substance use treatment services given by its contracted private nonprofit providers, similarly to DMHAS, and also, through licensure, all adolescent residential substance use treatment facilities.

Department of Public Health (DPH). The Department of Public Health is involved in access to treatment in two ways. First, it is involved with regulation of facilities and practitioners through both the certificate of need process and licensure, except for facilities that are state-operated or provide certain types of children's behavioral healthcare.

Second, the department must issue a Statewide Health Care Facilities and Services Plan. The plan focuses on data that are useful to the certificate of need process but also incorporates additional information that can help policymakers and others improve access to and quality of healthcare. The first plan was issued in October 2012. Its behavioral health section mainly explains the types of services offered directly by the state, the number of providers funded by the state, and trends in behavioral healthcare (recovery-focused and integration with primary care). This section was guided by a subcommittee formed specifically for the purpose of assisting with the behavioral health portion of the plan.

Specific to substance use, the plan's assessment of the overall level of need for services and existing treatment settings available rely on federal data also used in this study. The pertinent recommendations focus largely on developing better information on the accessibility of treatment services to the state's whole population. Review of the behavioral health subcommittee's meeting minutes indicates that a more ambitious assessment of capacity was considered by the group, which helped develop the plan; ultimately, it seems that idea was not pursued due to resource constraints. This and all other subcommittees will be reconvened in spring 2013 to explore implementing the plan's recommendations.

[15] C.G.S. Sec. 17a-3(a)

Office of the Healthcare Advocate (OHA). The office has dual roles of assisting healthcare consumers in understanding and accessing insurance coverage, and issuing policy recommendations to improve access to insurance-covered healthcare. It also is charged more specifically with overseeing access to mental health care by facilitating communication among mental health care consumers, providers, and insurers surrounding best practices and mental health (and similar) parity, and annually reporting to the legislature on those activities.[16]

Under this latter charge, OHA held an October 2012 hearing on access to behavioral healthcare. Subsequently the office issued a January 2013 report, calling for several steps to improve access to mental health and substance use care.[17]

Others. The Office of the Child Advocate and the Office of the Attorney General fill watchdog roles and at times have investigated and spoken out about access to behavioral healthcare.[18]

Overall. *There has been little sustained attention to ensuring access to substance use treatment for the state's whole population.* DMHAS and DCF, along with their councils,[19] largely – and understandably – have been focused on improving services to their clients. It would be appropriate for a cross-agency entity that involves providers, advocates, and people in recovery to have as a main goal ensuring access to treatment. The ADPC may be best suited for this role, but it has lost momentum recently and its future direction is unclear. A reinvigorated ADPC could serve the state well in this capacity.

Recommendation. The program review committee recommends:

1. The Alcohol and Drug Policy Council should include as one of its main missions the goal of ensuring access to appropriate substance use treatment for the entire state's population, including adolescents and young adults. The group should explore, develop, and advance comprehensive strategies for improving access to treatment for all Connecticut residents.

Insurer Network Adequacy

The Connecticut Insurance Department (CID) conducts some activities to monitor whether fully-insured plans within the state have sufficient in-network services availability. These activities involve enforcement of a few state laws and publication of certain network information, as described below. (The insurance policies to be available on state insurance exchanges will have to meet certain other network adequacy requirements, as explained in

[16] C.G.S. Sec. 38a-1041(e)

[17] "Findings and Recommendations: Access to Mental Health and Substance Use Services," Victoria Veltri, Office of the Healthcare Advocate, January 2, 2013. Accessed January 3, 2013 at: http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf.

[18] For example, see: "Connecticut Children Losing Access to Psychiatric Care; A Report of the Attorney General and Child Advocate's Investigation of Mental Health Care Available to Children in Connecticut," Richard Blumenthal and Jeanne Milstein, April 12, 2007.

[19] Based on program review committee staff review of recent meeting minutes for the Joint Behavioral Health Planning Council, the Child Behavioral Health Advisory Council, and the Alcohol and Drug Policy Council.

Appendix C.) The department also tracks adequacy through complaints, by methods described in the program review committee's December 2012 Phase I report.

The extent of a health insurer's service network has a substantial impact on whether enrollees can access needed, covered services in a timely way that is also affordable. (Some plans cover out-of-network service benefits but at a higher cost-sharing rate; others do not, placing the full financial burden on the enrollee.) Ideally a network would include sufficient numbers of various types of providers accepting new patients who are within a reasonable distance from all plan enrollees. Technological tools (e.g., GeoAccess) and numerical benchmarks (such as provider-to-enrollee ratios) can assist a plan, accrediting agencies, or insurance regulators in determining whether a network is adequate. However, geographical provider shortages may mean that even if a plan makes an earnest attempt to have an adequate network, one cannot be maintained. In such a situation, national accrediting organizations and an insurance regulators would certify a health plan as having a sufficient network.

Laws. In Connecticut, network adequacy is regulated by two different statutes. The first has long required preferred provider networks contracting with managed care organizations (MCOs) to demonstrate adequacy to the satisfaction of the MCOs.[20] The other, effective January 1, 2012, requires MCOs and preferred provider networks to meet the network adequacy standards of either major health accrediting organization, the National Committee for Quality Assurance (NCQA) or URAC.[21] Detailed explanations of both standards are found in Appendix C. The standards are not numerical (e.g., no set provider-to-enrollee ratio). Instead, they require health plans to set and assess progress toward reasonable goals incorporating geographical and ease of appointment aspects, among others.

The Connecticut Insurance Department is enforcing the more recent network adequacy law by asking carriers to certify compliance as part of an existing annual reporting process (for the Consumer Report Card, which is described below). The department is not requiring supporting documentation be submitted for the certification, even for companies lacking NCQA or URAC accreditation. As of fall 2012, ten of the fifteen indemnity MCOs had not applied for NCQA accreditation.[22] (URAC accreditation information is not included in the report card.)

Of note, while the statute was effective January 1, 2012, which means that sometime after that compliance was required, the department decided to implement it based on calendar year 2012 data, to coincide with the Consumer Report Card timeframe. This effectively gave the health carriers until May 2013 to report compliance for the full year to CID, which seems to be an overly lengthy period of time.

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[20] C.G.S. Sec. 38a-479bb(d)(1). (Enacted via P.A. 03-169, effective May 1, 2004.) The statute provides that the adequacy determination takes into account "geographic distribution of enrollees and participating providers and whether participating providers are accepting new patients."

[21] C.G.S. Sec. 38a-472f. (Enacted via P.A. 11-58.) URAC formerly was known as the Utilization Review Accreditation Commission.

[22] Five indemnity MCOs and all health maintenance organizations were NCQA-accredited. ("Consumer Report Card on Health Insurance Carriers in Connecticut," Connecticut Insurance Department, October 2012. Accessed February 1, 2013 at: http://www.ct.gov/cid/lib/cid/2012_CT_Consumer_Report_Card_on_Health_Insurance.pdf.

Information. The insurance department's Consumer Report Card contains a limited amount of other information relevant to network adequacy. The mandated publication is annually issued to help people understand utilization review results, enrollee satisfaction, and number of providers regarding the state's fully-insured plans.

The report card gives two types of network adequacy information. First, it presents, for each HMO and indemnity managed care organization, the numbers of different types of providers – primary care physicians, physician specialists (generally), hospitals, and pharmacies – by county. Notably there is no breakdown by types of specialists or ratio of providers to enrollees. Second, the report card includes for each plan selected member satisfaction survey data, including ease of access to specialist and other appointments. There is no survey information specific to behavioral health, due to limitations of the dataset.[23]

Data received by the program review committee from the five major carriers of Connecticut fully-insured health plans indicates variation in the number of in-network substance use or behavioral health treatment providers at a few levels of care (shown in Appendix C, Table C-5). The precise reasons for the network differences and the implications of them are unclear.

Overall. *Connecticut's network adequacy laws and information collected from plans are weak*, compared to what is done by about 20 other states or recommended by the National Association of Insurance Commissioners (NAIC), described in Appendix C. For example, health carriers in Connecticut are not required to file data (beyond limited counts of certain types of providers) or written plans demonstrating in-network provider accessibility. Information on the number of behavioral health or substance use treatment in-network providers is not collected; data given to program review committee staff show some differences among the major carriers.

It is unclear if stronger traditional network adequacy laws would be an effective way to improve access to covered substance use treatment, for a few reasons. First, the impact of traditional network adequacy standards on enrollee access to any type of care is not well-researched. No such evaluations were located by program review committee staff. Second, in public hearings recently held by OHA and multiple legislative committees, families seeking behavioral healthcare and practitioners themselves have testified mainly about issues that would not be remedied by typical network adequacy laws. Particular complaints have been about difficulty and work involved in receiving coverage authorizations (i.e., utilization review), onerous requirements to be admitted to the network, and, for both Medicaid and commercial insurance, low reimbursement rates.

While the committee's December 2012 Phase I report made recommendations regarding one area of insurance access complaints (utilization review), *additional steps should be taken to address access to covered substance use treatment related to the physical availability of appropriate services.* Some behavioral healthcare providers, individual practitioners, and clients have expressed growing frustration – through the committee survey, public hearing, and staff's interviews – with clients' difficulty accessing covered substance use treatment, especially for those with commercial insurance. Their frustration with managed care's role in accessing

[23] The survey data are drawn from the national Healthcare Effectiveness Data and Information Set (HEDIS) database, in which all the MCOs participate.

substance use treatment is found beyond Connecticut, [24] and within this state, extends to mental health treatment.[25]

One way to begin to better understand and address access to treatment is through an approach similar to that of a model law developed by a national bipartisan group. The President's Commission on Model State Drug Laws in 1993 recommended that states require each health carrier to submit plans and data describing access to substance use treatment and how the carrier intends to increase access.[26] The proposed model law includes provisions for a network adequacy and outreach plan, and thorough information (e.g., length of stay by level of care) on utilization.[27]

Recommendations. Drawing on the substance use treatment access plan and data proposed by The President's Commission on Model State Drug Laws, the program review committee recommends:

2. C.G.S. Sec. 38a-478c shall be amended to require health carriers to annually report on:

a. By county, for inclusion in the Consumer Report Card:

- **i. The estimated prevalence of substance use disorders among child, young adult, and other adult enrollees;**
- **ii. The number and percent of child, young adult, and other adult enrollees who received covered substance use treatment, by level of care;**
- **iii. The median length of substance use treatment for child, young adult, and other adult enrollees, by level of care;**
- **iv. The per member per month child, young adult, and other adult claim expenses for substance use treatment;**
- **v. The number of in-network substance use treatment providers, by level of care, showing the percentage of in-network providers that are taking new clients with that insurance;**

b. For the entire state:

[24] As noted in the committee's December 2012 report, Pennsylvania in 1986 removed the ability of insurers to conduct utilization review on substance use treatment prescribed by a licensed physician or psychologist. The law was challenged in the 2000s by health carriers but court decisions upheld the laws and their enforcement. More recently, there has been press coverage of insurer restrictions in New Jersey. (See: "Insurance Companies Frustrate N.J. Families Seeking Addiction Treatment," Dan Goldberg, The Star-Ledger, February 17, 2013. Accessed February 20, 2013 at: http://www.nj.com/news/index.ssf/2013/02/new_jersey_heroin_insurance_tr.html.)

[25] See: "Findings and Recommendations: Access to Mental Health and Substance Use Services," Victoria Veltri, Office of the Healthcare Advocate, January 2, 2013 at: http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf. Also: "Waiting for the Next Crisis: Parents Struggle with Children's Mental Health Needs," Arielle Levin Becker, The CT Mirror, February 15, 2013 at: http://www.ctmirror.com/story/19136/waiting-next-crisis-parents-struggle-childrens-mental-health-needs.

[26] "Model Managed Care Consumer Protection Act," The President's Commission on Model State Drug Laws, December 1993. Accessed March 7, 2013 at: http://www.namsdl.org/resources/v4d%20model%20managed%20care%20consumer%20protection%20act-.pdf.

[27] Ibid, Sections 14 and 15

i. The number, by licensure type, of behavioral health practitioners and, by level of care provided, facilities that have applied for in-network status, and for each, the percent that were accepted; and

ii. The number and percentage of behavioral health practitioners by licensure type and, by level of care, facilities that have halted participation in the network.

c. Identification and explanation of factors that may be impacting access to substance use care, including but not limited to screening, statewide supply of certain practitioner types, provider capacity limitations, and reimbursement rates.

d. Plans and ongoing or completed activities to address the identified factors that may be negatively impacting access to care.

The health carrier may request the commissioner to deem any of the information in (b), (c), or (d) above proprietary and unavailable to the public. The commissioner may approve or deny such request. If any information is deemed proprietary, the insurance department and the Office of the Healthcare Advocate may view the information but not make it public.

Finally, to augment the Phase I report recommendations and further assist the insurance department in evaluating access to care, the program review committee recommends:

3. The Connecticut Insurance Department should, for the Consumer Report Card, request fully-insured health carriers to submit behavioral health utilization review (including coverage requests and adverse determinations) data:

a. according to specific levels of care (for example, inpatient, residential, partial hospitalization, et cetera);

b. separately for mental health treatment, substance use treatment, and co-occurring disorders;

c. separately for children, young adults, and other adults; and

d. including, separately, internal appeals and external appeals information.

These data will result in report card information that more closely matches the information presented in the committee's phase one report. It will enable not only the insurance department but also the public to better understand utilization review outcomes for behavioral health and how they may change over time – particularly if the committee's recommendations regarding utilization review and/or the insurer access plan are enacted.

Chapter II

Substance Use Treatment Service Availability for Insured Youth

This chapter explains how youth can become connected to treatment services. It then describes elements of an ideal system for helping insured youth access and engage in needed substance use treatment, drawing largely on a 2012 report from the National Center for Addiction and Substance Abuse at Columbia University.[28] The elements are:

- screening within primary care;
- locating available treatment;
- receiving appropriate treatment; and
- receiving support for recovery.

Within each element, Connecticut is compared to the ideal. Recommendations in a variety of areas collectively would move Connecticut toward an ideal system.[29]

Background: How Youth Reach Treatment

Youth can become connected to substance use treatment through the initiative or requirement of a range of people or institutions. These include family, school, healthcare practitioners, community organizations, and – though not addressed by this study – state systems (e.g., justice, child welfare). The justice system is by far the most common referral source, accounting for nearly half of all adolescent admissions to substance use treatment.[30]

Youth also can independently choose to search for treatment options or seek out counseling at school. Some may first turn to mutual assistance groups like Narcotics Anonymous or Alcoholics Anonymous, although committee staff heard during the study that it is unlikely most youth will feel comfortable with and persist in such groups, unless the group is connected with a school or geared to their age group.

Parents or guardians may seek guidance from clergy or their child's pediatrician, or choose to independently search for treatment options. Frequently, parents will not request assistance from or notify school due to the possibility of sanctions, such as suspension, on their child. Parents may also present, with the youth, at an emergency department within a general hospital.

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[28] "Addiction Medicine: Closing the Gap Between Science and Practice," National Center on Addiction and Substance Abuse, June 2012, pp. 107-109. Accessed June 29, 2012 at: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf.

[29] In some instances, recommendations address behavioral health (i.e., both substance use and mental health) because of the close relationship between substance use and mental health disorders (e.g., co-occurring disorders, practitioners and facilities may treat both, state agencies' roles encompass both).

[30] Adolescent referral sources were, according to CASA (based on federal survey data): criminal justice (48 percent), themselves (16 percent), school (11 percent), healthcare provider (5 percent), and other community providers (12 percent). ("Adolescent Substance Use: America's #1 Public Health Problem," The National Center on Addiction and Substance Use at Columbia University, June 2011. Accessed May 23, 2012 at: http://www.casacolumbia.org/upload/2011/20110629adolescentsubstanceuse.pdf.)

Element 1: Screening Within Primary Care

Ideal. Primary care providers screen adolescent, young adult, and older adult patients for risky substance use periodically – at routine check-ups – and upon trauma admissions. Screening helps providers identify those needing treatment. In some cases, providers can give a brief intervention, which has been proven by several studies to be an effective method at reducing risky use and possible effects (e.g., hospitalization, arrest). In others, a referral to treatment is necessary. Providers administer screens when they are comfortable with the idea of screening, the tool used, and what to do when a positive result is obtained.

Connecticut. *Trauma patients are screened for substance use, per C.G.S. Sec. 19a-490h,*[31] *and generally adult physicals include at least a cursory alcohol screen. Adolescents, however, might not be routinely screened – as is recommended – for risky substance use, although screening tools are available*. Recent public hearing testimony indicated that a limited portion of pediatricians and other primary care providers uses a standardized, formal method to check child and adolescent behavioral health. There are a few substance use screening tools meant for primary care, such as CRAFFT, which consists of six questions.[32] Routine substance use screening for adolescents, using a validated tool, was recommended by the American Academy of Pediatrics in October 2011.[33]

There are many possible reasons for why screening is not uniformly conducted. Some providers have indicated being reluctant to screen because it was not part of their training and therefore feel unprepared to do so. However, state law implies these activities, related to substance use, should be included in Connecticut training programs: Public Act (P.A.) 98-201 required a variety of behavioral and primary care practitioner preparation programs to create plans to implement substance use screening and referral into their curricula. The program review committee staff was unable to locate any information on whether these plans had been submitted to the Board of Governors of Higher Education as required by the law.[34]

For practicing adolescent providers, free behavioral health screening training (among other types of education) is made available by the Child Health and Development Institute. The

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[31] Enacted by Public Act 98-201. The national trauma center accrediting organization also requires certain trauma centers to screen for substance use.

[32] CRAFFT's acronym is based on the six questions. One other tool is the GAIN-SS (Short Screen), which is widely used by behavioral health agencies, including Connecticut's Department of Children and Families. It takes three to five minutes and involves a range of behavioral health disorders. As it requires minimal training, it could perhaps be used in primary care settings. (See: "Brief Introduction to the GAIN-SS and Assessments.com," Assessments.com. Accessed March 1, 2013 at: https://www.assessments.com/assessments_documentation/gain_ss/GAIN%20SS%20Fact%20Sheet.pdf.) Additional tools are described at the Centre for Addiction and Mental Health's website, accessed March 8, 2013 at: http://knowledgex.camh.net/amhspecialists/screening_assessment/screening/navigating_screeningcd/pages/api_screen_substance.aspx.

[33] "Substance Use Screening, Brief Intervention, and Referral to Treatment for Pediatricians," From the American Academy of Pediatrics with lead authors Sharon Levy and Patricia Kokotailo, Pediatrics 128(5):e1330-e1340, October 31, 2011. Abstract accessed March 1, 2013 at: http://pediatrics.aappublications.org/content/128/5/e1330.full.

[34] The Board of Governors of Higher Education was replaced by the Board of Regents for Higher Education on July 1, 2011. At that time, the administrative higher education agency changed from the Department of Higher Education to the Office of Higher Education.

independent organization (associated with a foundation) has indicated low participation in this particular training.

Other primary care providers may be unaware of the treatment resources available, uncertain which service would be most appropriate, or reluctant to widely screen when they perceive it is difficult for patients to access needed treatment for substance use.

Finally, time and/or financial pressures may impact screening practices. It is unclear whether commercial insurers will give additional reimbursement for very brief screens, as part of routine care, and providers may feel they lack the time or income cushion to perform additional duties without extra pay.

It is possible to mandate substance use or (more comprehensively) behavioral health screening;[35] however, most people with whom committee staff spoke are reluctant to embrace that step. There is doubt that primary care providers would embrace screening if not sufficiently comfortable with the tool or what to do if a need for treatment is found.

Connecticut lacks a behavioral health consultation service for children's primary care providers, a program that may increase screening rates through giving providers training, information, and referral assistance. Twenty-four states – including Maine, Massachusetts, New Jersey, New York, New Hampshire, and Vermont – have a consultation program.

In Massachusetts, the program involves active outreach to and training for all providers of care to children, a telephone consultation line, referral assistance, and in-person evaluations when necessary. It has yielded a higher rate of comfort with mental health screening[36] and better provider satisfaction with ability to meet children's behavioral health needs.[37] The program is

[35] Massachusetts's Medicaid program recently began requiring a behavioral health screening at routine children's physical healthcare appointments, due to a 2006 court ruling. (See, for a description of the case and results of the screening requirement: "*Rosie D.* and Mental Health Screening; A Case Study in Providing Mental Health Screening at the Medicaid EPSDT Visit," Julianna Belelieu, TeenScreen National Center for Mental Health Checkups at Columbia University. Accessed February 5, 3013 at: http://www.mass.gov/eohhs/docs/masshealth/cbhi/rosie-d-white-mhscreening.pdf.) Legislation pending in the Connecticut General Assembly (Senate Bill 169) would require behavioral health screening among the health-oriented mandates for public school children.

[36] Fifty-seven percent of pediatric primary care providers indicated their ability to use behavioral health screening tools had improved (with one-quarter not giving an opinion), according to a recent presentation during a Connecticut legislative meeting. (Presentation of John Straus and Barry Sarvet, March 4, 2013.) There is some indication that a strong increase in screening was due largely to a judicial mandate for screening of children with Medicaid insurance, which also ultimately yielded better Medicaid billing terms for this screening. ("Increases in Behavioral Health Screening in Pediatric Care for Massachusetts Medicaid Patients," Karen Kuhlthau et. al, *Archives of Pediatric Adolescent Medicine 165*(7):660-664, 2011. Accessed February 5, 2013 at: http://archpedi.jamanetwork.com/article.aspx?articleid=1107548.)

[37] Once the program was implemented, the percent of primary care providers agreeing they are able to meet the needs of children with psychiatric problems increased nearly 8-fold (from 8 percent pre-program, to 63 percent). ("The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care," Wendy Holt, DMA Health Strategies for The Commonwealth Fund, March 2010. Accessed February 5, 2013 at: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2010/Mar/1378_Holt_MCPAP_case_study_32.pdf.)

now aiming to expand substance use screening; previous efforts focused on mental health. About 95 percent of the children in the state are seen by providers participating in the program.[38]

While patients with commercial insurance have benefited from the Massachusetts program, private insurers have played no role. The majority of patients for whom providers have sought consultation are covered under private insurance, but the program's operations are funded solely by government sources. Commercial insurance has neither contributed to operations costs nor reimbursed providers calling for consultations with the program.

Implementation of a similar model within Connecticut – which may happen soon – likely would both help primary care providers become comfortable screening for behavioral health concerns and alleviate the shortage of child and adolescent psychiatrists. In early March 2013, creation of a comparable program in Connecticut was unanimously recommended by the legislature's Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety.

The extent to which adult primary care providers routinely screen for substance use or other behavioral health needs is unclear. There is, however, a burgeoning interest in integrated or collaborative care, of which screening for problems with the other aspect of health is just one of many models.[39] As this interest grows – fed through government grants and requirements, as well as initiative of insurers, providers, and professional associations – it is likely that screening for and connection to behavioral healthcare will improve.

Recommendations. The Massachusetts consultation program model could be strengthened, when it is adapted for use in Connecticut, by incorporating substance use and commercial insurance participation. The program review committee recommends:

> **4. The State of Connecticut should have a comprehensive pediatric behavioral health consultation program. The consultation line's screening, training, consultation, and referral activities should include both mental health and substance use. The program should work with commercial insurers to explore how those insurers can play a role in the project.**[40]

The consultation program likely will yield higher behavioral health screening rates among primary care providers serving children and adolescents. It would make sense to simultaneously expand screening training to students in medical preparation programs. The

[38] "The Massachusetts Child Psychiatry Access Project: Supporting Mental Health Treatment in Primary Care," Wendy Holt, DMA Health Strategies for The Commonwealth Fund, March 2010. Accessed February 5, 2013 at: http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2010/Mar/1378_Holt_MCPAP_case_study_32.pdf.

[39] For a description of the various meanings and types of integrated and collaborative care, see: "Evolving Models of Behavioral Health Integration in Primary Care," Chris Collins, Denise Levis Hewson, Richard Munger, and Torlen Wade, Milbank Memorial Fund, 2010. Accessed March 6, 2013 at: http://www.milbank.org/uploads/documents/10430EvolvingCare/EvolvingCare.pdf.

[40] Public Act 13-3, signed into law on April 4, requires a substantially similar program. This recommendation was proposed, along with the others, in March 2013; the committee endorsed the recommendation in June in support of the now-mandated program.

extent to which these preparation programs offer screening training is unclear. The program review committee recommends:

> **5. The Alcohol and Drug Policy Council should assess whether Connecticut's physician, nurse, and physician assistant preparation programs include training on behavioral health screening, administering a brief intervention for substance use, and referring to treatment. The council then should encourage and assist the preparation programs not offering the training, to do so, on at least a voluntary basis.**

Element 2: Locating Available Treatment

Ideal. An appropriate substance use treatment program is easily found and quickly entered. Treatment must be available when a person (or provider, or family member) seeks it because many are uncertain about entering.[41]

Connecticut treatment locators. Multiple substance use treatment locators are available to help people find treatment options. Six major substance use treatment locators, detailed in Appendix D, were found. Of these:

- three are affiliated with the Department of Mental Health and Addiction Services (DMHAS), including one listing town-specific telephone numbers for crisis services;
- one is operated by the federal behavioral health services agency;
- another is run by the United Way; and
- one is funded by a variety of government and private partners.

All but one enable the user to locate treatment options using only the Internet; two additionally offer a telephone option. Several link to each other. Most, if not all, do not include small private behavioral healthcare practices.

In addition to these tools, there are online locators specific to some types of treatment (e.g., residential facility, buprenorphine, recovery housing) and behavioral health practitioners (e.g., social worker). General search engines or tools – such as Google, Yellow Pages, and insurer in-network provider listings – may also be a resource. Some healthcare providers or other community resources keep their own lists of possible treatment options.

The major substance use treatment locators' program listings are deficient in two ways. First, the locators are inconsistent. Program review committee staff conducted basic searches for a variety of care levels, using three locators, and found discrepancies in the number of options produced for various care levels, as described in Appendix F. Second, none of the locators shows whether treatment providers are accepting new clients. This information would make it easier for

[41] National Institute on Drug Abuse, National Institutes of Health Publication No. 09-4180, *Principles of Drug Addiction Treatment: A Research-Based Guide (Second Edition)*, April 2009. Accessed June 11, 2012: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment.

healthcare providers, families, people with a substance use disorder, and others to easily and quickly find an appropriate placement.[42]

While maintaining multiple locators could be helpful in trying to reach as many people as possible, it may be more cost-effective and consumer-accessible if one up-to-date, comprehensive locator were maintained. Then, other sites could link to this single listing.

Recommendation. To improve the ease of finding available treatment, the program review committee recommends:

> **6. The Alcohol and Drug Policy Council should assess the various substance use treatment locators maintained at the state level. The assessment should be used to select one of the locators to be Connecticut's primary source of information on substance use treatment options. The relevant state agencies should publicize this locator online and encourage private nonprofits to do the same.**
>
> **The locator should contain information on whether each treatment program is accepting new clients – updated at least daily – and what insurance plans, if any, are accepted. An effort should be made, working through the healthcare practitioner associations, to include in the locator private behavioral healthcare practices.**

Connecticut's treatment capacity. *For most levels of care, the precise capacity of the state's substance use treatment system is unknown.* This is due in part to the fragmented nature of the system, as discussed in Chapter I.

Treatment services may be obtained at facilities or practices with or without specialty substance use treatment licenses, depending on the level of care and size of the practice. To assess the capacity and availability of substance use treatment services, program review committee staff reviewed a variety of state agency documents. Surveys of licensed treatment providers and colleges also were conducted. Appendix E contains information on the provider survey results and methods, and Appendix F discusses the capacity information available by source.

Specialty licensed facilities. There are 205 licensed, private substance use treatment facilities in Connecticut. Of these:

- 199 are private substance use treatment facilities licensed by the Department of Public Health (DPH);[43]
- two are specialty psychiatric hospitals, also licensed by DPH;[44] and

[42] The emergency department focus groups convened for the Department of Public Health's Office of Health Care Access's 2012 Statewide Health Care Facilities and Services Plan included among their recommendations an up-to-date source of information on behavioral health treatment programs' availability.
[43] DMHAS-operated facilities are not licensed.

- four provide residential substance use treatment for children, and are licensed by the Department of Children and Families (DCF).

The number of substance use treatment facilities likely has declined over the past decade, according to a federal survey.[45]

Levels of care. The entire range of substance use treatment levels of care is represented among the DPH-licensed facilities:

1. Inpatient, involving medically managed or monitored care
2. Residential rehabilitation, which can have stays that are short (30 days or fewer), intermediate, or long-term (90 days or more)
3. Supervised community living arrangement with clinically managed services, such as a halfway house[46]
4. Partial hospitalization (involving medical management) or day or evening treatment, usually for someone who is transitioning out of residential care
5. In-home treatment using evidence-based models
6. Intensive outpatient, with at least nine hours weekly of clinical (e.g., individual and group counseling) services
7. Outpatient, which can be individual or group counseling

Detoxification can be done on an inpatient or outpatient basis, depending on the level and substance(s) of use.

The majority of facilities offers – and most clients engage in – some type of outpatient (broadly) treatment. Among specialty licensed providers responding to a federal survey, methadone maintenance served the largest portion of all people in treatment (45 percent), while regular outpatient counseling was the second most popular care (37 percent).[47]

The precise capacities for the various types of outpatient care available in DPH-licensed facilities are not known, but collectively they far exceed 36,000 spaces for substance use and mental health outpatient care overall.[48] The DPH licensure process does not collect information on the number of slots for any type of outpatient treatment.

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[44] "Statewide Health Care Facilities and Services Plan," Connecticut Department of Public Health Office of Health Care Access, October 2012.

[45] The number of facilities known to an annual federal survey of treatment facilities (N-SSATS) declined by 24 percent between 2002 and 2011 (from 263 to 201 facilities). See Appendix F for more information.

[46] A halfway or recovery house that does not provide clinically managed services is not required to be licensed as a substance use treatment provider.

[47] "2011 State Profile – Connecticut," National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf.

[48] DPH licensure information shows capacity for residential treatment and inpatient care, but not for outpatient (e.g., day/evening treatment) services. N-SSATS indicates 24,294 clients were receiving some type of outpatient service in March 2011 (including 9,663 in regular outpatient counseling and 11,647 in methadone maintenance) but the number of behavioral health (i.e., not specific to substance use) treatment spaces well exceeds 36,000, based on the program review committee's provider survey. These spaces for many providers are shared between clients who have only mental health disorders and those with disorders involving substance use.

Residential and inpatient treatment capacity is much smaller than outpatient capacity. There are about 1,570 residential treatment beds and under 200 specialty hospital inpatient beds, among DPH-licensed substance use treatment providers. Most (64 percent) of the state's DPH-licensed adult residential treatment slots are in programs that offer only long-term (three to six month) stays. These programs likely are for only state agency or Medicaid clients, as commercial insurance generally will not pay for residential treatment of that duration.

In Connecticut, there has been over the past decade a slight capacity shift away from long-term residential care and day/evening treatment or partial hospitalization, and toward intensive and regular outpatient counseling treatment.[49] This shift has been occurring across the country, and over a longer period of time than for which data were examined.[50] The change is due to various factors, including the cost of residential treatment compared to outpatient, some research questioning the effectiveness of residential treatment in certain circumstances, and a movement to serve people needing behavioral health treatment within their communities, instead of in residential settings.

Payment. A large majority of specialty treatment facilities accepts private insurance, and an even larger share accepts Medicaid.[51] A portion of those taking private insurance – roughly one-third of program review committee's survey respondents – are not in-network providers for all the major insurers (entailing higher patient out-of-network cost-sharing, if applicable).

Youth services. Fewer providers at every level of care appear to offer substance use treatment to adolescents than to adults, based on the committee's survey results. DPH and DCF licensing data show that adolescent residential treatment capacity is about one-tenth of the state's adult residential treatment capacity.[52]

Non-specialty-licensed services. Some treatment-related services or facilities do not need to be DPH-licensed for substance use care, such as those given by certain providers or practitioners primarily giving medical healthcare. Each of the state's 29 general and children's hospitals can provide substance use treatment under its hospital licensure. The treatment may be for any level of care (e.g., inpatient, outpatient); more than one-third offer at least one type of outpatient substance use treatment, according to the Connecticut Clearinghouse treatment locator. In addition, school-based health centers provide counseling, though the portion that has actually provided substance use-related counseling is small.[53] Finally, non-behavioral healthcare

[49] "2011 State Profile – Connecticut," National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf.

[50] "Mental Health Financing in the United States: A Primer," Rachel L. Garfield, The Kaiser Commission on Medicaid and the Uninsured, April 2011. Accessed February 6, 2013 at: http://www.kff.org/medicaid/upload/8182.pdf.

[51] Among the N-SSATS 2011 survey respondents, 71 percent accepted private insurance and 79 percent took Medicaid. These percentages were even higher among the program review committee survey respondents (which, unlike N-SSATS, excluded government-operated facilities): 89 and 94 percent, respectively.

[52] Including only adult facilities offering treatment stays of four weeks or less, to ensure a reasonable comparison to adolescent residential treatment, which generally – for a center setting – does not exceed that timeframe.

[53] In FY10, six state-funded SBHCs (of about 71) – located in middle and high schools – provided substance use counseling, with an additional 13 (including a few elementary schools) providing "other counseling" that may have included care for substance use issues, according to data provided by DPH.

licensed practitioners may deliver very brief interventions when routine or other examinations indicate there is a substance use problem.

Outpatient counseling also can be given by small independent behavioral healthcare practices and, on most of the state's baccalaureate-level campuses, college counseling centers.

Connecticut's treatment availability. *Currently, there is no comprehensive assessment of Connecticut substance use treatment sites or programs that systematically examines service capacity and whether it is sufficient.* There have been, however, a few efforts to examine one or both aspects, usually for behavioral healthcare (i.e., not specific to substance use), as described in depth in Appendix G.

Combined with the results of the program review committee's survey of licensed providers, these information sources indicate that there is inadequate behavioral health capacity at several levels of treatment:

- *inpatient care;*
- *detoxification;*
- *residential treatment, especially for youth;*
- *in-home treatment models; and*
- *outpatient individual counseling*.[54]

In addition, some of these sources found a need for: treatment facilities that would accept new clients outside of normal business hours; youth-specific services (including young adults); and greater capacity for programs to serve Spanish-speaking clients.

Within college behavioral health outpatient counseling services, there could also be a shortage, with half of the survey respondents indicating a wait for treatment of at least four days. As noted in this study's prior report, it is important that substance use treatment be available very quickly.

Adolescents' access to effective in-home treatment models is limited. These models – Multidimensional Family Therapy (MDFT), Multisystemic Therapy (MST), and Functional Family Therapy (FFT) – are described in Appendix H. Each has been proven effective for adolescents, according to the National Center on Addiction and Substance Use at Columbia University.[55] In Connecticut, the Department of Children and Families grew these services through an intentional effort to make its substance use care community-based and, to the extent possible, evidence-based. Children may seek access to these services – which are covered for BHP enrollees – through methods that vary among the programs (as described in the appendix). The services generally are in high demand; an adolescent can wait longer than a month.

[54] These are the levels of care cited by at least two sources discussed in Appendix G as having substantial waitlists or generally inadequate capacity.

[55] Cognitive Behavioral Therapy (CBT) integrating family members has also been proven effective for adolescents. The aim of this therapy is to change unhealthy patterns of thinking and beliefs. CBT, more generally, is an evidence-based approach for many behavioral health disorders. It is not a model that is offered, as a distinct program, by the Department of Children and Families, though certain applications (e.g., Trauma-Focused CBT) are.

DCF contracts with providers to support these and other services for all adolescents, but it is not clear to what extent these programs serve those who are commercially insured.[56] A few providers told program review committee staff that, for the most part, there is limited accessibility to in-home models for children without Medicaid or DCF involvement. In addition, these providers noted that these evidence-based models are expensive to implement and maintain, with Medicaid reimbursement falling short of the actual costs. The precise expense of an in-home model varies among the options, but the full-length course of MDFT, for example, requires about $13,000 for one family. For commercially insured youth, providers attempt to bill commercial insurance for these services, reportedly with varying degrees of success. Two of the five Connecticut commercial health plans told committee staff that models such as MDFT are covered; an additional plan indicated an intention to explore such coverage.[57]

The Department of Children and Families noted that adolescents are to have equal access to the in-home programs, regardless of involvement with state agencies or insurance coverage. The contracted providers are to use their state funding to both: 1) serve adolescents who are uninsured, under-insured, or state agency clients; and 2) fill the gap between any reimbursement from Medicaid or commercial insurance and the true cost of delivering an evidence-based model.

Even if a commercial insurer agrees to cover in-home services, the cost-sharing most plans require could make these treatments prohibitively expensive for a portion of enrollees, without the state paying for some or all of the remainder. At the same time, in-home services are both evidence-based and, providers reported, less costly than either short-term residential treatment combined with appropriate after-care or the traditional 28-day stay in residential treatment.

If the state is serving a large number of commercially-insured youth through its evidence-based in-home behavioral health treatment models, it is spending a substantial amount to do so. Without data, however, it is difficult to accurately assess either the true accessibility of these models to privately insured youth, or the extent of the cost-shifting to the public sector and its nonprofit providers.

There is indication that certain additional types of care are strained. First, Connecticut hospitals have reported struggling with an increased volume of behavioral health patients of all ages, particularly those seeking care from emergency departments. For visits involving behavioral health, emergency department presentations not resulting in an inpatient admission increased 40 percent from FY 2008 to FY 2012, while inpatient discharges rose 13 percent.[58]

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[56] It is known, however, that commercially insured children are about one-third of DCF's Emergency Mobile Psychiatric Services (EMPS) participants.

[57] The other two plans indicated via the Connecticut Association of Health Plans that certain in-home behavioral health treatments, such as Applied Behavior Analysis for autism, are covered, but not MDFT and other, similar models.

[58] "Testimony of Carl Schiessl; Director, Regulatory Advocacy; Connecticut Hospital Association Before the Office of the Healthcare Advocate," October 17, 2012.

One way to relieve hospitals and improve people's access to behavioral healthcare would be to open a 24-hour behavioral health urgent care center. This has been done in a few states[59] and was endorsed by the emergency department focus groups convened by DPH for the facilities plan. Because Connecticut is geographically small, this could be an option that would increase quick access to care for people statewide.

Second, child and adolescent psychiatrists are difficult to access, according to parents, pediatricians, and private nonprofits, with a statewide shortage that may be reflective of a national deficiency. In some situations, cost may be a barrier – with either particular insurance accepted or none at all – while in others, practices are full, with waits of weeks or even months.[60] While other types of practitioners can provide behavioral healthcare, child and adolescent psychiatrists are sought by most parents who seek psychiatric medication for their offspring.[61] This issue affects children with mental illnesses most deeply, but a portion of them have or will develop a co-occurring substance use disorder in adolescence – particularly if unable to receive appropriate treatment for mental illness.

The consultation program recommendations above would aim to ease the impact of this shortage. Massachusetts and other states have found that having a consultation and referral line has helped alleviate long waits for child psychiatrists by helping primary care providers shoulder some medication responsibilities, referring children who need counseling but probably not medication to non-psychiatrist therapists, and reserving psychiatry referrals for those with the most severe needs.

Other factors impacting capacity adequacy. Capacity adequacy from the perspective of a person seeking treatment may be impacted by payment method. From a macro view, an adequacy assessment is most accurate when the true need for services and referral patterns are considered.

Payment method. A share of private behavioral healthcare practices – including a small portion of specialty substance use treatment providers – does not accept commercial insurance.[62]

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[59] The Olive View Community Mental Health Urgent Care Center in Sylmar (Los Angeles County) opened in August 2011. The project, which cost $10.8 million to build, was funded by both private and public contributions. (News release accessed on February 6, 2013 at: http://dmh.lacounty.gov.) In St. Paul, the Urgent Care for Adult Mental Health clinic was launched one month later through collaboration among hospitals, health plans, consumer groups, and state agencies. (Television news report accessed on February 6, 2013 at: http://www.kare11.com/rss/article/985970/20/Urgent-care-for-mental-health-opens-in-St-Paul.)

[60] See, for example, Dr. Kenneth Spiegelman's testimony at the Mental Health Working Group's January 29, 2013 public hearing (accessed February 15, 2013 at: http://www.cga.ct.gov/ASaferConnecticut/docs/2013MHWG00129-R001030-INF.pdf).

[61] Pediatricians and Advanced Practice Registered Nurses (A.P.R.N.s) may prescribe medication. Interviewees indicated that pediatricians have grown comfortable with prescribing attention-deficit medication but not with doing so for other types of pharmaceuticals designed to treat mental health disorders.

[62] For example, nearly half (47 percent) of the 147 Connecticut child and adolescent psychiatrists who responded to a 2007 survey indicated they do not accept any major managed care health plan. The survey was conducted for a study of access to mental health care completed by two state offices. ("Connecticut Children Losing Access to Psychiatric Care; A Report of the Attorney General and Child Advocate's Investigation of Mental Health Care Available to Children in Connecticut," Richard Blumenthal and Jeanne Milstein, April 12, 2007.)

Individuals with commercial insurance receive substance use treatment at lower rates than others, for unclear reasons.[63]

Someone seeking to pay for treatment with insurance may also be delayed in receiving care due to insurance utilization review (i.e., the process used to determine if requested or received treatment will be covered). The committee's December 2012 Phase I recommendations regarding commercial fully-insured plans' substance use treatment utilization review requirements, contained in Raised Bill 6557, aim to help ensure that commercial insurer coverage determination practices are not a barrier to prompt and appropriate treatment.

Need for treatment. The capacity assessment given above is limited because it includes only provider and family experiences of those who have sought treatment. A substantial share of the population needs but does not receive substance use care. According to a federal estimate, in a recent year more than 87 percent of non-institutionalized Connecticut youth who needed treatment for a substance use disorder involving illicit substances did not receive it (at least, from a specialty facility),[64] and the figure rises to 96 percent for a disorder involving alcohol. If all youth needing treatment were to seek it out, it is likely the current specialty substance use treatment system would be unable to handle the influx of patients; however, it is possible a portion could be appropriately treated by private counseling practices. Wider screening, as discussed above, would translate into more accurate capacity adequacy information.

Appropriate care level. Capacity adequacy is influenced by referral patterns – not only which providers frequently receive referrals, but also whether certain levels of care are more often sought. There is some concern among state agency personnel and insurers that residential treatment in particular is requested when it might not be the most appropriate level of care. At the same time, it is clear that certain clients need residential treatment. The committee's December 2012 Phase I recommendations regarding commercial fully-insured plans' substance use treatment utilization review protocols (i.e., criteria) – which are contained in Raised Bill 6557 – would ensure that these criteria are not a barrier to appropriate treatment. This report's screening-related recommendations would help ensure providers know what treatment level is necessary.

Recommendations. To improve quick access to urgent behavioral healthcare, the program review committee recommends:

> **7. The Departments of Mental Health and Addiction Services, Public Health, and Children and Families should develop a proposal to launch an urgent care center for behavioral health, bringing in both public and private partners.**

To understand whether DCF's in-home treatment models for behavioral healthcare are accessible to adolescents with commercial health insurance, and to determine if there is cost-shifting, the program review committee recommends:

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[63] "Type of Health Insurance and the Substance Abuse Treatment Gap," Ellen Englert Bouchery, Henrick J. Harwood, Joan Dilonardo, and Rita Vandivoert-Warren, 2012, *Journal of Substance Abuse Treatment* 42:289-300.
[64] Illicit substances are either illegal substances or legal substances used improperly.

8. The Department of Children and Families should instruct its funded providers to keep data, for a short period (e.g., three to six months), on:

c. the name of the insurance carrier (if any) of each child whose parent(s) seeks treatment in an in-home behavioral healthcare model, including the employer if the plan is self-insured;

d. whether the child was accepted into the program;

And for those children accepted:

d. whether the insurance carrier agreed to cover the treatment;

e. for those parents whose commercial insurance agreed to cover the treatment,

i. voluntary reporting on the terms of the cost-sharing, and

ii. whether the child did in fact then participate in the program; and

f. for those children who had commercial insurance that did not agree to cover the treatment, the per-child cost of the treatment and voluntary reporting by the parent on whether the coverage denial was due to exceeding insurance spending limits.

The Department of Children and Families should use this information to assess the accessibility of these models to commercially insured youth and the extent of cost-shifting to the state and its contracted nonprofit providers. If the department finds extensive cost-shifting, it should propose ways to alleviate the burden on the state and its providers.

Finally, the program review committee's Chapter I recommendations are intended to further help the state assess and address capacity problems.

Element 3: Receiving Appropriate Treatment

Ideal. A person receives treatment that is sensitive to his or her characteristics. For example, an adolescent or a young adult receives treatment that is appropriate to developmental and life stage. If there is a co-occurring mental health disorder, treatment for both is simultaneously given, in an integrated way.

Connecticut. *There are some indications that a portion of Connecticut adolescents and young adults are not receiving age-appropriate substance use treatment services.* Federal data indicate that Connecticut lags the nation in adolescent substance use treatment. Compared to the national average, the state has had smaller shares of adolescents being treated by a facility that offers an adolescent-focused program and facilities offering adolescent-focused programs, despite similar need.[65]

While young adults generally can access services that are open to adults, services rarely are tailored to this specific group.[66] There has been some recognition by DMHAS that its

[65] "2011 State Profile – Connecticut," National Survey of Substance Abuse Treatment Services (N-SSATS), Substance Abuse and Mental Health Services Administration (SAMHSA). Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf. See Appendix F for details.

[66] Based on program review committee staff interviews and survey data (presented in Appendix E).

services for young adults (even beyond those given to youth transitioning to that agency from DCF) could be more age-specific, in order to increase treatment persistence and benefit.[67]

Co-occurring disorders generally are treated in an integrated way, according to program review committee provider survey respondents.

Recommendation. To improve the appropriateness of substance use treatment received by adolescents and young adults, the program review committee recommends:

> **9. The Department of Children and Families and the Department of Mental Health and Addiction Services should offer training and/or other resources to substance use treatment providers – including those who are not state-contracted – to ensure that adolescents and young adults receive developmentally appropriate substance use treatment.**

Element 4: Receiving Support for Recovery

Ideal. After intensive substance use treatment, a person is connected with less-intensive clinical services and appropriate recovery supports.[68] These services can help maintain treatment gains and, if relapse occurs, facilitate quick re-entry into intensive treatment. Ongoing care management involves check-ins and connections to services, while recovery supports are nonclinical things or programs that provide assistance in dealing with life stressors that can trigger relapse. Recovery supports can include housing (group or independent), transportation, and peer coaching.[69] Both care management and recovery supports are supported by research and reflect the chronic nature, for many, of a substance use disorder.

Connecticut care management. *People with substance use disorders who are enrolled in BHP or are DMHAS clients have access to case management services, while similar services are available with coverage to only a subset of commercially insured people*.[70] All five Connecticut commercial health plans indicated that care management services of two to five months are provided directly by plan staff. For two plans, these services are given to about 30 percent of enrollees who are admitted to inpatient substance use treatment – not to everyone in inpatient care, or to enrollees participating in lower levels of care. The other plans indicated a wider scope of potential care management participants, though not everyone with a substance use disorder necessarily would be included. Most, if not all, plans use data analysis to identify

[67] "2012 Report on Statewide Priority Services," Connecticut Department of Mental Health and Addiction Services, September 2012.

[68] Recovery itself is "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential," according to SAMHSA (http://blog.samhsa.gov/2012/03/23/defintion-of-recovery-updated/, accessed February 26, 2013.)

[69] Other recovery supports are: case management, childcare, faith support services, financial support, mutual support groups, recovery check-ins, recovery-specific schools and vocational programs, and wellness services.

[70] See, for example, DMHAS Commissioner Patricia Rehmer's testimony to at the Mental Health Working Group's January 29, 2013 public hearing (accessed February 15, 2013 at: http://www.cga.ct.gov/ASaferConnecticut/docs/2013MHWG00129-R001030-INF.pdf). Case management can include assessing, planning, referring and linking to services, coordinating services, and monitoring.

enrollees for care or case management. Generally commercial health plans do not reimburse providers for case management.[71]

Some substance use treatment advocates are frustrated with the disparity between disease management services provided to people with medical ailments and those given to people with substance use or other behavioral health disorders. In Connecticut as nationally, substance use and other behavioral health disorders generally are not included in ailments targeted by chronic disease management programs offered by or mandated for some insurers (private and public).[72,73]

However, it is unclear whether people with substance use disorders would benefit from inclusion in typical disease management programs. The evidence on the cost-effectiveness of chronic disease management programs is mixed.[74] Research suggests chronic disease management programs most likely to lower healthcare costs involve an individualized plan, in-person check-ins with a care manager, a focus on reducing hospital utilization, and low cost-sharing for recommended care.[75]

In contrast, there is research to support care or case management for people with substance use disorders.[76] Short of mandating health plans cover or directly provide care / case management services for people with a substance use disorder, or the state funding these services directly, it is unclear how to uniformly expand these services to commercially-insured youth.

Connecticut recovery supports. *Youth in Connecticut who have substance use disorders generally do not have insured access to the recovery supports that also can help maintain treatment effects*. As nonclinical services, recovery supports generally fall outside traditional private insurance coverage, although insurance pays for sustained outpatient counseling for a person in recovery and may cover or subsidize some wellness services. Other recovery supports may be provided or funded by family members, friends, or others, when there is a desire and means.

Some support services – such as weekly telephone peer check-ins and recovery drop-in centers – are available free to the general public, largely through the Connecticut Community for

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[71] "Mental Health Financing in the United States: A Primer," Rachel L. Garfield, The Kaiser Commission on Medicaid and the Uninsured, April 2011.

[72] The ACA requires small group and individual health plans to include chronic disease management, beginning in 2014 (i.e., it is defined by the law as an essential health benefit).

[73] For example, the State Employee Health Plan's Health Enhancement Program does not include behavioral health disorders in the list of maladies that require chronic disease management components. The included ailments are diabetes, heart disease/heart failure, asthma and chronic obstructive pulmonary disease, hyperlipidemia, or hypertension. ("Health Enhancement Program Chronic Condition Tracker," accessed February 20, 2013 at: http://www.osc.ct.gov/empret/healthin/2011hcplan/HEPprogress/HEPChronicConditionRequirements.pdf .)

[74] "Chronic Disease Management," Lara Cartwright-Smith. HealthReformGPS (a project of the George Washington University's Hirsh Health Law and Policy Program and the Robert Wood Johnson Foundation), February 23, 2011. Accessed January 29, 2013 at: http://healthreformgps.org/resources/chronic-disease-management/.

[75] "Issue Brief: Disease Management: Does It Work?" Jill Bernstein, Deborah Chollet, and G. Gregory Peterson. Mathematica Policy Research, May 2010, Number 4. Accessed January 29, 2013 at: http://www.mathematica-mpr.com/publications/PDFs/health/reformhealthcare_IB4.pdf.

[76] "Addiction Medicine: Closing the Gap Between Science and Practice," National Center on Addiction and Substance Abuse, June 2012, pp. 107-109. Accessed June 29, 2012 at: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf.

Addiction Recovery and mutual support groups.[77] In addition, comprehensive recovery support services are available to some DMHAS clients, largely through a federal grant.[78]

Few recovery supports specific to youth, however, are available in this state, even for DMHAS clients or BHP enrollees. For example, there is no high school for youth in recovery, unlike in 16 other states.[79] Only one college participating in the committee's survey indicated having a recovery program for its students. Some adult recovery supports – such as mutual support groups or telephone check-ins with adults in recovery – might not be appropriate for youth, because adolescents and young adults are different in several ways from mature adults (e.g., still developing, shorter substance use history).

The creation of youth recovery support services is sought by a relatively new youth recovery advocacy organization.[80] At the group's urging, recently there has been some state agency collaboration around this goal. There have been no concrete outcomes of that effort yet; the agencies have been awaiting state budget information because that will shape what is feasible. Although state funds are scarce, even if no funding is obtained this year, it would be helpful to have a concrete action plan ready to aid in grant application submissions and identification of priorities for future state budget cycles.

Recommendation. To help maintain the treatment investments made by BHP, commercial insurers, state agencies, youth in recovery, and their families, the program review committee recommends:

10. The Department of Children and Families and the Department of Mental Health and Addiction Services, as well as other state agencies, should continue the effort to develop youth recovery supports that are reasonably accessible statewide to adolescents and young adults both in and out of state agency systems.

The interagency group should set a date by which it will complete a plan describing:

a. the supports to be built (including using existing advocacy or mutual support groups as a foundation);
b. how the supports will be found by and accessible to youth; and
c. options for implementation, including but not limited to funding.

[77] The Connecticut Community for Addiction Recovery is a recovery advocacy group that has been supported in part through DMHAS funding. It was created in 1998.
[78] DMHAS recovery supports are funded by the federal Access to Recovery grant and a small portion of its federal Substance Abuse Prevention and Treatment Block Grant.
[79] "High Schools," Association of Recovery Schools. Accessed February 28, 2013 at: http://www.recoveryschools.org/schools_highschool.html.
[80] Connecticut Turning to Youth and Families is a recovery advocacy organization that was launched in 2008 through a DCF-received federal grant.

Appendices

A: Estimate of Youth Substance Use Treatment Need
B: Study Methods
C: Network Adequacy
D: Treatment Locators
E: Licensed Substance Use Treatment Provider Survey
F: Available Treatment Services
G: Examinations of the State's Substance Use Treatment Capacity Adequacy
H: Adolescent In-Home Treatment Models
I: Agency Responses

Appendix A

Estimate of Youth Substance Use Treatment Need

Table A-1. Youth Substance Use Disorder Treatment Need and Receipt of Treatment, 2010-2011 Estimates				
	Ages 12-17		***Ages 18-25***	
	CT	***US***	***CT***	***US***
Illicit substances				
Had abuse or dependence disorder in last 12 months	4.6%	4.7%	7.9%	7.7%
Received treatment	0.6%	0.4%	0.9%	0.6%
Needed, did not receive	4.0%	4.3%	7.0%	7.1%
Of those needing treatment, percent who did not receive it in specialty facility	87.3%	92.5%	88.4%	91.8%
Alcohol				
Had abuse or dependence disorder in last 12 months	4.2%	4.2%	17.2%	15.0%
Received treatment	0.1%	0.1%	0.7%	0.6%
Needed, did not receive	4.1%	4.0%	16.5%	14.5%
Of those needing treatment, percent who did not receive it in specialty facility	96.7%	96.6%	96.2%	96.2%
Had either substance or alcohol abuse or dependence in last 12 months	7.3%	7.1%	21.2%	19.3%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2010 and 2011 (2010 Data – Revised March 2012); and PRI staff analysis of the data (Received treatment, Percent needing treatment that did not receive it in specialty facility). Accessed February 21, 2013 at: http://www.samhsa.gov/data/NSDUH/ 2k11State/NSDUHsaeTables2011.pdf.

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Appendix B

Study Methods

This report draws upon a variety of information sources. Program review committee staff had conversations and electronic communications with: youth in recovery, and parents of some; substance use treatment providers; commercial insurance staff and representatives; personnel from numerous state agencies and offices - the Insurance Department, the Department of Social Services, the Department of Mental Health and Addiction Services (DMHAS), the Department of Children and Families (DCF), the Department of Public Health, the Office of the Attorney General, the Office of the Child Advocate, and the Office of the Healthcare Advocate (OHA); former state agency employees; advocates for substance use treatment, nonprofit providers, healthcare professional associations, and children's health; and researchers.

Committee staff also listened to or read testimony from the study's June 2012 public hearing, a May 2012 forum on the experiences of youth in recovery, the OHA-sponsored October 2012 hearing on mental health parity, the January 2013 hearing held by the Mental Health Services Working Group of the Bipartisan Task Force on Gun Violence Prevention and Children's Safety, and the March 2013 public hearing on bills containing recommendations from this study's Phase I report. The committee also held an informational forum on the youth substance use treatment system on May 2, 2013, with invited guests including the DMHAS commissioner, the Healthcare Advocate, and representatives from DCF.

These communications and events informed all aspects of this report. The following table lists information sources (other than those mentioned above) specific to particular areas.

Table B-1. Additional Information Sources	
Chapter 1	
State agency and council activities	• Council reports and meeting minutes
Insurer network adequacy	• State and federal laws • National health plan accrediting organization staff • National health plan accrediting standards • State agency personnel in nearby states (as well as Connecticut) • Literature
Chapter II	
Connection to treatment	• Department of Public Health (DPH) facilities plan • Reports from the National Center on Addiction and Substance Use
Screening within primary care	• Independent nonprofit staff • Massachusetts Child Psychiatry Access Project staff, and project's March 2013 presentation to Connecticut legislature • Literature
Locating available treatment	• Plans produced by the Departments of: Children and Families (DCF), Mental Health and Addiction Services (DMHAS), and Public Health • Program review committee surveys of licensed treatment providers and college counseling centers • Federal substance use treatment facility and treatment need data • Online treatment locators • Information from DPH and DCF on school-based health center services and in-home treatment models
Receiving appropriate treatment	• Federal substance use treatment facility data
Receiving support for recovery	• Connecticut Association of Health Plans data and information • Literature

Appendix C

Network Adequacy

Health plans, insurance regulators, or accrediting agencies may aim for or require certain standards regarding access to in-network providers. These are called network adequacy standards, and generally include assessment of: whether the number of in-network providers is sufficient; if in-network providers are reachable by health plan enrollees within a certain amount of time or distance; and if in-network appointments are available.[81]

Affordable Care Act (ACA)

The ACA has several provisions that aim to ensure the plans available on insurance exchanges – called "qualified health plans" (QHPs) – have sufficient networks. A plan must:

- post its provider network directory online, with identification of providers not accepting new patients;
- include essential community providers in their network;[82] and
- have a network sufficiently diverse – including providers specializing in mental health and substance use services – and large to make services available "without unreasonable delay."

QHPs must be accredited as an attestation to compliance with certain quality measures, including "network adequacy and access." For an interim first phase (until a rule establishing phase two is issued), accreditation by either the National Committee for Quality Assurance (NCQA) or URAC is required.[83]

In addition to this accreditation, each exchange board must certify all the plans offered within it, monitor to ensure that all standards are being met (including accreditation standards), and publicize each QHP's standards data to inform consumers. The Office of the Healthcare Advocate has indicated that Connecticut's exchange board (on which the advocate sits) will require a QHP to provide and make publicly available its network adequacy measures and data.

[81] See, for example: "Network Adequacy in the Commonwealth Care Program," Bailit Health Purchasing for the Blue Cross Blue Shield of Massachusetts Foundation, April 2009. Accessed January 10, 2013 at: http://bluecrossmafoundation.org/sites/default/files/090422NetworkStandardsFINAL.pdf.

[82] Essential community providers are those that serve mostly low-income, medically underserved people, including FQHCs, Indian Health Centers, rural health clinics, and disproportionate share and critical access hospitals. An exchange may require that a QHP contract with all willing essential community providers.

[83] When phase two commences, the accrediting entities will be selected through an evaluation based on criteria set out in future federal rules. (45 CFR Part 156. Friday, July 20, 2012 Federal Register, Vol. 77, No. 140)

Standards at the National and State Levels

Existing standards available at the national level include those of the National Association of Insurance Commissioners (NAIC) Managed Care Plan Network Adequacy Model Act; URAC; NCQA; Medicaid; and Medicare.[84] The URAC and NCQA standards are discussed in depth below, given their recognition by the federal government for exchange health plan purposes and prominent role in Connecticut's network adequacy law. The NAIC model act is also described.

NAIC. The NAIC model act on network adequacy calls for, among many things, each health insurance carrier to submit an access plan to the insurance department.[85] The act does not explicitly state whether the department shall have approval power, but embedded drafting notes explain that such power may be given to that or another department.

In NAIC's June 2012 guidance on how insurance regulators may handle determining exchanges' qualified health plans' network adequacy, it is implied that at least some states actively check for commercial plans' adequacy through formal analysis. The purpose is to ensure that covered services "accessible without unreasonable delay." The paper enumerates that included in the analysis are reviews – at least annually – of:

- geographical considerations, including population, density, provider willingness to participate under reasonable terms, and geographical barriers;
- medical care referral patterns and hospital admission privileges;
- whether hospital-based providers are in the hospital's same network;
- access to medically intensive and critical care services (e.g., burn units, transplants);
- availability of different provider types; and
- ability of providers to accept new patients.

The guidance notes proprietary tools (e.g., OptumInsight, Quest Analytics) may be used to evaluate a plan's network. It also notes that an analysis of provider willingness to participate under reasonable terms and conditions could be done, but unaddressed is how to resolve whether terms and conditions are reasonable. If a plan or actual network is found insufficient by the insurance department, corrective action can be required.[86]

URAC. The URAC standards are not easily available to the public; however, the organization provided a copy to program review committee staff upon request. The standards directly relating to enrollee access – as well as what URAC expects to see for each standard – are

[84] "Plan Management Function: Network Adequacy White Paper," NAIC Health Insurance and Managed Care (B) Committee, June 27, 2012. http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.
[85] Other components of the Model Act address: various aspects of the relationship between in-network providers and the health carrier; provider network admission standards; and insurance department review of forms and contracts.
[86] "Plan Management Function: Network Adequacy White Paper," NAIC Health Insurance and Managed Care (B) Committee, June 27, 2012. http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf .

Table C-1. URAC Accreditation Measures Related to Network Adequacy				
Title	***Number***	***Reqd?****	***Standard's Description***	***URAC Expectations (beyond standard's language)***
Scope of Services	P-NM 1	No	Define network's types of services and geographic area served	Census data (e.g., age, rural vs. urban, ethnicities)
Provider Network Access and Availability	P-NM 2	No	Regarding access and availability: • Set goals • Monitor performance and report to organization's quality management committee • Make improvements where necessary to maintain network and meet contractual requirements	1. Accessibility goals: (could vary based on geography) • Primary care: Providers within 25 miles or minutes • Specialists: within 50 miles 2. Availability goals: • Appointments possible • Wait times for emergent, urgent, symptomatic, preventive visits • Business hours 3. Compare network to universe of providers in area 4. Provider-enrollee ratio 5. Monitor through software, secret shoppers, surveys, complaints, out-of-network use, ER use
Out of Network and Emergency Services	P-NM 4	Yes	Ensure access to covered services not available in-network and emergency care	---

*URAC accreditation, like NCQA's, is based on weighted scores on a variety of performance measures. Failure to perform or submit documentation on a standard will negatively impact the overall score and therefore harm the chance for / level of accreditation; therefore, it is likely that health plans aim to gather as many points as possible by completing both mandatory and non-required measures.

Source: PRI staff analysis of URAC's *Health Plan Standards, Version 7.1* and URAC powerpoint presentation to Hawaii regulators, entitled "URAC Accreditation & Network Adequacy," Christine Leyden and Mark Gorden, 2012.

described in Table C-1. As part of the accreditation process, URAC's staff is to confirm that the network composition plan and network itself is sufficient and evaluate whether the plan is on track to meet its self-set goals. If a problem is found during that process, then the health plan must create a plan to solve it, with follow-up by URAC.[87]

NCQA. NCQA standards similarly are not freely accessible to the public; however, the organization provided a copy to program review committee staff upon request. The standards involve an examination of whether there are sufficient primary and specialty care providers given plan enrollment, the plan's performance against self-set standards, and if patients report problems accessing care.

The standards directly relating to enrollee access – as well as what NCQA expects to see for each standard – are described in the table below. There is particular emphasis on access to behavioral health care.

Medicaid and Medicare. Federal law requires Medicaid managed care plans and Medicare Advantage plans to meet certain standards, including provider to enrollee ratios – which can be specific to types of providers (e.g., obstetrician-gynecologist, behavioral health) and time / distance requirements.[88]

[87] Correspondence from URAC President & CEO Alan P. Spielman to CMS Acting Administrator Marilyn Tavenner, RE: Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans; July 5, 2012.
[88] "Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges," Sabrina Corlette, JoAnn Volk, and Kevin Lucia, Report from the Study Panel on Health Insurance Exchanges Created Under the Patient Protection and Affordable Care Act, May 2012. Accessed February 1, 2013 at: http://www.healthreformgps.org/wp-content/uploads/Plan_Management_Issues_for_Exchanges.pdf.

Table C-2. NCQA Accreditation Measures Related to Network Adequacy				
Title	***Number / Element***	***Reqd?****	***Standard's Description***	***NCQA Expectations (beyond standard's language)***
Availability of Practitioners	**QI** 4**	**No**	**Ensures its network has sufficient numbers and types of practitioners who provide primary care, behavioral healthcare and specialty care**	**Intent: Maintain an adequate network in each care area and monitor how effectively members' needs and preferences are met**
Cultural Needs and Preferences	QI 4: Element A	No	• Assesses members' cultural, ethnic, racial and linguistic needs • Adjusts practitioner availability within network, if necessary	1. Identify members' language needs and cultural background, as well as expressed preferences, through survey / Census / employer / complaint data 2. Identify those of practitioners and compare to members 3. Adjust the network if members' needs / preferences not met, through recruitment and credentialing of new providers / requiring provider cultural competency training; also facilitate linking members to practitioners meeting preferences

Practitioners Providing --	QI 4:	No; Equal weight per element	• For specialty and behavioral care, defines the types of practitioners who are high-volume; for primary care, those are GPs, internists, pediatricians
			• Establishes quantifiable and measurable standards for the:
			  • Number of each high-volume / primary care type
			  • Geographic distribution of each high-volume / primary care type
			• Analyzes performance against the standards (at least) annually
				• Standards realistic for community, delivery system and clinical safety
				• Number and distribution expressed through (e.g.) –
				  • Ratio of members: practitioners in each area
				  • Ratio of providers taking new patients: practitioners in each area
				  • Percentage of members with practitioner of each type available within certain miles or (to those taking new members) driving times

Primary Care	Element B			
Specialty Care	Element C			
Ensuring Availability of Behavioral Healthcare Practitioners	Element D			
Accessibility of Services	**QI 5**	**No**	**Provides and maintains appropriate access to primary care, behavioral healthcare and member services.** For each element, using valid	**Intent: Maintain an adequate network in each care area and monitor how effectively members' needs and preferences are met**

Table C-2. NCQA Accreditation Measures Related to Network Adequacy				
Title	***Number / Element***	***Reqd?****	***Standard's Description***	***NCQA Expectations (beyond standard's language)***
			methodology, organization collects and performs annual analysis to measure performance against standards of access.	
Assessment Against Access Standards	QI 5 Element A	No	Access to: 1. Regular and routine care appointments 2. Urgent care appointments 3. After-hours care 4. Member services, by phone	• Member satisfaction with appointment / care timeliness in various ways • Practitioner timeliness in responding to after-hours calls
Behavioral Healthcare Access Standards	QI 5 Element B	No	Access to: 1. Care for non-life-threatening emergency within 6 hours 2. Urgent care within 48 hours 3. Appointment for routine office visit within 10 days	Can be supplemented by member surveys and complaints (as with other elements)
Behavioral Healthcare Telephone Access Standards	QI 5 Element C	No	1. Quarterly average for screening and triage calls shows that phones are answered by live voice within 30 seconds 2. Quarterly average for those calls reflects a phone abandonment rate within 5%	(Only applicable if there is centralized screening and triage)

*NCQA accreditation, like URAC's, is based on weighted scores on a variety of performance measures. Failure to perform or submit documentation on a standard will negatively impact the overall score and therefore harm the chance for / level of accreditation; therefore, it is likely that health plans aim to gather as many points as possible by completing both mandatory and non-required measures.
*Quality Improvement
NCQA accreditation relies on a plan's score. Half the score derives from a plan's score on accreditation standards performance, such as those described in this chart, while the other portion is based on the plan's performance on certain health insurance industry measures (HEDIS and CAHPS).
Source: NCQA's accreditation standards "QI 4: Availability of Practitioners" and "QI 5: Accessibility of Services", and PRI staff review of NCQA powerpoint presentation entitled "Quality Improvement Standards in Access and Availability; Introduction to NCQA Accreditation for Health Plans and MBHOs," 2011.

State Laws

Several states have adopted laws incorporating the NAIC model act's network adequacy provisions, as shown by the table below. At least a few additional states have other, non-Model Act network adequacy standards; some states rely on solely the insurance department to determine compliance, while others draw in the state health agency.[89]

Table C-3. State Adoption of NAIC Model Act on Network Adequacy			
Entire Act: 5	***Portions: 2***	***Related / Similar: 13***	
Colorado	New Jersey	Alabama	New York
Missouri	Tennessee	Florida	North Carolina
Montana		Georgia	Oregon
Nebraska		Illinois	Pennsylvania
South Dakota		Kansas	Rhode Island
		Maine	Washington
		New Hampshire	
Source: PRI staff analysis of *Managed Care Plan Network Adequacy Model Act; Model Regulation Service – October 1996* (Rev. 2010), NAIC.			

Several states have specific quantitative provider-to-enrollee and time or distance-to-provider requirements in law or regulation.[90]

It is unclear to what extent other states' insurance regulators actively examine fully-insured plans' network adequacy and access to care. One report, issued in 2000, indicated that a few states did at that time examine network adequacy through investigating provider network listings. Although these states found substantial inaccuracies, the report noted that other states had chosen not to engage in such resource-intensive efforts.[91]

Northeastern states. Several northeastern states have network adequacy requirements. Regulating entities in four states provided program review committee staff with information on the extent of their laws and oversight. Highlights are provided below.

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[89] Arizona, Minnesota, and Wisconsin were cited in one report reviewed for this study as having adequacy laws that differ from the Model Act; however, these - along with Tennessee's Model Act-type law – apply their laws solely to HMOs and closed network plans. ("Plan Management: Issues for State, Partnership and Federally Facilitated Health Insurance Exchanges," Sabrina Corlette, JoAnn Volk, and Kevin Lucia, The Center on Health Insurance Reforms at Georgetown University Health Policy Institute and the National Academy of Social Insurance, May 2012. Accessed February 1, 2013 at: http://www.healthreformgps.org/wpcontent/uploads/Plan_Management_Issues_for_Exchanges.pdf)

[90] "Background Paper on Network Adequacy and Essential Community Providers," Prepared by Exchange staff, June 2012. Accessed January 10, 2013 at: http://mn.gov/commerce/insurance/images/ExchPlanBkgndPaper6-27-12.pdf. See also: "Plan Management Function: Network Adequacy White Paper," NAIC Health Insurance and Managed Care (B) Committee, June 27, 2012. Accessed January 10, 2013 at: http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

[91] "Consumer Protection in Private Insurance: State Implementation and Enforcement Experience," Stephanie Lewis and Karen Pollitz, Institute for Health Care Research and Policy at Georgetown University for the Office of Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, October 2000. Accessed February 19, 2013 at: http://aspe.hhs.gov/health/reports/consumer/stateimp/private.htm.

New Jersey and New Hampshire have specific access standards that health plans must meet, shown in the table below. New Jersey's standards apply to health maintenance organizations (HMOs). The regulating agency requires an annual supplement to be filed, giving updated information on the network parameters and activities done to ensure network listings are accurate. New Hampshire's standards apply to health insurance carriers (not only HMOs). The health carrier annually must report to the regulating agency, showing compliance with the standards and also addressing, for primary care, wait times for appointments and whether providers are accepting new patients.

Table C-4. Nearby States' Prescriptive Network Adequacy Standards

	New Hampshire	***New Jersey***
Psychiatrist	45 miles or one hour of driving time	lesser of 45 miles or one hour of driving time
Primary care	>= 2 providers within 15 miles or 40 minutes of driving time	>= 2 physicians within 10 miles or 30 minutes of travel time
Inpatient psychiatric care	45 miles or 60 minutes	lesser of 45 miles or one hour of driving time
Medical hospital		20 miles or 30 minutes of driving time
Residential substance use Treatment		lesser of 45 miles or one hour of driving time
Outpatient behavioral health	25 miles or 45 minutes of travel time	20 miles or 30 minutes of driving time
Within	County or hospital service area	90 percent of members within county or sub-county service area

Source: PRI staff review of New Jersey and New Hampshire insurance regulations as provided by regulating entities.

Maine had prescriptive access standards similar to New Hampshire and New Jersey's, but those requirements were replaced a few years ago. The current standards require that insurers meet the NCQA adequacy provisions.[92]

New York does not have specific adequacy standards in law or regulation, but communication with regulating entities indicated that HMOs must meet certain requirements.

Connecticut Health Carriers' Networks for Substance Use Treatment

The five major carriers of Connecticut fully-insured health plans provided program review committee staff with information, shown in Table C-5, on their provider networks related to substance use treatment. Although the plans varied in whether they included only substance

[92] According to a March 2013 conversation with staff from the Consumer Health Care Division, Bureau of Insurance, Maine Department of Professional and Financial Regulation.

use treatment providers, both substance use and mental health treatment providers, or did not specify which types of providers are included, it is clear there are some differences. The reasons for and implications of the differences are uncertain.

Table C-5. Connecticut Major Health Carriers' Networks Related to Substance Use Treatment Facilities

	Plans A & D	***Plan B***	***Plan C***	***Plan E***
Inpatient detoxification	43	40	29	24
Inpatient residential	16	10	24	31
Residential	12	12	7	12
Partial hospitalization	59	54	25	42
Intensive outpatient	71	88	66	69

Notes:
Plans A and D share a network.
Program review committee staff asked for the number of in-network providers (i.e., facilities), by level of care, giving substance use treatment.
Outpatient network information is omitted due to apparent differences among the plans (e.g., whether each in-network practitioner in a facility or practice is counted).
Source: CT Association of Health Plans.

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Appendix D

Treatment Locators

Table D-1. Substance Use Treatment Locators or Search Tools			
Range	***Locator / Tool Name***	***Operator***	***Web Address (if applicable)***
Substance use and mental health	CT Clearinghouse *(DMHAS-operated or -funded services only)*	Wheeler Clinic's CT Clearinghouse (DMHAS funded)	https://www.ctclearinghouse.org/Directory/default.asp
	How to Find Services in Your Area *(DMHAS-operated or -funded services only)*	DMHAS	http://www.ct.gov/dmhas/cwp/view.asp?a=2902&q=335206
	24-Hour Crisis Services	DMHAS	http://www.ct.gov/dmhas/cwp/view.asp?a=2902&Q=378578&dmhasNav=|#M [to find the phone number for crisis services in a given town]
	Behavioral Health Treatment Services Locator	SAMHSA	http://findtreatment.samhsa.gov/ [or dial 1-800-662-HELP (4357)]
Behavioral health and social services	Infoline 2-1-1	United Way of Connecticut (partly state-funded)	http://www.211ct.org [or dial 2-1-1 from a landline telephone]
	Network of Care: Embrace Hope, Expect Change	Trilogy Integrated Resources, LLC (funded by federal, state and private partners)	http://connecticut.networkofcare.org/mh/
Source: PRI staff research.			

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Appendix E

Licensed Substance Use Treatment Facility Survey

The program review committee surveyed substance use treatment providers licensed by the Department of Public Health to gather capacity, treatment, and insurance information.[93] This appendix describes survey distribution, participation, and results (including a list, for respondents, of services offered and payment methods). It also contains, at the end, a copy of the survey (Figure E-1).

Distribution

Program review committee staff primarily distributed the survey electronically, via the Connecticut Community Providers Association and e-mail addresses found online or obtained through telephone calls by committee staff. Electronic contact information for a few providers could not be located; these were sent hard copies of the survey.

The first round of survey distribution occurred in late September 2012. In mid-October, reminders were sent. Additional attempts to obtain responses were made in November 2012 and in January 2013. Roughly half of responses were provided upon the initial contact, with approximately one-quarter each given in the second and third rounds. The survey response dates therefore ranged across months. Consequently, the capacity and waitlist information should be interpreted with caution – as one source, among several, of information in this area.

Participation

The precise participation rate is difficult to calculate because many providers have multiple sites and not all respondents answers for the entirety of their employer's services. Thirty-seven of the seventy-one providers who had DPH-licensed substance use treatment facilities or specialty psychiatric hospitals were included in the final survey data analysis. Two of those providers also accounted for three of the four children's residential treatment facilities, which are licensed by the Department of Children and Families. These responses represented 102 of 205 facilities and specialty hospitals. Two outpatient mental health clinics also participated. It was not determined whether any particular type of provider (in terms of level of care, geographic area, clients served, or other characteristic) was over- or under-represented. The survey respondents are listed – along with levels of care offered and payment methods accepted – at the end of this appendix.

Data Entry and Analysis

The survey was administered via SurveyMonkey and manipulated using Excel and SPSS. Generally, multiple responses concerning a single organization were consolidated into one response, except when there were large variations in the population served or payment methods

[93] The December 2012 Phase I report contains information about other surveys conducted by PRI for this study.

accepted. Program review committee staff attempted to contact respondents for clarifications and more complete information when necessary.

Respondent Characteristics

Levels of care offered. The entire range of substance use treatment levels of care was offered by survey respondents. There were 39 providers or major subsets of providers represented. Table E-1 indicates regular, individual outpatient treatment was offered by the vast majority of providers (82 percent), and inpatient care was the rarest type (15 percent).

Table E-1. Levels of Care Offered By Survey Respondents

	# Respondents	*% of All Respondents*	*Of Respondents Providing Certain Level of Care, Minimum Percent Offering Level to Different Populations*		
			Adults	*Pregnant Women*	*Adolescents*
Inpatient	6	15%	83%	17%	17%
Detox.					
Inpatient	6	15%	83%	17%	17%
Outpt.	7	18%	100%	14%	14%
Resid.	2	5%	Not applic.	Not applic.	Not applic.
Resid.	16	41%	69%	50%	13%
Comm. Liv.	7	18%	100%	29%	0%
Part. Hosp.	7	18%	100%	57%	29%
Day/Eve.	18	46%	72%	56%	44%
In-home	8	21%	Not applic.	Not applic.	Not applic.
Intensive Outpt.	20	51%	85%	75%	25%
Outpt. – Indiv.	32	82%	78%	66%	63%
Outpt. – Group	29	74%	79%	72%	52%
Med.-assist.	17	44%	*	*	*

* Information on the specific types of patients to whom pharmacological therapies were offered frequently was not provided by survey respondents. Therefore, the percentages are omitted here.
Source: PRI survey.

Clients served. One-third of survey respondents served exclusively clients with a substance use or co-occurring disorder, as shown in the table below.

Table E-2. Percent of Survey Respondents' Clients That Have A Substance Use or Co-Occurring Disorder

Clients With a Substance Use or Co-Occurring Disorder	*% Respondents*	*# Respondents*
1 to 24 percent	13%	5
25 to 50 percent	15%	6
51 to 75 percent	21%	8
76 to 99 percent	13%	5
100 percent	33%	13

Note: There were 39 respondents to this question.
Source: PRI survey.

Capacity Information

The survey gathered information on capacity and waits for services, for substance use treatment. The information is not age-specific. Committee staff considered but decided not to ask for capacity information separately for children, young adults, and other populations. This was one of several decisions made to make the survey manageable for respondents, in response to survey piloting feedback.

Respondent capacity. The client capacity (i.e., the number of people who can be served at each level) for thirty-six providers responding to the survey is presented in the table below. This is a minimum estimate of respondents' collective capacity because seven omitted capacity numbers for at least one level of care offered, and three respondents did not provide any. Based on these numbers, survey respondents can provide substance use treatment to more than 36,000 people.[94] No information on slots or wait-times specific to youth was gathered in an effort to make the survey manageable for respondents (in response to survey piloting feedback).

Table E-3. Survey Respondents' Collective Substance Use Treatment Capacity, By Level of Care

	Number of Clients That Can Be Served at One Time
Inpatient	175
Residential	864
Comm. living arr.	411
Partial hospitalization	151
Day/evening treatment	11,502
In-home services	421
Intensive outpatient	1,110
Outpatient - Individual	12,155
Outpatient - Group	9,061
Med.-assisted treatment	10,060

Source: PRI survey.

Twenty-three respondents offered services to adolescents. These services represented nearly the entire range of levels of care, except for community living arrangements.

Wait for services. The presence and length of a wait for services varied among the levels of care, and within levels, by survey respondents, as shown in the table below.

[94] When the capacity is summed for all levels of care except outpatient group sessions and medically-assisted treatment – because those clients often are engaged simultaneously in another level of care – the total is 26,789.

Table E-4. Wait for Survey Respondents' Substance Use Treatment Services, by Level of Care								
	None		***1-2 Days***		***3-6 Days***		***7+ Days***	
	%	***n***	***%***	***n***	***%***	***n***	***%***	***n***
Inpatient	50%	3	33%	2	17%	1	0%	0
Residential	13%	2	19%	3	31%	5	38%	6
Comm. living arr.	43%	3	0%	0	0%	0	57%	4
Partial hospitalization	71%	5	0%	0	14%	1	14%	1
Day/evening treatment	58%	11	16%	3	11%	2	11%	2
In-home services	29%	2	0%	0	14%	1	57%	4
Intensive outpatient	72%	13	0%	0	22%	4	6%	1
Outpatient - Individual	48%	15	10%	3	13%	4	29%	9
Outpatient - Group	74%	20	7%	2	11%	3	7%	2
Source: PRI survey.								

Partial hospitalization, day/evening treatment, and outpatient group sessions were the levels of care for which more than half of survey respondents reported no wait. However, within each of these levels, at least one provider indicated a wait of at least a week for these same services.

Residential treatment and in-home services were reported by less than one-third of respondents to have no wait for services. The length of wait for residential treatment was at least three days for more than two-thirds of respondents' services, and for in-home treatment, more than half reported a wait of at least one week.

Some respondents chose to comment on the types of programs and clients that experience the longest waits. Longer waits for Spanish-speaking clients and those with Court Support Services Division (CSSD) involvement were noted by one provider each.[95] A few wrote that family or personal scheduling limitations could lead to a wait, particularly for evening services. The area of most comment was in-home programs: three respondents explained that these have the longest wait, of the service array offered.

Adolescents. Both survey respondents offering residential treatment to adolescents indicated this level of care has a wait of three to six days, although one noted that the wait is sometimes due to family coordination needs. Four of the five respondents providing intensive outpatient said there usually is no wait for that level of services; the other indicated a wait of three to six days. As noted above, a few providers wrote that the wait for an in-home program can extend far beyond one week (the longest option provided in the multiple-choice question).

[95] The Court Support Services Division of the Judicial Branch provides probation, bail, and juvenile detention services.

Payment Methods

Insurance acceptance, whether a provider is in the insurer's network, and the cost of private pay each could impact access to substance use care.

About 80 percent of respondents accepted private payment on a sliding scale.[96] This method, which takes into consideration a client or family's income and ability to pay, can make it easier for non-wealthy people to access care. Only six respondents had a fixed-fee policy.[97]

A similarly large share of respondents – 89 percent – accepted at least one type of private insurance, while 94 percent accepted Medicaid. Just under ten percent took only Medicaid insurance, while one respondent was purely private-pay (i.e., no insurance accepted).

A provider may accept a type of private insurance but not be part of the health plan's network. Out-of-network care could mean a higher rate of cost-sharing for the client and/or a lower reimbursement rate for the provider.

Among those responding providers accepting private insurance, about two-thirds were in-network providers for all six of the major private health plans.[98] Of the remaining one-third of responding providers, 13 percent were in-network providers for five major plans, while 21 percent were in-network for four or fewer of the plans. The survey asked these respondents to explain (using multiple options) why certain insurance is not accepted.

Overall, no pattern emerged from the survey data regarding particular health plan network admission decisions or factors that could lead a provider to decide not to pursue network admission. Five responding providers indicated they had applied for in-network status but been rejected, for between one and all private insurers - with no insurer named more than once, among providers not rejected from all networks. Between four and six respondents each (with some overlap) cited insurer requirements or decisions regarding level of care authorization and/or length of care authorization as a reason for their insurance status. Just two providers stated that the level of paperwork required to receive reimbursement was a factor in their insurance status.

Experiences with Private and Public (BHP) Insurance

The survey asked respondents that accept both private and Medicaid (BHP) insurance to compare their experiences with each type in obtaining authorizations for treatment. The table below shows that a majority of respondents found it easier to receive the level and length of treatment requested from Medicaid, with about one-quarter to one-third reporting no difference between the two. Less than ten percent of respondents found private insurance easier to work with, in each respect.

[96] Twenty-nine of thirty-six respondents to the question.
[97] These six providers were: two outpatient clinics serving both children and adults; one adult outpatient clinic; one adult residential treatment center; one inpatient children and adult hospital; and one clinic providing outpatient and day/evening treatment to both children and adults.
[98] Twenty-four respondents gave insurance network information.

Table E-5. Survey Respondents' Comparison of Ease in Obtaining Care Authorizations From Medicaid (BHP) and Private Insurance			
	No difference	***Medicaid easier***	***Private insurance easier***
Level of care requested	23%	73%	3%
Length of care desired	33%	60%	7%
Note: There were 30 respondents to this question. Source: PRI survey.			

Changes over time. The survey also asked respondents to identify whether the level of private insurer restrictions had changed over the last two years. About half (53 percent) said it had not. Just over one-third (37 percent) indicated private insurers had become more restrictive, while one-tenth stated that these insurers were less restrictive.

The optional comments showed that a respondent's assessment generally depended largely on the specific type of care offered by that provider. For example, two of the three respondents who have found less restrictive coverage decisions noted that insurers are increasingly covering methadone maintenance, which they offer. Those who indicated more restrictive policies wrote about:

- more difficulties receiving authorization for intensive outpatient, residential and inpatient detoxification, and residential treatment;
- an increase in credentialing requirements; and
- a demand for more detailed authorization requests that must be supplied more frequently.

General comments regarding payors. Four respondents chose to offer further comments at the end of the survey. While two additionally addressed other issues, each noted that at least some private health plans are difficult to work with. Specific complaints were:

- conflicting and inappropriate reasons for denials of coverage, given "on a regular basis;"
- the variation in insurer requirements (not further specified), which are "labor intensive" for providers to track and comply with;
- inadequacy of reimbursement rates to cover the cost of evidence-based practices; and
- strict requirements restricting reimbursement to certain licensure statuses.

One respondent wrote about Medicaid. This person noted that, "Medicaid rates are generally insufficient on their own for the provision of high quality services and much of the service system relies on state grants to serve those without coverage or to provide services that are necessary but not covered by insurance or Medicaid."

Therapies

The survey asked respondents a few questions regarding the therapeutic treatment offered to clients with substance use disorders. The first question asked whether co-occurring substance use and mental health disorders are treated in an integrated way; the vast majority (91 percent) of respondents indicated yes.

Youth. Additional questions attempted to understand treatment that is offered specifically to adolescents and young adults.

All respondents indicated that they employ at least one type of evidence-based therapeutic approach or model when working with this population. Cognitive behavioral therapy – either the traditional version or the approach incorporating family – was marked by every respondent. The use of these and other approaches is described by the table below.

Table E-6. Approaches Used By Survey Respondents, When Working with Adolescents

	%	*n*
Cognitive behavioral therapy (CBT)	78%	18
Cognitive behavioral therapy (CBT) with family involvement	87%	20
Incentives	13%	3
Motivational interviewing	91%	21
Multidimensional family therapy (MDFT)	26%	6
Multisystemic family therapy (MST)	22%	5
Seven Challenges	13%	3
12-Step facilitation	43%	10

Note: There was an option to write in additional approaches. One respondent each added the following: Adolescent Community Reinforcement Approach (A-CRA) and Assertive Continuing Care (ACC); Trauma-Based CBT; family counseling, family and parent support groups, intervention; and Functional Family Therapy (FFT).
Source: PRI survey.

One question attempted to determine whether adolescents and young adults were being treated with different approaches, compared to older adults. However, one respondent's write-in response led committee staff to doubt that all respondents were interpreting the question as intended - as a comparison of approaches, not merely the levels of care available. Despite this possible limitation, the data are presented below.

Table E-7. Comparison of Survey Respondents' Services / Approaches for Youth

	% Yes (different)	*% No (same/ very similar)*	*n*
Is adolescents' treatment different from young adults'?	30%	70%	20
Is young adults' treatment different from older adults'?	7%	93%	29

Source: PRI survey.

Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents												
Provider	***Locations Included***	***Detox.***	***Inpatient***	***MAT***	***Resid.***	***CLA***	***PHP/ DE***	***In-home***	***IOP***	***OP-I***	***OP-G***	***Payment***
Alcohol & Drug Recovery Centers, Inc.*	Hartford	Inpatient Adult	Incl detox: Adult	Adult Preg.	Adult Preg.	Adult Preg.	---	---	Adult Preg.	Adult Preg.	Adult Preg.	State agency clients (no CLA) Sliding scale MCaid All mj priv ins
APT Foundation*	N. Haven Bridgeport	---	---	Methad. Bupe.	Adult Preg.	---	---	---	Adult Preg.	Adult Preg.	Adult Preg.	State agency clients Sliding scale MCaid Most priv. ins. (except Anthem), in-network
BHcare (incl. Shoreline Clinic)	Ansonia Branford	---	---	---	Adult (mostly CO)	Adult	DE Adult	---	Adult Preg.	Adult Preg.	Adult Preg.	State agency clients Sliding scale MCaid All mj priv ins in-network
Catholic Charities – Archdiocese of Hartford	Hartford	---	---	---	---	---	---	---	Adult Preg.	Child Adult Preg.	Child Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network
Catholic Charities – Fairfield Cty.	Bridgeport Danbury Norwalk Stamford	---	---	Bupe. Other(s)	---	---	Child Adult Preg.	---	---	Child Adult Preg.	---	State agency clients Sliding scale Mcaid All mj priv ins in-network
Center for Change (DBA) CT Clinical Services Inc.*	N. Haven	---	---	---	---	---	---	---	Men	Men	Men	Fixed fee All mj priv ins
Central Naugatuck Valley Help Inc.*	Danbury Torrington Waterbury	---	---	---	Adult	---	---	---	Adult Preg.	Child Adult Preg.	Adult Preg.	State agency clients Sliding scale Mcaid
Chem. Abuse Services	N. Haven	Outpt. Adult	---	Methad. Bupe.	---	---	Adult Preg.	---	Adult Preg.	Adult Preg.	Adult Preg.	Sliding scale Medicaid

Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents												
Provider	***Locations Included***	***Detox.***	***Inpatient***	***MAT***	***Resid.***	***CLA***	***PHP/ DE***	***In-home***	***IOP***	***OP-I***	***OP-G***	***Payment***
Agency: Multicultural Ambulatory												
Child and Family Agency of SE CT, Inc.**	Essex Groton N. London	---	---	---	---	---	---	Child	---	Child	---	State agency clients Sliding scale Mcaid All mj priv ins in-network
Child and Family Guidance	Bridgeport	---	---	---	---	---	---	Child Adult	---	Child Adult	Child	State agency clients Sliding scale Medicaid All mj priv ins
Child Guidance Center of S. CT	Stamford	---	---	---	---	---	---	Child	---	Child	---	State agency clients Sliding scale Mcaid All mj priv ins in-network
Community Health Resources	Bloomfield Danielson Enfield Manchstr. Putnam Willimntc.	---	---	Methad. Adult Preg.	Adult Preg.	Adult	DE: Child Adult Preg. PHP: Adult Preg.	Child	Adult Preg.	Child Adult Preg.	Child Adult Preg.	State agency clients Sliding scale Medicaid Most priv. ins. (except Anthem), in-network
CT Counseling Centers, Inc.*	Danbury	Outpt. Adult	---	Methad. Adult Preg.	---	---	---	---	Adult Preg.	Adult Preg.	Adult Preg.	State agency clients Sliding scale Medicaid
CT Junior Republic	Waterbury	---	---	---	---	---	DE: Child	Child	--	Child	Child	State agency clients Medicaid
CT Renaissance	Bridgeport Norwalk Stamford	---	---	Bupe. Adult Preg.	Men	---	---	Child	Adult Preg.	Child Adult Preg.	Child Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network
Cornell Scott Hill	N. Haven	---	---	---	---	---	DE Child	---	---	Child	Child	State agency clients Sliding scale

Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents												
Provider	***Locations Included***	***Detox.***	***Inpatient***	***MAT***	***Resid.***	***CLA***	***PHP/ DE***	***In-home***	***IOP***	***OP-I***	***OP-G***	***Payment***
Health Center-Child & Family Guidance							Preg.					MCaid All mj priv ins
Cornell Scott Hill Health Center-Grant St. Partnership	N. Haven	---	---	Bupe. Other(s)	Men Mil.	Adult Preg. Mil.	PHP, DE Adults Preg. Mil.	---	Adult Preg.	Adult Preg.	Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network
Family Intervention Center	Waterbury	---	---	Other(s)	---	---	---	---	---	Child Adult Preg.	Adult Preg.	State agency clients Fixed fee All mj priv ins
Family Resource Associates	Stratford	---	---	---					Child Adults	Unclear	Girl Men	State agency clients (no OP-G) Fixed fee All mj priv ins in-network
Farrell Treatment Center*	N. Britain	---	Men	---	Men	---	---	---	Men	Adult	Adult	State agency clients Sliding fee
Hartford Dispensary*	Bristol Hartford Manchstr. N. Britain N. London Norwich Windham	Outpt. Methad. Adult Preg.	---	Methad. Bupe. Adult Preg.	---	---	DE Adult Preg.	---	---	---	---	State agency clients Sliding scale Medicaid
High Watch Recovery Center*	Kent	---	---	---	Adult Preg.	---	---	---	---	---	---	Fixed fee
MCCA, Inc.*	Danbury N. Milford Waterbury	Inpt.: Adult Preg. (Dby.) Outpt.: Child		Bupe. Adult	Adult Preg. (Dby.) Incl. Detox.	Adult	DE Child Adults	---	Child Adult Preg.	Child Adult Preg.	Child Adult Preg.	State agency clients (no CLA) Sliding scale Mcaid All mj priv ins in-network

Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents												
Provider	***Locations Included***	***Detox.***	***Inpatient***	***MAT***	***Resid.***	***CLA***	***PHP/ DE***	***In-home***	***IOP***	***OP-I***	***OP-G***	***Payment***
		Adult										
New Directions, Inc.	Enfield	---	---	---	---	---	PHP: YA DE: Women	---	Adult	Child Adult	Child Adult	State agency clients Sliding scale Mcaid All mj priv ins in-network
New Hope Community Counseling	Manchstr.	---	---	Other(s)	---	---	---	---	---	Child Adult Preg.	Child Adult Preg.	State agency clients Sliding scale Medicaid All mj priv ins acc; all but Cigna in-network
Newtown Youth & Family Services	Newtown	---	---	---	---	---	---	---	---	Child Adult Preg.	Adult Preg.	State agency clients (OP-I) Sliding scale Mcaid All mj priv ins in-network
Optimus Health Center (CO)	Bridgeport	---	---	---	---	---	PHP: Child Adult Preg. DE: Child Preg. Adult26+	---	---	Child Adult	Adult	State agency clients Sliding scale Mcaid All mj priv ins in-network
Recovery Network	Bridgeport Shelton	Outpt.: Adult Inpt.: Men	Adult Preg.	Methad. Bupe. Adult Child	Adult	---	---	---	Adult Preg.	Child Adult Preg.	Child Adult Preg.	State agency clients Mcaid All mj priv ins; Aetna and Anthem in-network
Rushford Center, Inc.	Durham Meriden Middltwn. Portland	Resid. Adult Preg.	---	---	Boys Adult Preg.		PHP, DE Child Adult Preg.	---	Child Adult Preg. Seniors	Child Adult Preg. Seniors	Child Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network

Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents												
Provider	***Locations Included***	***Detox.***	***Inpatient***	***MAT***	***Resid.***	***CLA***	***PHP/ DE***	***In-home***	***IOP***	***OP-I***	***OP-G***	***Payment***
South Central Rehab. Center (SCRC), Cornell Scott Hill Health	N. Haven	Inpt. Outpt. Adult	Adults	Methad. Bupe. Other(s) Adult Preg.	---	---	DE	---	---	Adult Preg.	Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network
Silver Hill Hospital	New Canaan	Inpt. Child Adult	Child Adult	Bupe. Other(s)	---	---	---	---	Adult Preg.	---	---	Fixed fee All mj priv ins in-network
Stonington Institute*	Groton N. Stngton.	Adult Active Mil. Inpt. Resid. Outpt.	Adult	---	Adult	Adult	PHP, DE Adult	---	---	---	---	Sliding scale Mcaid All mj priv ins in-network
The Children's Center of Hamden	Hamden	---	---	---	Child	---	DE Child (st. ag. clients only)	---	Child	Child	Child	State agency clients Medicaid All mj priv in acc; only Aetna and Anthem in-network
The Connection Inc. – Counseling Centers	Groton Meriden Middltwn. N. Haven Old Sybrk.	---	---	---	Preg.	---	DE Adult Preg.	Preg.	---	Adult Preg.	Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins acc; only Anthem in-network
The Connection, Inc.	Groton Meriden Middltwn. N. Haven Old Sybrk.	---	---	---	Women Preg.	---	DE Adult	---	---	Adult Preg.	Adult Preg.	State agency clients Sliding scale Mcaid Most mj priv ins acc in-network; CTCare and United/Oxford not accepted

Table E-8. Substance Use Treatment Services Available in CT: Survey Respondents												
Provider	***Locations Included***	***Detox.***	***Inpatient***	***MAT***	***Resid.***	***CLA***	***PHP/ DE***	***In-home***	***IOP***	***OP-I***	***OP-G***	***Payment***
United Community & Family Services	Colchester Jewett City N. London Norwich	---	---	Other(s) Adult Preg.	---	---	---	Child Adult Preg.	---	Child Adult Preg.	Child Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network
United Services, Inc.	Columbia Dayville Willimntc.	---	---	---	---	---	DE Child Adult Preg.	---	---	Child Adult Preg.	---	State agency clients Fixed fee Medicaid Anthem & CTCare in-network; Aetna, Cigna, United/Oxford acc.
Wellmore Behavioral Health*	Shelton Waterbury	---	---	Other(s) Child	Adult Preg.	Men	PHP Adult	Child	Child Adult Preg.	Child	Child Adult Preg.	State agency clients Sliding scale Mcaid All mj priv ins in-network

Levels of Care: Detox. is Detoxification. MAT is medically assisted treatment. Resid. is residential treatment. CLA is community living arrangement. PHP is partial hospitalization. DE is day/evening treatment. IOP is intensive outpatient. OP-I is regular outpatient individual counseling, while OP-G is group outpatient counseling.
* Exclusively treats clients with SU (no solo MH) in programs incl in inventory
**Refers out of SU complaint is primary. Is a CGC.
Mil. Noted they also serve veterans and active duty military. Active Mil. indicates active military.
YA = Young Adults (18-25)
CO = Co-occurring disorders (mental health and substance use)
acc = accepted
Source: PRI staff review of survey responses.

Figure E-1. Survey

Introduction

Thank you for participating in this survey of the Legislative Program Review & Investigations Committee. You are helping us understand licensed providers' capacity and treatment, to what extent treatment is available to those with insurance, and provider experiences with insurance.

The survey will take 10 to 30 minutes to complete. Detailed information on capacity is requested.

General information about your facility or clinic - name, location, levels of care offered, whether different types of clients are served, and types of payment accepted - may be shared in a section of the study's report that aims to catalog treatment options available. No other information about your facility or clinic's policies or experiences will be shared with identifiable information; results from those aspects of the survey will only be presented aggregately.

If you need to close the survey before you have fully completed it, please **close your browser window** so you can later return where you left off. To return to where you left off, you will need to click on the link to the survey using the same computer and browser, and have cookies enabled. Alternately, you can re-start the survey, by clicking on the survey link using a different computer or browser (or one that does not accept cookies).

Basic Information

1. Facility / clinic name:

2. City / town: (please list all your organization's sites that are included in your response)

3. Please provide your contact information so we can follow up with you if any responses are unclear. Your name or contact information will not appear in any study reports or related documents.

Name:

Work telephone number:

Work e-mail address:

4. Approximately what percent of your facility or clinic's clients are dealing with a substance use or co-occurring disorder? (Please enter a whole number; do not use punctuation or a percentage sign.)

Detoxification Services

5. Does your facility offer detoxification services (in any type of setting)?

- Yes
- No

Detoxification Services

Figure E-1. Survey

6. In which setting(s) does your facility offer detoxification services? (Check all that apply.)

- ☐ Inpatient
- ☐ Residential treatment
- ☐ Partial hospitalization
- ☐ Outpatient / Ambulatory

7. How many people who are using detoxification services can your facility treat at a time? (Please enter a whole number, without punctuation.)

8. Which type(s) of people can receive detoxification services at your facility? Please mark in which settings detoxification services are available, for each type of client.

	Inpatient	Residential	Partial Hospitalization	Outpatient / Ambulatory	None of these settings
Girls (under 18)	☐	☐	☐	☐	☐
Boys (under 18)	☐	☐	☐	☐	☐
Women 18-25	☐	☐	☐	☐	☐
Men 18-25	☐	☐	☐	☐	☐
Pregnant women	☐	☐	☐	☐	☐
Women above 25 and not pregnant	☐	☐	☐	☐	☐
Men above 25	☐	☐	☐	☐	☐
State agency clients (DOC, DMHAS, CSSD, DCF)	☐	☐	☐	☐	☐
Any other special group(s)	☐	☐	☐	☐	☐

Please specify other special group(s):

9. About what percent of the time are your detoxification services full (i.e., cannot take any more clients)? Please enter a whole number and do not use punctuation (e.g., no % sign).

10. If whether the services are full tends to vary by type of client (e.g., boys vs. men), please explain for which client types your facility tends to be full.

Medication-Assisted Treatment

Figure E-1. Survey

11. Does your facility offer medication-assisted treatment?

- ◯ Yes
- ◯ No

Medication-Assisted Treatment

12. Which types of medication-assisted treatment are offered? (Please check all that apply.)

- ☐ Methadone maintenance
- ☐ Buprenorphine (Suboxone)
- ☐ Other(s)

Levels of Care and Capacity: Partial Hospitalization and Higher Levels

For the following questions, please respond *only* for your facility's services that are available to people with a substance use or co-occurring disorder.

13. What levels of care / types of services are offered at your facility? Please check what is offered for each type of client. If none of these levels / types of care is offered for a client type, please check "None of these."

	Inpatient	Residential Treatment	Community Living Arrangement	Partial Hospitalization	Day/evening Treatment	None of these
Girls (under 18)	☐	☐	☐	☐	☐	☐
Boys (under 18)	☐	☐	☐	☐	☐	☐
Women 18-25	☐	☐	☐	☐	☐	☐
Men 18-25	☐	☐	☐	☐	☐	☐
Pregnant women	☐	☐	☐	☐	☐	☐
Women above 25 and not pregnant	☐	☐	☐	☐	☐	☐
Men above 25	☐	☐	☐	☐	☐	☐
State agency clients (DOC, DMHAS, CSSD, DCF)	☐	☐	☐	☐	☐	☐
Any other special group(s)	☐	☐	☐	☐	☐	☐

Please specify other special group(s):

Figure E-1. Survey

14. What is the total capacity for each level of care? (In other words, how many clients can be served at the same time?)

Inpatient	
Residential Treatment	
Community Living Arrangement	
Partial Hospitalization	
Day/evening Treatment	

15. What levels of care / types of services are usually at capacity or have a waitlist? If there is a waitlist, about how long is the wait? (If the wait varies by type of client / payment method, please respond for the *longest* wait, and describe how the wait varies, below.)

	There usually is space / no waitlist	Usually is waitlist: 1-2 days until served	Usually is waitlist: 3-6 days until served	Usually is waitlist: At least one week until served	This level/type of care is not offered
Inpatient	○	○	○	○	○
Residential Treatment	○	○	○	○	○
Community Living Arrangement	○	○	○	○	○
Partial Hospitalization	○	○	○	○	○
Day/evening Treatment	○	○	○	○	○

If the wait varies by client type / payment method, please describe which have the longest and shortest waits:

Levels of Care and Capacity: Intensive Outpatient and Lower

Again, please respond *only* for those services that are available to people with substance use or co-occurring disorders.

Figure E-1. Survey

16. What levels of care / types of services are offered at your facility? Please check what is offered for each type of client. If no care is offered for a client type, please check "None."

	Intensive Outpatient	Regular Outpatient (Individual sessions)	Outpatient Group Sessions	In-home Services	Medically-assisted Treatment	None of these
Girls (under 18)	☐	☐	☐	☐	☐	☐
Boys (under 18)	☐	☐	☐	☐	☐	☐
Women 18-25	☐	☐	☐	☐	☐	☐
Men 18-25	☐	☐	☐	☐	☐	☐
Pregnant women	☐	☐	☐	☐	☐	☐
Women above 25 and not pregnant	☐	☐	☐	☐	☐	☐
Men above 25	☐	☐	☐	☐	☐	☐
State agency clients (DOC, DMHAS, CSSD, DCF)	☐	☐	☐	☐	☐	☐
Any other special group(s)	☐	☐	☐	☐	☐	☐

Please specify other special group(s):

17. What is the total capacity for each level of care? (In other words, how many clients can be served at the same time?)

Intensive Outpatient	
Regular Outpatient (Individual sessions)	
Outpatient Group Sessions	
In-home Services	
Medically-assisted Treatment	

Figure E-1. Survey

18. What levels of care / types of services are usually at capacity or have a waitlist? If there is a waitlist, about how long is the wait? (If the wait varies by type of client / payment method, please respond for the *longest* wait, and describe how to wait varies, below.)

	There usually is space / no waitlist	Usually is waitlist: 1-2 days until served	Usually is waitlist: 3-6 days until served	Usually is waitlist: At least one week until served	This level/type of care is not offered
Intensive Outpatient	○	○	○	○	○
Regular Outpatient (Individual)	○	○	○	○	○
Outpatient Group Sessions	○	○	○	○	○
In-home Services	○	○	○	○	○
Medically-assisted Treatment	○	○	○	○	○

If the wait varies by client type / payment method, please describe which have the longest and shortest waits:

Client Level of Care Decisions

19. How do practitioners at your facility determine what level of substance use / co-occurring disorder care is necessary?

- ☐ We have a unique facility- or company-specific protocol.
- ☐ We use an established protocol, used by others in the field.
- ☐ We allow our practitioners to use a variety of appropriate sources.

20. Which sources are used by your facility / company / practitioners? Check all that apply.

- ☐ General expertise / knowledge
- ☐ American Academy of Pediatrics guidelines
- ☐ American Society for Addiction Medicine Patient Placement Criteria (ASAM PPC)
- ☐ Connecticut Client Placement Criteria
- ☐ American Psychiatric Association guidelines
- ☐ American Academy of Child and Adolescent Psychiatry guidelines
- ☐ Other

Other (please specify):

Figure E-1. Survey

Care Offered for Youth

21. Is counseling or other care offered for those under 18 with substance use or co-occurring disorders?

- ◯ Yes
- ◯ No

Care Offered for Youth

22. What specific therapies does your facility / clinic employ with those under 18 who have a substance use disorder or problem? (Please check all that apply.)

- ☐ Cognitive Behavioral Therapy (CBT)
- ☐ Cognitive Behavioral Therapy (CBT) with family involvement
- ☐ Multidimensional Family Therapy (MDFT)
- ☐ Multisystemic Therapy (MST)
- ☐ Motivational Interviewing
- ☐ Incentives
- ☐ Seven Challenges
- ☐ 12-Step Facilitation
- ☐ We do not employ specific therapies when working with adolescents.

Other (please specify)

23. How does your facility's/clinic's substance use treatment for young adults (18-25) compare to its treatment for other age groups listed? (If there are any differences, please describe.)

	Same / very similar	Different	Not applicable: We do not care for clients in this age group
Ages 12-17	◯	◯	◯
Age 26 and above	◯	◯	◯

Please describe differences:

Figure E-1. Survey

24. Are substance use and mental health disorders treated in an integrated way, when someone has a co-occurring disorder?

- ◯ Yes
- ◯ No

Payment Methods

25. Does your facility accept private payment (e.g., cash, credit card, check), and if so, what type?

- ◯ Yes: Fixed fee
- ◯ Yes: Sliding scale
- ◯ No

Payment Methods: Insurance

26. For each major insurance carrier listed below, please mark whether it is accepted by your facility/clinic and whether your facility is in-network.

	Accepted?	In-network?
Aetna	☐	☐
Anthem BC-BS	☐	☐
CIGNA	☐	☐
ConnectiCare	☐	☐
HealthNet	☐	☐
United/ Oxford	☐	☐
Medicaid (BHP)	☐	☐

27. If you accept Medicaid: About what percent of your facility's clients have Medicaid as their payment method? (Please enter a whole number, without a percentage sign.)

☐

Figure E-1. Survey

28. If your facility/clinic does not accept one or more of the major carriers: Why not? (Please check all reasons that apply, by insurer - or, "all of these".)

	Aetna	Anthem BC-BS	CIGNA	ConnectiCare	HealthNet	United/ Oxford	Medicaid (BHP)	All of these
Applied but was not accepted into network.	☐	☐	☐	☐	☐	☐	☐	☐
Company does not generally authorize the level of care we seek to provide.	☐	☐	☐	☐	☐	☐	☐	☐
Company does not generally authorize the length of care we seek to provide.	☐	☐	☐	☐	☐	☐	☐	☐
Level of effort required to persuade company of level of care needed.	☐	☐	☐	☐	☐	☐	☐	☐
Level of paperwork required to deal with insurance billing.	☐	☐	☐	☐	☐	☐	☐	☐
Reimbursement level.	☐	☐	☐	☐	☐	☐	☐	☐
Client no-show rate.	☐	☐	☐	☐	☐	☐	☐	☐

Other (please specify):

29. Have you found any difference in the ease of getting requested substance use treatment care approved for coverage by insurers for whom your facility/clinic is on the panel, versus those for whom your facility/clinic is not on the panel?

- ◯ Not applicable: We are not on any insurer panels or only take insurance when we are in-network.
- ◯ No
- ◯ Yes: Harder to get requested care approved, when we are "on" the insurer's panel
- ◯ Yes: Harder to get requested care approved, when we are "not" on the insurer's panel

Figure E-1. Survey

30. In the last two years, across private insurers, have you seen any changes in insurer requirements or coverage concerning substance use or co-occurring treatment?

- ◯ No
- ◯ Yes: Less restrictive
- ◯ Yes: More restrictive

Please explain what changes you've seen, if any:

Payment Methods: Other Public Insurance

31. Does your facility / clinic accept any of the following other types of public insurance? (Check all that apply; if none, please respond "No".)

- ☐ Medicare
- ☐ TRICARE
- ☐ No

Insurance: Experiences

32. If you accept both private insurance (at least one type) and Medicaid (BHP), with which type of insurance is it easier to do each of the following:

	Private Insurance	Medicaid (BHP)	No difference between private insurance and Medicaid	No experience in trying to do this
Join the insurer panel	◯	◯	◯	◯
Get approval for the level of care your practitioners believe is necessary (without an appeal)	◯	◯	◯	◯
Get approval for the length of care your practitioners believe is necessary (without an appeal)	◯	◯	◯	◯

Appeals

Figure E-1. Survey

33. Does your facility have a policy (either written or in practice) regarding pursuing appeals of insurer adverse determinations (i.e., full or partial denials of coverage)? (Please check all that apply.)

- [ ] We do not appeal.
- [ ] We will pursue internal appeals for a client in our care.
- [ ] We will pursue external appeals for a client in our care.
- [ ] We will pursue internal appeals for a potential client.
- [ ] We will pursue external appeals for a potential client.

Any Additional Comments

34. Please share any other comments on matters addressed in this survey.

Thank you for completing this survey!

Thank you very much for your time, effort, and thoughts.

If you have any questions about the survey or study, or would like to be added to the study's e-mail list, please contact the study's staff at:

860-240-0300
or
janelle.stevens@cga.ct.gov

Appendix F

Available Treatment Services

Information on the substance use treatment services available to youth in Connecticut was gathered from a variety of sources, including:

- the Statewide Health Care Facilities and Services Plan issued in October 2012 by the Office of Health Care Access (OHCA) within the Department of Public Health (DPH);
- three treatment locators;
- program review committee surveys of both the state's DPH-licensed substance use treatment providers and Connecticut colleges and universities; and
- the National Survey of Substance Abuse Treatment Services (N-SSATS), a federal point-in-time survey.

State agency sources. The OHCA Facilities and Services Plan contains the most comprehensive information on the capacity of residential substance use treatment providers. The plan indicates there are 205 sites that offer adult and/or child substance use treatment.[99] Generally these are not state-operated programs (which are not required to hold licensure). The levels of care, locations, and, where available, capacity information are depicted in Table F-1.

Contracted services. The Department of Mental Health and Addiction Services (DMHAS) and the Department of Children and Families (DCF) both fund, through contracts, many of the licensed private behavioral health care providers. These dollars are intended to help providers serve clients without ability to pay through insurance or income.[100]

[99] Table 20, in the plan's appendix, lists the 199 DPH-licensed providers of substance use treatment. In addition to these, there are two DPH-licensed specialty psychiatric hospitals that can provide treatment and four DCF-licensed facilities giving residential substance use treatment to adolescents.

[100] For example, DCF funds 12 outpatient substance use treatment clinics, as well as 34 enhanced care behavioral health clinics, which are to have demonstrated co-occurring treatment competency.

Table F-1. Substance Use Treatment Offered by Facilities, Clinics, and Specialty Hospitals [a] Holding Specialty Licensure from the Department of Public Health or the Department of Children and Families			
Level / Type of Care	***Min. Number of Slots (Point-in-time), unless otherwise noted***		***Locations***
	Adolescents (12-17)	***Adults (18 and up)***	
Specialty Hospital	189		Mansfield and New Canaan
Residential: 3-6 month stay [b]	Not applic.	972	Bridgeport, Canaan, Glastonbury, Groton, Hartford, Lebanon, Middletown, New Haven, New London, Norwich, Plainfield, Portland, Putnam, Stamford, Torrington, Waterbury, Windham
Residential: 3-4 week stay [c]	Not applic.	128	Kent, Sharon
Residential: Short stay [d]	Not applic.	265	Bridgeport, Danbury, Hartford, Middletown, New Britain, N. Stonington, Putnam, Torrington, Waterbury
Residential: Detox. and Evaluation	Not applic.	147	Bridgeport, Danbury, Hartford, Middletown, New Haven, New London, North Stonington
Residential: Adolescents only	58 [e]	Not applic.	Durham, Hamden, Manchester
Day / evening Treatment	21 sites		Bloomfield, Bridgeport, Danbury, Enfield, Groton, Hartford, Kent, Middletown, New Haven, N. Stonington, Waterbury
Outpatient	153 sites		Statewide

[a] Excludes state-operated facilities (e.g., DMHAS-operated Connecticut Valley Hospital and Blue Hills Campus, which have 152 inpatient slots, according to the governor's February 2013 proposed budget), school clinics, and small outpatient clinics unlicensed by the Department of Public Health. Also excludes general hospitals, which are not required to obtain a separate license for substance use treatment services.
[b] DPH licensure: Intermediate and Long Term Treatment and Rehabilitation. Because of the duration, it is likely these facilities serve mostly/all DMHAS clients.
[c] DPH licensure: Care and Rehabilitation
[d] DPH licensure: Intensive Treatment
[e] Some slots are reserved for state clients (e.g., juvenile justice-involved). Licensed by DCF.
Source: PRI staff analysis of OHCA 2012 Facilities Plan.

Treatment locators. There are numerous treatment locators. Three tools – the United Way's 2-1-1, the Connecticut Clearinghouse's, and the Network of Care – were reviewed. Although capacity information is not given, the sites do show the number of programs offering various types of care (as well as program-specific information to help consumers determine whether the program is appropriate for them). There is some disagreement among the sites' listings. The numbers of programs from each locator is listed in the table below. It is clear there are many more outpatient providers than those for any other level of care.

Table F-2. Number of Substance Use Treatment Providers by Level of Care, According to Three Treatment Locators			
Type of Treatment	***2-1-1***	***CT Clearinghouse***	***Network of Care***
Detoxification: Inpatient	23 alcohol; 22 drug	27	19
Detoxification: Outpatient	4 alcohol; 25 drug	36	24
Inpatient	9	28	7
Residential treatment	51	55	49
Community living arrangement	23	23	Not included
Partial hospitalization / day or evening treatment	73	34	67
Outpatient counseling	140	132	151
Care / case management	62	Not included	Not included
Source: PRI staff review of treatment programs listed at these treatment locators.			

Study survey: Providers. The program review committee surveyed all DPH-licensed substance use treatment providers and received responses from thirty-seven of seventy-one provider organizations (including specialty psychiatric hospitals), as well as from two providers licensed as mental health outpatient clinics. These responses represented 99 of the 201 substance use treatment and specialty psychiatric hospital licensed sites.

Because the survey results do not encompass all providers, and it is unclear whether geographical, level of care, and other characteristics are properly represented, information on capacity from the survey is not included here. However, the survey results can help fill the knowledge gap for capacity of treatment levels below inpatient. These results, given in the following below, should be interpreted as potential capacity for substance use treatment because many of the respondents additionally provide services to those with mental health (not co-occurring) diagnoses.

Table F-3. Survey Respondents' Collective Substance Use Treatment Capacity, By Level of Care	
	Number of Clients That Can Be Served at One Time
Inpatient	175
Residential	864
Comm. living arr.	411
Partial hospitalization	151
Day/evening treatment	11,502
In-home services	421
Intensive outpatient	1,110
Outpatient - Individual	12,155
Outpatient - Group	9,061
Med.-assisted treatment	10,060
Source: PRI survey.	

National survey (N-SSATS). The federal Substance Abuse and Mental Health Services Administration (SAMHSA) annually conducts the National Survey of Substance Abuse Treatment Services (N-SSATS), resulting in a point-in-time view of treatment facilities and their clients, as noted in this study's June 2012 update.[101] The data discussed below are the most recently available - from March 31, 2011 - and pertain to Connecticut (except where otherwise noted).[102]

Youth in care. Just over two percent of those receiving treatment in Connecticut were under age 18 (adolescents);[103] data specific to other age groups, beyond "all adults," are not collected. The percentage of those in care who are adolescents has fluctuated over the past five years for which data are available, ranging from 3.5 percent in 2008 to 1.9 percent two years later. In Connecticut, adolescents have been a much smaller subset of those receiving treatment, than nationally (6.7 to 9.1 percent, in 2007 through 2011).

Nearly all (97.4 percent) of adolescents in the 2011 survey were receiving outpatient treatment, with the remainder in non-hospital residential care. This is an increase from 93.9 percent in 2010. Nationally in 2011, a higher percentage of adolescent clients was in residential care (11.8 percent in non-hospital care, and 1.3 percent in hospital inpatient care).

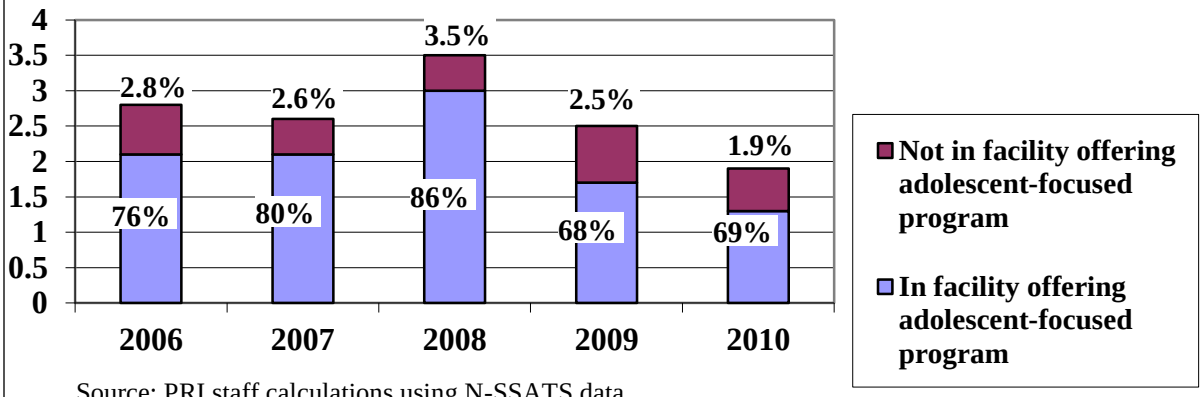
Data are not collected regarding if adolescents are in a program specific to their age; it is known only whether the facility at which they were receiving treatment offered such a program. There has been variation recently in the percentage of adolescents who are in facilities that offer special adolescent programs or groups, as shown in Figure F-1. In the past two years for which data are available (2009 and 2010), however, the percentage has been relatively stable, at 68 to 69 percent. This is well below the national averages of about 81 percent in both 2009 and 2010.

[101] N-SSATS, conducted by SAMHSA, includes all facilities that are either government-operated or state-licensed. Some providers that are neither (e.g., small group counseling practices, hospital-based programs) also participate, but the extent to which they do so is unknown. Solo practices might not be captured at all. Those providers who have requested inclusion in SAMHSA's online treatment locator are sent an N-SSATS survey, according to a June 15, 2012 committee staff conversation with DMHAS staff.

[102] The 2011 N-SSATS state-to-state comparison data have not yet been published; therefore, in some cases, 2010 data are the most recently available.

[103] The number of adolescents in treatment was 612.

Figure F-1. Percent of Connecticut Clients Who Were Adolescents (Under Age 18), and Whether Those Clients Were Receiving Treatment in a Facility that Offered an Adolescent-Focused Program, 2006-2010

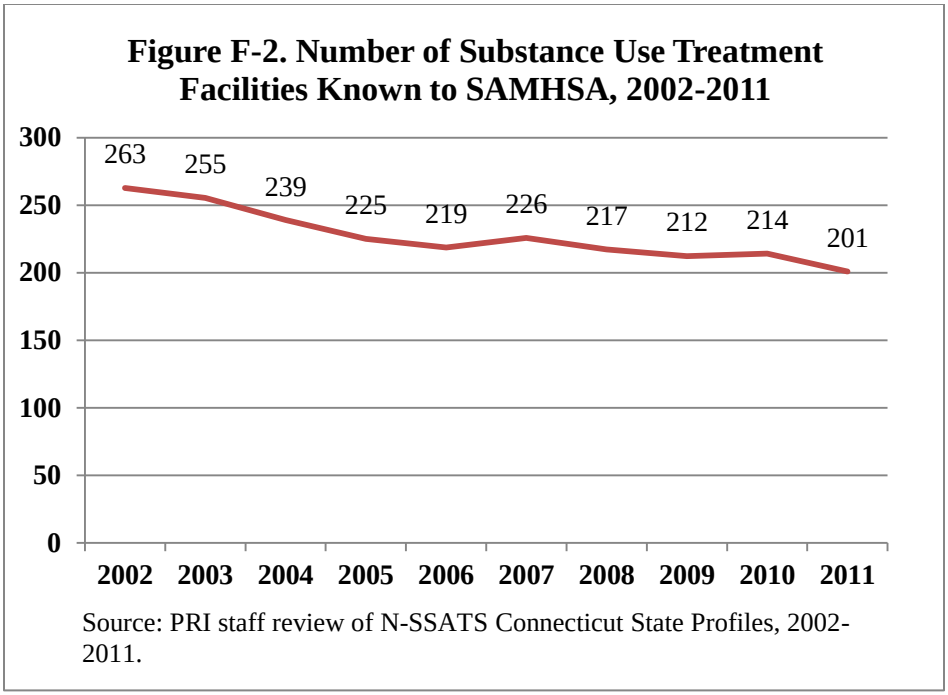


Source: PRI staff calculations using N-SSATS data.

In 2011, 16 percent of Connecticut facilities offered an adolescent-focused program or group, substantially lower than the rate nationally (28 percent). Connecticut was among the five states with the lowest percentage of facilities with these programs, in 2010. (State comparison data were not available for 2011.)

Number of treatment facilities. There were 188 Connecticut treatment facilities participating in the 2011 survey; 68 percent received public funds for substance use treatment. The total number of participating facilities has declined 13 percent from its recent-year peak of 216, in 2007 (and 10 percent when using the 2010 data). This contraction is more pronounced than the 3 percent national decline between 2006 and 2010.

The number of Connecticut treatment facilities known to SAMHSA (i.e., that received an N-SSATS survey) has declined substantially in recent years. The chart below shows these facilities have declined from 263 in 2002 (the earliest year for which data are available) to 201 in 2011, a drop of 24 percent.



Levels of care offered. Many facilities offer multiple levels of care, ranging from the most intensive (hospital inpatient) to different types of treatment provided on an outpatient basis. The overall percentages of Connecticut facilities offering the various levels in 2011 are shown in the table below.

Table F-4. Levels of Care Offered by Connecticut Substance Use Treatment Facilities, 2011

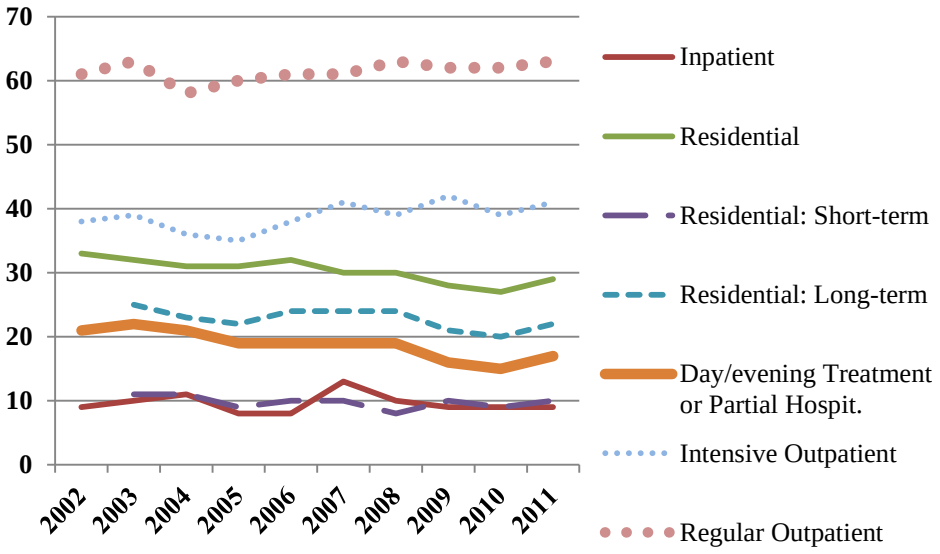
Level of Care/Setting	***Percent of Facilities Offering***
Hospital Inpatient	8.5
Detoxification	8.0
Treatment	6.4
Residential (non-hospital)	28.7
Detoxification	1.1
Long-term	22.3
Short-term	9.6
Outpatient	71.3
Detoxification	14.4
Day/evening treatment or partial hospitalization	17.0
Intensive	41.0
Regular	63.3
Methadone maintenance	16.0

Source: N-SSATS data. Accessed January 25, 2013 at: http://wwwdasis.samhsa.gov/webt/state_data/CT11.pdf

There have been only small changes in the levels of care offered by those facilities responding to N-SSATS over the last ten survey years. The chart below shows that there have been:

- slight increases in the percent of respondents offering intensive and regular outpatient;
- essentially no change regarding inpatient or short-term residential treatment; and
- slight declines for long-term residential treatment and day/evening treatment or partial hospitalization.

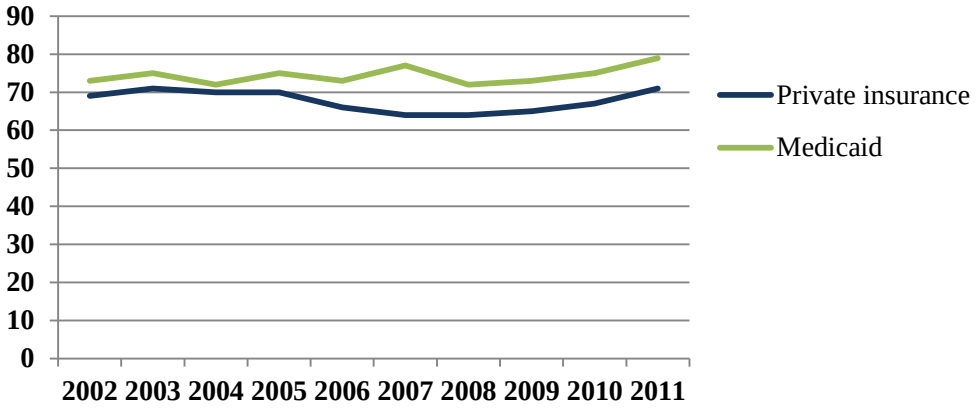
Figure F-3. Levels of Care Offered by Facilities Participating in N-SSATS



Source: PRI staff review of N-SSATS Connecticut State Profiles, 2002-2011.

Insurance acceptance. The chart below indicates that over the past ten years, the majority of facilities that participated in the N-SSATS survey have accepted Medicaid and/or private insurance. Medicaid acceptance has ranged from 72 (in 2004 and 2008) to 79 (in 2011) percent, with a recent upswing. Private insurance acceptance was about flat at 70 percent until declining in the mid-2000s, to a low of 64 percent in 2007 and 2008. Since then, there has been a gradual increase, resulting in a 2011 return to the previous high of 71 percent.

Figure F-4. Percent of N-SSATS Responding Facilities Accepting Certain Types of Insurance, 2002-2011



Source: PRI staff review of N-SSATS Connecticut State Profiles, 2002-2011.

School-based services. Adolescents and young adults may seek and receive substance use counseling at school.

Public school system. Many elementary and secondary public schools in Connecticut have at least one behavioral healthcare practitioner (e.g., school psychologist, social worker) who potentially could provide substance use-related counseling. The availability of these professionals and extent of counseling services they could provide on an ongoing basis is unknown.

Substance use counseling may be sought by adolescents at school-based health centers (SBHCs), which offer physical and behavioral health care (along with, in some, dental care). Twenty-two towns have among them 121 school-based health centers.

It does not appear, however, that SBHCs frequently provide substance use counseling. In FY10, six state-funded SBHCs – located in middle and high schools – provided substance use counseling, with an additional 13 (including a few elementary schools) providing "other counseling" that may have included care for substance use issues.[104]

Beyond personal counseling, few substance-use specific services within schools (e.g., recovery support groups) appear to exist in Connecticut. Neither are there such options as a school specifically for students in recovery, which are available in a few states. One Bridgeport public high school, however, appears to have been very successful at reducing substance use. The school continues to offer substance use groups at several times during the school day, as

[104] According to the Department of Public Health. In FY11, the state supported about two-thirds of all SBHCs (71 clinics). ("Adolescent Health Coordination and School-Based Health Centers in Connecticut: RBA Project 2011," Legislative Program Review and Investigations Committee, March 2012 (p. 42). Accessed January 30, 2013 at: http://www.cga.ct.gov/pri/docs/2011/Adol_Health_Final_%20Report.PDF)

well as a substance use counselor who is available after school.[105] Providers and parents expressed to program review committee staff that some schools seem reluctant to offer substance use-related programs (other than strictly prevention), perhaps due to lack of support for such efforts among the schools' broader communities.

Postsecondary institutions. The majority of the Connecticut four-year colleges and universities responding to a program review committee survey offer behavioral health counseling, including for substance use. The state's community colleges have counseling centers but counseling is focused on academic coursework and addressing barriers to educational success.

Respondents. The survey, which was sent in October, requested information from all of Connecticut's public and private postsecondary institutions, except for the state community colleges (which generally lack personal counseling services). Eighteen campuses responded: three University of Connecticut sites (including the Storrs branch), all four of the Connecticut State Universities, and 11 private institutions.[106] The median estimated enrollment was 3,308, with an average enrollment of 5,880.

Substance use counseling offered. Nearly all (but one) respondents have a behavioral health counseling center; of those, about three-quarters (76 percent) of the centers offer counseling for substance use and/or co-occurring disorders, with an additional one providing only substance use assessment (not substance use counseling). For the most part, centers provide integrated treatment for co-occurring disorders.[107]

Accessibility. Although only one center had a waitlist for services, students at most of the responding colleges would not have immediate access to counseling. The following table indicates that students at more than two-thirds of responding colleges would have a wait of more than one day for counseling services; students at just over half would experience a delay of four or more days.

Table F-5. Wait for Counseling Services Among College Counseling Center Survey Respondents

Wait	***Percent of Respondents***	***Number of Respondents***
One day	31%	4
Two to three days	15%	2
Four to five days	23%	3
Seven days	23%	3
14 days	7%	1

Source: PRI survey.

[105] "Peer to Peer Program," Bridgeport Central High School. Accessed January 30, 2013 at: http://bridgeport.ct.schoolwebpages.com/education/school/school.php?sectionid=351. http://bridgeport.ct.schoolwebpages.com/education/school/school.php?sectionid=351

[106] Four institutions that offer undergraduate degrees did not respond: Yale University, Quinnipiac University, Trinity College, and the University of Bridgeport. (Rensselaer Polytechnic Institute Hartford offers exclusively graduate-level degrees.)

[107] There were 14 respondents to this question; 12 (86 percent) indicated they treat co-occurring disorders in an integrated way.

Types of counseling offered. Regular (non-intensive) outpatient is the only level of treatment offered among responding schools. About forty percent of respondents (seven of 18) offer at least one outpatient group for students with substance use or co-occurring disorders. Some groups are open to any students (as at three colleges), while others are specific to:

- women or men (two colleges, each);
- student-athletes (one college)
- violators of the school's substance policies (three colleges);
- students with co-occurring disorders (three colleges); and
- students in long-term recovery (one college).

There appears to be sufficient group counseling capacity given demonstrated demand; no school reported a waitlist.

Limitations on counseling. Some counseling centers (42 percent of respondents) restrict the number of sessions available to any particular student.[108] The individual session limit ranged from six to 12 sessions per semester, and from 12 to 20 for an academic year.

Payment. Just one of the 18 respondents charges for counseling center services. This center's staff noted that all the college's students must have health insurance, and one popular student insurance option provides behavioral health coverage without any cost-sharing. If a student feels unable to bear a co-pay or deductible required under a policy, then the counseling center will assist the person in finding a low- or no-cost option. This particular center does have a session limit and a substantial wait for an individual counseling appointment.

Other substance use services on campus. Six of the 18 respondents have an office separate from the counseling center that provides substance use prevention and assessment services, with one additional school having an office providing only prevention. Among the six, two offer individual counseling for substance use. One of these limits counseling to a few sessions, while the other allows several.

The majority (61 percent) of respondents does not have mutual support groups on campus. Five campuses host Alcoholics Anonymous meetings, while two more offer similar mutual support group meetings.

One-third of respondents whose campuses include student housing indicated there are substance-free housing options available.[109] These four campuses have at least a substance-free floor in a residence hall, with two offering an entire substance-free residence hall and three offering a substance-free "house" option.

One campus reported a program specifically for students in recovery.[110] This program, which enrolls 12 people, includes individual and group counseling, Alcoholics/Narcotics Anonymous meetings, and a special recovery lounge. This particular school has DMHAS grants that are supporting this and other efforts to address substance use, such as offering multiple

[108] There were 12 respondents to this question; five indicated limitations on the number of counseling sessions.
[109] An additional campus reported that the whole location is substance-free.
[110] Fifteen campuses responded to the question of whether a recovery program is offered on-campus.

substance use-focused group counseling sessions. (Three other colleges – including some state universities – also receive these grants but do not have recovery programs.)

Primary care. The OHCA plan notes that providers typically associated with primary care also give substance use treatment. First, general or children's hospitals – which are required by law to screen trauma patients for substance abuse – may directly provide treatment at any level of care.[111] In recent years, all 29 of the state's general or children's hospitals have provided substance abuse treatment at some level of care. The table below lists the eleven hospitals that are listed in the Connecticut Clearinghouse treatment locator as having outpatient treatment programs, and displays the type of program at each.

Table F-6. General Hospitals Providing Outpatient-Setting Substance Use Treatment

Hospital	***Town of Treatment Services***	***Partial Hosp./ Day or Evening Treatment***	***Outpatient Counseling***
Bristol Hospital	Bristol	✓	✓
Danbury Hospital	Danbury	✓	✓
Greenwich Hospital	Greenwich	No	✓
Griffin Hospital	Derby	✓	✓
Hospital of Central CT at New Britain General	New Britain	No	✓
Norwalk Hospital	Norwalk	No	✓
St. Francis Care	Manchester	✓	No
St. Mary's Hospital	Waterbury	✓	✓
UConn. Health Center	Farmington	No	✓
Waterbury Hospital	Waterbury	✓	✓
Yale-New Haven Hospital, St. Raphael Campus	New Haven	✓	✓

Source: PRI staff review of the Connecticut Clearinghouse's treatment locator, "Behavioral Health Services in Connecticut."

Second, at least a few pediatric outpatient practices offer both physical and behavioral healthcare services.[112]

The integration of primary and behavioral health care recently has been gaining momentum. For example, the federal Patient Protection and Affordable Care Act (ACA) of 2010 gave states increased Medicaid reimbursement for using a medical home approach to manage patients' care. The medical home could be either a physical or behavioral health care provider.

Within Connecticut, there are a few efforts to improve access to behavioral health care through boosting screening and connection to treatment in medical settings.

[111] C.G.S. Sec. 19a-490h, enacted by P.A. 98-201.
[112] "Behavioral Health Services in Pediatric Primary Care: Meeting the Needs in Connecticut," Julian Ford, Anne Pidano, and Lisa Honigfeld, Child Health and Development Institute of Connecticut, September 2006.

SBIRT. DMHAS received a federal grant to offer Screening, Brief Intervention and Referral to Treatment (SBIRT) at eleven community health center sites.[113] Primary care providers screen for substance use. Those patients indicating troublesome use are asked to see a co-located behavioral health educator, who conducts further assessment and then gives either a brief intervention or appropriate referral to treatment. From February 2012, when SBIRT implementation began, through December 2012, more than 9,000 people were screened.

This grant also involves an SBIRT Training Institute at the UConn Health Center, which aims to assist general hospitals and DMHAS's Military Support Program for National Guard-affiliated people in adopting SBIRT.

Alternative-to-Hospitalization. This program, begun in 2005, attempts to divert substance use and co-occurring patients from acute inpatient mental health treatment. Emergency department staff in nine participating general hospitals assess patients. Those who are willing to contract for safety and to try care in a different setting are connected with a DMHAS / Advanced Behavioral Health, Inc. case manager who helps the hospital and patient locate and travel to a more appropriate treatment setting. Eighty percent of 313 emergency department presentations were successfully diverted through this program, in FY 2012. DMHAS selected participating hospitals when it was responsible for providing behavioral health services to General Assistance state clients, based on data showing which venues could improve substance use treatment diversion of those clients.

Educating Practices in the Community. The Child Health and Development Institute of Connecticut, Inc. – an independent research and technical assistance organization – offers healthcare providers in-office trainings on a range of topics. One training helps pediatricians and others learn how to integrate behavioral health screenings into routine visits, including familiarizing them with different screening tools.

[113] The grant, from SAMHSA, is for a collaborative partnership among DMHAS, the Community Health Center Association of Connecticut, and the University of Connecticut Health Center.

Appendix G

Examinations of the State's Substance Use Treatment Capacity Adequacy

Office of Health Care Access (OHCA) Facilities Plan

The Department of Public Health's (DPH) OHCA 2012 Statewide Health Care Facilities and Services Plan catalogs DPH-licensed services but did not, in the behavioral health chapter, assess whether need exceeds capacity. However, emergency department staff focus groups conducted for the purposes of the plan's development discussed behavioral health capacity problems. The focus groups found shortages in:

- outpatient care, stating hospital-associated outpatient behavioral health services generally have a three-to-six week wait, with this care being difficult to locate for those patients without insurance but ineligible for any state assistance;
- adult inpatient care;
- child residential care; and
- community behavioral health care available for intakes in the evening and early morning hours.[114]

The focus groups also discussed issues that result in capacity problems. Provider policies can lead to higher than necessary volume for the emergency department. For example, some sober houses simply discharge people who have relapsed, instead of connecting them with alternative services, while some detoxification centers require, for intake, a referral from an emergency department. Other contributing factors are the absence of both community-based case management services - to help coordinate care across hospitals and community providers - and a "comprehensive resource directory and an up-to-date census report" focusing on treatment beds.

These shortages, policies (among others), and deficiencies "add days to untreated behavioral health needs, huge costs to hospitals and insurers, and disruption in patients' and family members' lives."[115]

To alleviate these problems, focus group participants discussed numerous possible approaches:

- expansion of diversion programs or initiatives, such as Emergency Mobile Psychiatric Services (a Department of Children and Families program) and the

[114] "Statewide Health Care Facilities and Services Plan," Department of Public Health Office of Health Care Access, October 2012. Appendix G.
[115] Ibid.

Department of Mental Health and Addiction Services's (DMHAS's) diversion program;

- hospital initiatives, such as engagement of community providers to educate them on appropriate emergency department use, admitting minors with behavioral health concerns into inpatient pediatric care for observation instead of holding them in the emergency department, and staffing emergency departments with more (unbillable) case managers;

- development of state-funded, self-contained psychiatric emergency facilities like California and New York;

- integration of care coordinated across systems;

- creation of a bridge care program, with observation / respite beds and a patient/peer navigator;

- urgent walk-in behavioral health care centers, perhaps co-located with existing primary care centers; and

- a comprehensive "On-line Capacity Management System," to assist in connecting patients with other levels of care.[116]

The plan's behavioral health recommendations largely center on creating a comprehensive inventory of services and an assessment of capacity adequacy.

Practitioners. The plan notes Connecticut has a mental health care practitioner shortage, equal to about half the shortage of primary care and dental professionals. It also states that roughly one-fifth (27 of 106 areas) of the state has a mental health care shortage.[117] Substance use specifically is not addressed.

DMHAS Priorities Report

Every two years, DMHAS develops a priority-setting report for its mental health and substance use services. Its 2012 report[118] relied on a survey of DMHAS-funded providers, as well as on regional focus groups, which included providers, clients, family members of clients, and referring organizations. In addition to the statewide report, each region has its own priority report.

[116] Ibid.
[117] "Statewide Health Care Facilities and Services Plan," Department of Public Health Office of Health Care Access, October 2012. Chapter 2.
[118] "2012 Report on Statewide Priority Services," Connecticut Department of Mental Health and Addiction Services, September 2012.

Service availability. The following services were indicated by the survey to have limited availability, with more than 50 percent of providers stating the service is "not available or sometimes available":[119]

- residential care, for everyone but especially pregnant women and people with co-occurring disorders; those in need of long-term residential care (including DMHAS clients) also were pointed out as a particular need, during the focus groups;

- detoxification in all settings: ambulatory (including buprenorphine), residential, and hospital-based, with an average wait time of one day – with shortness of stay described as problematic, in the focus groups;

- intensive outpatient, for pregnant women; and

- chemical maintenance.[120]

The report considers the other types and settings of services – standard and intensive outpatient, assessment, screening and brief intervention, methadone maintenance, and access lines – to generally be available. The data indicate, however, that a substantial percent of providers find even those sometimes or never available. For example, more than 20 percent indicated standard outpatient has limited availability – and nearly 40 percent did so, for intensive outpatient.

Survey respondents also rated several types of recovery support services (discussed more below) as limited availability: transportation, education, employment services, sober/recovery housing, and faith based services. (Case management services were found to be usually available by just over half of respondents.) In focus groups, housing was discussed as a particular shortage. Participants said the housing that exists can be difficult to locate and largely is in proximity to wide-scale drug availability, making it especially hard for residents to remain substance-free.

The focus group participants underscored the need for young adult-specific services, due to developmental stage and "difficulty connecting with older adults who make-up [sic] the majority of clients in substance abuse programs." Providers stated that a key factor in youth treatment drop-out is that age-specific services are not available.

Availability specific to youth. The focus groups also noted that capacity adequacy varies within and across regions, with shortages for young adults specifically in:

- inpatient treatment;
- residential treatment;
- outpatient treatment, in some regions (unspecified);
- age-appropriate mutual help groups, in rural areas;

[119] "Don't know" responses were excluded from DMHAS's analysis.
[120] Buprenorphine was included in two categories: ambulatory detoxification and chemical maintenance.

- specialized services for lesbian, gay, bisexual, and transgender youth.

The focus groups noted that as with mental health services and services for those of other ages, youth need but often lack transportation, as well as other treatment and recovery supports. (Areas of need for other special groups, such as the elderly, also were discussed by the groups and summarized in the report.)

Focus group themes. Several themes emerged from the focus groups:

- "…difficulties in navigating the substance abuse system";
- "…barriers to accessing care by private insurance";
- troublesome treatment facility placement and inadequacy of treatment capacity, particularly for medication-assisted treatment, due to zoning resistance; and
- lack of recovery supports, including no recovery centers in the Northwest (which covers the western portion of the state, excepting Fairfield County) and South Central regions.

Recommendations. In response to the survey data and focus group information, the priority setting report sets out numerous recommendations to improve timely access to substance use treatment services and support recovery (i.e., sustain the effectiveness of treatment). The recommendations particularly relevant to this study are:

- improve timely placement into appropriate settings by launching: 1) a "24-hour access line"; and 2) a website with treatment bed availability across the state (inclusive of all state and nonprofit providers);
- "Explore and address policies and practices that are barriers to coordinated and effective behavioral health care equity";
- further facilitate access by: 1) clarifying, simply and in plain language, how to enter and navigate the public treatment system; and 2) establishing priority access points in community-based settings for people presenting at hospital emergency rooms;
- evaluate residential treatment bed capacity; and
- expand recovery and prevention supports, including through increased training for recovery coaches; and
- integrate substance use care into physical health care through encouraging all primary care settings to use the SBIRT tool and supporting the co-location of physical and behavioral health services.

Specific to young adults, key recommendations were to:

- ensure treatment and recovery services are age-appropriate, increase capacity of those services that are also evidence based, and educate providers on young adults' "unique needs"; and

- "Create an interagency coalition that promotes collaboration and improved communication between providers and agencies that work with youth."

Department of Children and Families Needs Assessment

The Department of Children and Families is conducting a comprehensive needs assessment for all of its purchased services, including substance use and mental health treatment. The effort involves an inventory and assessment of capacity, identification of resource gaps and unmet needs, and community resource mapping. The project began in October 2012 and is expected to be complete by fall 2013.

Office of the Healthcare Advocate Report

In January 2013, the Office of the Healthcare Advocate (OHA) issued a report on access to behavioral health care. Its analysis was based on the testimony of providers, practitioners, patients, and family members of patients in an October public hearing held on the topic by OHA; the knowledge gained through its daily activities in assisting the public with accessing healthcare; and prior reports issued by OHA and other state offices.

The OHA report found problems in accessing both substance use and mental health care treatment, stemming from "lack of capacity in our current system, denials from insurers of coverage and lack of provider participation" in insurance networks. Access to inpatient and child psychiatric care was noted as a particular problem, citing in part a 2007 report of the Offices of the Attorney General and of the Child Advocate finding less than half of child and adolescent psychiatrists responding to a survey accepted private insurance.

The OHA report described particular insurance practices (beyond utilization review) that can impede access to care by restricting the number of practitioners willing to participate in the network. One practice is maintaining relatively low reimbursement rates for some behavioral health care providers. For example, some licensed psychologists part of private insurer networks receive an insurance reimbursement rate lower than that of traditional trades' hourly rates (e.g., electrician, plumber) and master's level practitioners in at least one plan have had no reimbursement increase in at least a decade. Another practice is BHP's policy of not allowing licensed clinical social workers to give reimbursed services to HUSKY C and D clients, although they can offer helpful case management - and do, for the HUSKY A and B programs.

The report's recommendations included assigning responsibility for the state's behavioral health delivery system to a single coordinating entity. It notes that OHA is seeking funding to evaluate the Behavioral Health Partnership's suitability for this task.

Other Research

The views of nonprofit providers were obtained for this study in two ways: via a survey, and through conversations and other communications facilitated by the Connecticut Community

Providers Association (CCPA).[121] Much of the survey information presented below is also found in Appendix D.

Survey. The study survey asked each respondent whether there is usually space in each level of care offered, and if not, about how long the wait for care tends to be. The presence and length of a wait for services varied among the levels of care, and within levels, by survey respondents, as shown in the table below.

Table G-1. Wait for Survey Respondents' Substance Use Treatment Services, by Level of Care

	None		***1-2 Days***		***3-6 Days***		***7+ Days***	
	%	***n***	***%***	***n***	***%***	***n***	***%***	***n***
Inpatient	50%	3	33%	2	17%	1	0%	0
Residential	13%	2	19%	3	31%	5	38%	6
Comm. living arr.	43%	3	0%	0	0%	0	57%	4
Partial hospitalization	71%	5	0%	0	14%	1	14%	1
Day/evening treatment	58%	11	16%	3	11%	2	11%	2
In-home services	29%	2	0%	0	14%	1	57%	4
Intensive outpatient	72%	13	0%	0	22%	4	6%	1
Outpatient - Individual	48%	15	10%	3	13%	4	29%	9
Outpatient - Group	74%	20	7%	2	11%	3	7%	2

Source: PRI survey.

Partial hospitalization, day/evening treatment, intensive outpatient, and outpatient group sessions were the levels of care for which more than half of survey respondents reported no wait. However, within each of these levels, at least one provider indicated a wait of at least a week for these same services.

Residential treatment and in-home services were reported by less than one-third of respondents to have no wait for services. The length of wait for residential treatment was at least three days for more than two-thirds of respondents' services, and for in-home treatment, more than half reported a wait of at least one week.

Some respondents chose to comment on the types of programs and clients that experience the longest waits. One provider respondent each noted that Spanish-speaking clients and those with CSSD involvement face longer waits. A few wrote that family or personal scheduling limitations could lead to a wait, particularly for evening services. The area of most comment was in-home programs: Three respondents explained that these have the longest wait, of the service array offered.

Adolescents. Both of the survey respondents offering residential treatment indicated this level of care has a wait of three to six days, although one noted that the wait is sometimes due to

[121] The Connecticut Association of Nonprofits (i.e., CT Nonprofits) contacted and solicited views from members but received little response.

family coordination needs. Four of the five respondents providing intensive outpatient said there usually is no wait for that level of services; the other indicated a wait of three to six days. As noted above, a few providers wrote that the wait for an in-home program can extend far beyond one week (the longest option provided in the multiple-choice question).

Association communications. Connecticut Community Providers Association (CCPA) members in conversations identified inadequate service capacity for:

- individuals with private insurance, no insurance, or developmental disabilities, or who live in suburban areas (due to zoning restrictions);
- poor minority youth, who if caught with an illegal substance, appear to more often be sent to jail instead of treatment;
- children seeking outpatient or in-home treatment, with waits for the latter of five to seven weeks; and
- residential treatment.

CCPA members suggested that capacity could be improved by two state-level policy actions:

- requiring private insurers to reimburse providers for care given by someone in training; and
- returning DCF outpatient clinic funding to its prior level because demand exceeds capacity and the funding level is pressuring clinics to see fewer uninsured clients.

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Appendix H

Adolescent In-Home Treatment Models

The state's Department of Children and Families (DCF) developed three in-home treatment models to address adolescents' substance use treatment disorders:

- *Multidimensional Family Therapy (MDFT) for adolescents*: This therapy looks at adolescent use as a network of influences (individual, family, peer, community), and tries to increase positive behavior in multiple settings. The individual and family are counseled both separately and individually.

- *Multisystemic Therapy (MST)*: MST is family-based, involving joint counseling for the individual and family, with the intent of addressing a range of influences on the youth: individual (e.g., attitude toward use), family (e.g., discipline, conflict), peer, and community (e.g., school, neighborhood).

- *Functional Family Therapy (FFT)*: FFT's premise is that "behaviors influence and are influenced by multiple systems within the adolescent's life, including the family."[122]

DCF also established Intensive In-Home Child and Adolescent Psychiatric Services (IICAPS). This program is geared toward children with mental health disorders but able to serve those with a secondary substance use diagnosis.

Accessing the models. Families with private insurance and no DCF involvement can attempt to access MDFT and MST by directly calling the department's contracted nonprofit providers. Utilization review is done only for Medicaid clients. For FFT, access is managed through utilization review by the BHP administrative services organization. Voluntary Services enrollment is not necessary to access these programs.

IICAPS is freely available to children with HUSKY. Those with commercial or no insurance must apply (to DCF, via the department or service providers) for a partial Medicaid benefit that covers only the program costs. This process allows IICAPS providers to bill the Behavioral Health Partnership for the IICAPS services provided to non-HUSKY children, and is unique to the IICAPS program. About 60 percent of IICAPS clients are not DCF-involved (for child welfare or juvenile justice reasons).

[122] "Addiction Medicine: Closing the Gap Between Practice and Science," The National Center on Addiction and Substance Use at Columbia University, June 2012. Accessed August 23, 2012 at: http://www.casacolumbia.org/upload/2012/20120626addictionmed.pdf

Table H-1. DCF In-Home Substance Use Treatment Programs						
Program	***Distinctive Characteristics***	***# Sessions Per Week (except where noted)***	***Duration (months)***	***Evidence-Based?***	***Area Offices With Access to Program***	***Number of Families Served in FY 2012***
FFT	Youth often have other problematic behaviors.	2	4	Yes	All	519
MDFT	Focus on parent interventions; 1 clinician and case mgr./family. Structural and strategic family therapy.	3: 1 each family, parent, and individual child	4-6	Yes	All	713
MST	Structural family therapy. 1 clinician per family. Are special programs for: juvenile offenders, problem sexual behavior, transition age youth involved with juvenile or criminal justice, parole youth; and families with maltreatment and substance use (Building Stronger Families).	3	3-8 months, depending on program	Yes	Varies depending on program	327, plus 24 DCF-involved families
IICAPS	*Primary purpose is to prevent psychiatric inpatient admission; can have substance use as secondary diagnosis.*	*4-6 hrs./wk.*	*6*	*Research to establish as evidence-based is being conducted*	*All*	*Approx. 2,000 families (will be 2,500 in 2013)*
Source: PRI staff analysis of DCF-provided information and Commissioner Joette Katz's testimony to the Bipartisan Task Force on Gun Violence Prevention and Children's Safety; Mental Health Services Working Group, January 29, 2013. Accessed March 1, 2013 at: http://www.cga.ct.gov/asaferconnecticut/tmy/0129/Joette%20Katz,%20Commissioner%20of%20DCF.pdf.						

Appendix I

Agency Responses

State of Connecticut

THOMAS B. LEONARDI
INSURANCE COMMISSIONER

P. O. BOX 816
HARTFORD, CT 06142-0816

Hartford

July 8, 2013

Co - Chairman State Senator John E. Kissel
Co-Chairwoman Representative Mary M. Mushinsky
Members of the Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

Re: Access to Substance Abuse
Treatment for Insured Youth, Phase II

Dear Senator Kissel, Representative Mushinsky and Committee members,

Thank you for providing me an advance copy of the report and giving me an opportunity to comment. The broad overview provided by the Program Review Committee staff underscores the comprehensive consumer protection checks and balances that exist, highlighting those that are effective and those that can be enhanced. The Connecticut Insurance Department, as I am sure you are aware, plays an integral part, not only in regulation, but in consumer protection through our statutory authority under section 38a-9 of the Connecticut General Statutes. It is a responsibility the Department staff takes very seriously and will continue to work with lawmakers and other state agencies to improve what we all do for the well-being of our citizens and State.

As you recall, I provided comments in a detailed 12-page response on the Phase I report to the Committee on January 14, 2013. It is not necessary to repeat those comments, and I note that the Phase II report is aimed primarily on access to care issues and only in certain parts on commercial insurance issues and Connecticut Insurance Department activity. Yet within the scope of our authority, I believe there are opportunities to further strengthen the checks and balances by promoting greater synergy and information-sharing among the pertinent agencies. Finding solutions for those families who struggle with the issue of substance abuse and getting help for their children, cannot be just an issue for the Departments of Insurance or Mental Health and Addiction Services or Public Health or the Department of Children and Families or the Office of the Healthcare Advocate. We need a robust collaborative approach to build even more checks and balances in the system. It is an approach that I have strongly espoused since my appointment more than two years ago, and one that is evident in a number of initiatives the Department has underway on a variety of issues.

Before I outline some of those collaborative initiatives, permit me to take care of some housekeeping with the Phase II report. Specifically, I have substantive concerns related to the provider network adequacy issues described on page 11 of the Phase II Report. I respectfully request these issues be clarified in the final report. It appears to be the assessment of the PRI staff that the Insurance Department gave carriers an "overly lengthy period of time" to comply with the provider network adequacy law (section 38a-472f of the Connecticut General Statutes), which was effective January 1, 2012. In fact, the Department required carriers to certify compliance for the entire 2012 year when filing mandatory Consumer Report Card information on or before May 1, 2013. The deadlines were chosen to conform into the existing process and timetable for the Consumer Report Card and were not in any way intended to allow carriers a year to comply. The Department is prepared to fine or take other appropriate action against a carrier that is out of compliance from January 1, 2012 on.

As a follow-up to the carrier certification noted in the preceding paragraph, the Department's Market Conduct unit also monitors for documentation demonstrating NCQA or URAC network adequacy requirements (as required in the law) when it performs a market conduct exam of a health insurer or HMO. In addition to the carrier certification and Market Conduct check for supporting documentation, there is another "check" for consumers. Consumers may complain or inquire to the Department's Consumer Affairs unit about a perceived lack of network adequacy, and Consumer Affairs will investigate any such complaint.

Further adding to the "checks and balance" is the Department monitoring of any contract dispute between a health insurer or HMO and its participating hospitals or physician groups that has the potential to terminate a significant provider from a network. We always require that carriers demonstrate that termination will not alter their network adequacy requirement. We ensure that consumers have access to a sufficient number of hospitals and physician groups within a reasonable distance, even after a provider termination. In view of all the Department activity concerning network adequacy, we respectfully request a change in the report language.

The Phase II Report also recommends a proposed amendment to Section 38a-478c to include additional items to be included in the Consumer Report Card. I first want to note that the Report Card is primarily intended for a consumer to use for comparing plans. However, to the extent information is included which assists the Department to flag possible trends, we do utilize the data for those purposes. However, we do suggest that information collected for the Department to evaluate should not be included in the report card, as it may confuse or be of no value to consumers In terms of the latest proposed legislative changes from the Phase II report, I believe that health carriers will not have all of the requested information. Also, to the extent the data sought is broader than the commercial insurance market, it may be appropriate to compile and track the data elsewhere and at the same time ensure – either through policy or statutory changes – that there is a viable process for sharing this information among agencies for the regulatory "checks and balance" system to work as it is intended. For example, the Department regularly refers hundreds of consumers to the Healthcare Advocate for individual advocacy in appeals. By contrast, the Healthcare Advocate could enhance our regulatory activity by sharing and/or documenting network adequacy problems or other possible infractions of insurance law that the OHA encounters in its work. Under section 38a-1041 of the Connecticut General Statutes OHA is to make a referral to the Insurance Commissioner if OHA finds that a preferred provider network may have engaged in a pattern or practice that may be in violation of specified state insurance laws. In addition under this statute, OHA and the Insurance Commissioner are to

jointly compile a list of complaints against managed care organizations and preferred provider networks, with the list maintained by the Insurance Commissioner. I have not received this material from OHA.

Also, in 2005 the Legislative Program Review and Investigations Committee recognized the need for the Insurance Department to be aware of all complaints being filed against health insurers by consumers, providers or employers and made the following recommendation:

> "The Office of the Attorney General and the Office of the Healthcare Advocate should forward a quarterly report to the Connecticut Insurance Department containing information on each complaint that at minimum includes: the source of the complaint, the reason for it, the company named in the complaint, and its resolution. The Consumer Affairs division should include these complaints in its database when generating information for the Market Conduct Division for use in its examinations, and when calculating its annual rankings."

The Office of the Healthcare Advocate is not meeting this recommendation. The Department's Consumer Affairs and Market Conduct units have since their inception been a powerful tool to correct industry behaviors for the benefit of consumers, and their positive impact can be enhanced with the proper collaboration.

Even though I strongly believe that greater collaboration among state agencies can ameliorate many of the issues described in the report, I stand ready to work with this Committee and the Insurance and Real Estate Committee during the 2014 session on any amendments to the Consumer Report Card statutes or other insurance statutes, which the legislature may be considering.

The Report on page 6 lists the Office of Healthcare Advocate and the Attorney General's Office as providing consumer assistance but lists the Insurance Department for insurer regulation only. The Insurance Department does have a strong Consumer Affairs Unit established 25 years ago. I am sure it was probably an oversight, but it does not reflect the work of the men and women of our Consumer Affairs Unit who help Connecticut consumers every day on all kinds of insurance issues, fielding more than 10,000 questions and complaints a year and recovering more than $4 million annually on behalf of policyholders.

It is with those consumers in mind that the Department has several ongoing initiatives both internally and collaboratively with other agencies that I am pleased to share with the Committee as an update. They include:

(1) We established a team representing various disciplines within the Department and are actively working on implementation of the changes made to the insurance statutes in sections 70 through 79 of Public Act 13-3. We recognize that many of these legislative changes arose through the efforts of the PRI Committee, and we fully support the changes and are working hard to ensure full and timely implementation. I have issued Bulletin HC -92 on June 19, 2013 to provide guidance and requirements for carriers on these new provisions in Public Act 13-3.The following is a link to the Bulletin: http://www.ct.gov/cid/lib/cid/Bulletin_HC-92_-_Public_Act_13-3_Behavioral_Health_Changes.pdf

(2) Deputy Commissioner Anne Melissa Dowling and other Department staff are continuing to work with University of Connecticut Health Center on developing a claims toolkit for families and providers to utilize for obtaining approval and reimbursement for mental health and substance abuse claims. This claims toolkit will provide detailed information to families on best to assemble and develop needed documentation to support reimbursement under policy terms for the treatment plan they are seeking for a family member for mental health and substance abuse issues. The goal of this project is to increase the level of approval of care at the initial stage and to avoid the added stress of claim denials and claim appeals during an already difficult time for a family.

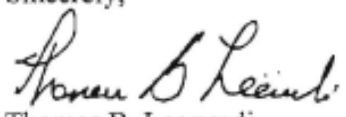
(3) The Department is revising our external review guide to incorporate recommendations from the Phase 1 Report, and. we will forward a copy to you upon completion. We believe these changes will make it clearer and easier for consumers to submit any claim denials based on medical necessity to the Department for a binding final review by a neutral third party with appropriate medical or psychiatric expertise and with no relationship with a health insurer or HMO.

(4) In addition, we are writing to the Sandy Hook Commission and suggesting that one of their recommendations may be that the Connecticut legislature develop non-quantitative standards relating to mental health services for health insurers and HMOs to follow (as I also suggested in my January 14, 2013 response to this Committee). The quantitative requirements (prohibiting different dollar and visit limits for mental health care than for medical care under state and federal mental health parity laws) are clear and well understood and administered on a state and federal level. But the federal agencies have provided little specific guidance on the non-quantitative requirements of mental health parity (involving pre-authorization and other utilization review functions as well as medical necessity and clinical issues). Deputy Insurance Commissioner Dowling has been in discussions with Commissioner Patricia Rehmer from Department of Mental Health and Addiction Services, and they would be pleased to chair a work group on this proposal, if the legislature desires. Connecticut could become a leader by coming out with its own non-quantitative requirements for Connecticut insured business.

My staff and I are seeking, with all these various activities, to do all we can to assist families in receiving prompt insurance reimbursement for necessary mental health and substance abuse treatment for family members.

Thank you for your consideration of the recommendations and suggestions I have offered and I would be happy to answer any questions or provide any additional information.

Sincerely,



Thomas B. Leonardi
Commissioner

Cc: Carrie E. Vibert, Director

DCF CONNECTICUT

DEPARTMENT of CHILDREN and FAMILIES

Making a Difference for Children, Families and Communities

Joette Katz
Commissioner

Dannel P. Malloy
Governor

TO: The Honorable John A. Kissel, Co-Chair
The Honorable Mary M. Mushinsky, Co-Chair
Program Review and Investigations Committee

FROM: Joette Katz, Commissioner
Department of Children and Families

DATE: July 3, 2013

SUBJECT: Access to Substance Use Treatment for Insured Youth: Phase II Report

This letter is in response to the Program Review and Investigations Committee *Access to Substance Use Treatment for Insured Youth: Phase II* report. Adolescent substance abuse is an important piece of the work the Department does with Connecticut families. Thank you for your thoughtful and thorough examination of access to substance use treatment for Connecticut youth.

The DCF Substance Abuse and Domestic Violence Division offers an array of evidence-based interventions statewide that have had significantly positive results for youth and their families but there is more work to be done. The Department of Children and Families is making continuous strides to improve our service delivery system, most recently by applying for federal funds, with the Department of Mental Health and Addiction Services, to support adolescent substance abuse and infrastructure and service delivery. Last month, we issued a Request for Proposal for a newly improved service delivery plan for outpatient adolescent substance abuse treatment. The Department of Children and Families has been working to improve access to substance abuse treatment and we have noted that the state service system often provides better access and treatment options than commercially insured youth. Our hope is that all youth are able to get the help they need.

Your report makes many valuable suggestions on how to improve substance abuse treatment options for Connecticut's youth. While we agree that the ability for families to locate treatment needs to be strengthened, we do not advocate creation of a second treatment locator at this time. Presently, we believe that the existing single treatment locator, 211 InfoLine, should be utilized, and strengthened to provide better understanding of treatment access options for families.

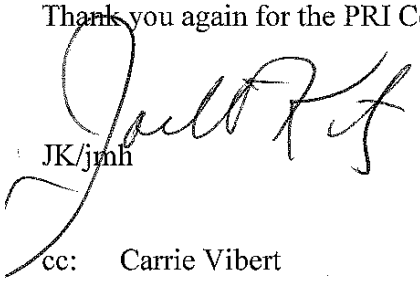
We recognize the increasing demands for emergency behavioral health interventions and the toll this is taking on the functioning of hospital emergency departments and the families who use them. We support continued further study of how best to resolve this problem.

We further agree that more screening needs to occur. The Department is currently in the process of developing "Access Mental Health", which was authorized during the most recent legislative session (Public Act 13-3). This initiative will establish a behavioral health consultation system for primary care providers.

We also wholeheartedly endorse your recommendation to support the establishment of youth-specific recovery supports to ensure that young people in recovery are an active part of the decision making process. There are several efforts underway to develop a youth-oriented Recovery Oriented System of Care, and we are optimistic that this will be fully achieved over time.

We also agree that commercial insurance providers should be held accountable for the adequacy of behavioral health services they provide, and that there is no single entity in charge of overseeing access to substance use treatment for the state's entire population. We disagree, however, with the recommendation of assigning oversight of access to care of commercially insured youth to an existing cross-agency council focused on substance treatment. We do not believe that this is the best path to obtaining optimal success in improving access for insured youth. As discussed recently with PRI staff, the only such existing council, the Alcohol and Drug Policy Council, is not currently set up to serve that function.

Thank you again for the PRI Committee's work on this important issue.



JK/jmh

cc: Carrie Vibert
Janelle Stevens
Mary Painter
Anne McIntyre-Lahner

STATE OF CONNECTICUT

DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES
A Healthcare Service Agency

Dannel P. Malloy
Governor

Patricia A. Rehmer, MSN
Commissioner

Memorandum:

TO: The Honorable Sen. John Kissel
The Honorable Rep. Mary Mushinsky
Program Review and Investigations Committee Members and Staff

FROM: Patricia Rehmer, MSN
Commissioner

DATE: July 8, 2013

SUBJECT: Access to Substance Use Treatment for Insured Youth Phase II

Thank you for this opportunity to respond to the staff findings and recommendations regarding access to substance use treatment for insured youth.

The report is a thorough examination of the current treatment system that is available for youth with health insurance seeking substance use treatment and the barriers they face. Though our expertise and treatment system is geared towards adults 18 years of age and older, we also believe the 18-25 year old young adult population has specific needs that must be addressed in an age appropriate manner.

DMHAS provides and funds prevention, treatment and recovery services to more than 110,000 adults in Connecticut needing care for psychiatric disabilities and substance use disorders. From inpatient psychiatric and substance use treatment to community support programs, jail diversion, peer supports, employment readiness and housing; we are available to individuals and their families who have significant symptoms and are medically indigent. Our major role is to be the safety net for those who do not have insurance coverage and the resources to meet their significant behavioral health needs.

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On the substance use side we operate approximately 152 inpatient beds that provide detoxification and rehabilitation for adults with serious substance use disorders; 42 of these beds are located in Hartford and the remaining 110 are on the campus of Connecticut Valley Hospital. These beds are not included in the bed count of the report. In addition, we fund a myriad of private providers for services such as detoxification, rehabilitation, intensive outpatient day programs, and methadone maintenance.

We fund prevention programs for all age groups that are spread throughout Connecticut's cities and towns, at our universities, and in our schools. These programs include prevention of underage drinking, prevention of smoking, and suicide prevention. These prevention programs are created specifically for youths and the developmental stage that they may be in.

We work hard to assure that individuals leaving an inpatient facility have a follow-up plan that is appropriate for them within a reasonable time period, and that individuals have access to peer supports, sponsors, warm lines, recovery telephone supports, employment services and sober housing. We track "connect to care rates" and providers are aware that connections after discharge are an integral part of the individual's recovery.

As noted in your report, the need for recovery supports after leaving treatment has been determined by DMHAS to be equally as important as treatment itself. The Connecticut Citizens for Addiction Recovery provides multiple services through a contract with DMHAS to individuals in the community. They operate Recovery Centers where individuals may go to seek assistance with housing, employment, or other community living issues that they are encountering. This agency is comprised of individuals in recovery. Over 80% of the board members are themselves in recovery. The telephonic support that CCAR provides that is mentioned in the report has been so successful that they are now looking to hire a manager to oversee it. The service is primarily staffed by volunteers who once again are individuals in recovery themselves.

The need for similar services that are age appropriate for adolescents and young adults is clear. Connecticut Turning to Youth and Family(CTYF), the recovery organization referenced in the report operates almost completely on a volunteer basis and does not have funding to increase the service or supports that are needed by youth in recovery. In a time when additional dollars for any services is highly unlikely, it may be that the CTYF should evaluate some sort of affiliation or collaboration with CCAR. The supports provided would still need to be focused on adolescents and youth, and they are very different from recovery supports for older adults, but funding the infrastructure and administrative costs of two separate agencies with very similar missions may not be possible.

DMHAS has seen an increase in individuals between the ages of 18 and 25 being admitted to our detoxification facilities. The majority of those individuals are being detoxed from either prescription narcotics or heroin. DMHAS is currently engaged with DPH and other state

agencies to address the issue of the rise in abuse of prescribed narcotic medication.

In addition, DMHAS has been working, through its well established Young Adult Service (YAS) Program to provide treatment for substance abuse. The YAS program is specifically designed for individuals between the ages of 18 and 25 because of the awareness of the different needs that this age group has from the other age groups that DMHAS treats.

Your report speaks to the need for Connecticut to have clinicians trained in recognizing signs of substance use among our youth and to create a system of training, screening and intervention for this population. DMHAS was recently awarded a grant from the federal government the purpose of which is to institute a Screening, Brief Intervention & Referral to Treatment (SBIRT) Program that will dramatically increase identification and treatment of **adults, ages 18 and older**, who are at-risk for substance misuse or diagnosed with a substance use disorder through the implementation of SBIRT services in nine partnering Federally Qualified Health Center (FQHC) sites statewide.

The SBIRT Program will include the following collaborative partners:

- The Connecticut Department of Mental Health and Addiction Services administers the program and provides leadership.
- The Community Health Center Association of Connecticut (CHCACT) employs nine health educators who provide the screening and brief interventions and referrals at the FQHCs as needed.
- The University of Connecticut Health Center (UCHC) is responsible for program evaluation and operates the SBIRT Training Institute which trains the health educators and ensures fidelity to the evidence-based practices. Other trainings to be offered in the near future include general hospitals and the DMHAS Military Support Program clinicians.

These partners are committed to implementing the *CT SBIRT Program*, monitoring outcomes, focusing on quality improvement, and developing statewide infrastructure to sustain SBIRT practices in Connecticut. But once again, this model is for adults ages 18 and older and is not a pediatric model.

Yale University also received an SBIRT grant from the federal government. **The Yale SBIRT model teaches pediatric residents and treats patients in their adolescent clinic ranging in age from 13 – 22.** Instituting this on a wider scale would be a very positive step but it cannot be done by one agency or counsel and cannot be done without additional resources.

The report also speaks to the need to create a referral to treatment system for this population. DMHAS's website lists all of our providers (by region) who serve individuals with and without insurance. This list however can only be helpful to those individuals looking for services that are

geared towards adults.

Many challenges need to be met in order to have good access to treatment for this population. There are no residential substance abuse programs for youth in CT, providers are scarce and there are few alternatives to offer families when they are in crisis and need behavioral health services for their children. Better insurance coverage for services, better reimbursement rates to providers and increased supports for new recovery models such as recovery high schools would go a long way towards meeting the needs of our youth in CT.

DMHAS's service delivery system, our clinicians, our agency's expertise is directed towards the care and treatment of young adults and adults with behavioral health disorders. While we believe that many of the recommendations contained in the report are valid in the general sense, the specifics as to which agencies or counsels should accept responsibility for advancing these recommendations for enhancing the substance use system for youth remains in question when the private insurance system and their individual benefit packages are so divergent in terms of what they will pay for as compared to service availability through the public system.

DMHAS and DCF are increasingly collaborating on the issues of adolescents and young adults with substance abuse disorders. We have recently submitted a grant application that would allow for the provision of in-home services for adolescents and age appropriate services for young adult individuals. We also collaborate on a program that often includes young adult women who are at risk of, or have lost custody of their child(ren) because of substance abuse. We are in the family court to immediately offer treatment and recovery supports so that the young woman, or man, may be reunified with their child.

In addition, DMHAS has been working with a for profit agency that is interested in opening the first sober high school in Connecticut. They anticipate opening sometime in October 2012. Unfortunately, at least at the outset, the agency will only take individuals who are insured or can pay themselves. It will be one addition to the system for treatment of adolescents that Connecticut has not had.

I want to stress that our system is adult focused, and we serve individuals who are medically indigent. That is how our system is built and that is where our expertise lies. We do not have the infrastructure to serve individuals under the age of 18. Historically, we have served very few individuals with private insurance. We are aware of the lack of parity primarily because we receive phone calls from parents who are seeking assistance. The new laws that include utilizing the Adult Society for Addiction Medicines (ASAM) criteria for identification of the appropriate level of care, in addition with specifying who is competent to conduct the concurrent reviews required by the private insurers may begin to address some of the access barriers.

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STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Office of Health Care Access

Janelle Stevens
Principal Analyst
Legislative Program Review and Investigations Committee
Connecticut General Assembly
State Capitol Room 506
Hartford, CT 06106

Dear Janelle:

Thank you for allowing the Department of Public Health (DPH) to review the *Committee Report: Access to Substance Abuse Treatment for Insured Youth: Phase II*. Below are my concerns and comments:

- The chart on page 6 does not include Certificate of Need (CON) in the DPH box (only licensing and facilities plan)

- The discussion on page 9 regarding DPH – only briefly mentions CON and does not indicate that it plays a key role in the "**oversight of access** to substance use treatment for adolescents and /or young adults."

- We understand the concern regarding lack of capacity assessment, but unfortunately, there are many barriers to determining capacity of behavioral health providers. While a more ambitious assessment of capacity was discussed and considered by the Statewide Health Care Services and Facilities Plan (Plan) Behavioral Health Subcommittee, the idea was not acted upon due to multiple resource constraints.

- While the Inventory is not mentioned by name, we are satisfied that Appendix F page F-1 notes that the Plan contains the most comprehensive information on the capacity of residential substance abuse treatment providers.

Thank you again for the opportunity to provide comments.

Kimberly Martone
Director of Operations

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Office of the Healthcare Advocate
STATE OF CONNECTICUT

Ms. Carrie E. Vibert, Director
Legislative Program Review and Investigations Committee
State Capitol, Room 506
Hartford, CT 06106

July 9, 2013

Dear Ms. Vibert,

I would like to commend you and your staff on your continued excellence and dedication to Connecticut's youth, evidenced by the recent study on Access to Substance Use Treatment for Insured Youth: Phase II (the "Study"). The Committee's initial phase of this very timely study released last fall greatly enhanced the ongoing dialogue concerning the challenges faced by individuals with mental illness, as well as their families, accessing Connecticut's behavioral healthcare system. The Committee's recommendations were well received by stakeholders and were pivotal in many of the important legislative changes that were achieved this year. As you know, our office held an independent hearing last October that focused on the challenges consumers in Connecticut face seeking treatment for mental illness and substance use, and our report identified many of the same issues and proposed some similar recommendations as the Committee's studies. Our report can be found at http://www.ct.gov/oha/lib/oha/documents/publications/report_of_findings_and_recs_on_oha_hearing_1-2-13.pdf.

This study expands its assessment of the challenges faced by individuals by more thoroughly assessing the behavioral healthcare system in Connecticut, identifying systemic inefficiencies and proposing several very thoughtful, innovative and reasonable recommendations for action and reform aimed at improving the experience and outcomes of not only Connecticut's youth, but all of our citizens. I wholeheartedly agree with the Study's recommendations, and recognize that while budgetary realities may play a role in the implementation of some, many are easily achievable. However, the action principles set forth in the study are essential to the physical, social and economic well being of our state and its citizens.

Specifically:

1) The Alcohol and Drug Policy Council is well situated to participate in the process, although its mission is somewhat narrow considering the demands facing our state. The task force established in P.A. 13-3 has a broader scope and mandate more appropriate to the task before us.

2) The Recommendation expanding insurance carriers' annual reporting requirements will provide a far greater level of detail concerning utilization of behavioral health services than has previously been available across payors and populations. In addition to the supplementary data recommended by the Study, it would be extremely helpful to receive data concerning consumer outcomes, such as the number of enrollees who were readmitted to a specific level of care.

3) Of critical importance in any examination of system reform is its capacity. This discussion is ongoing across our state and nation as a part of reform efforts under the ACA, but is particularly significant when we consider behavioral health. Recommendation 2 of the Study proposes that carriers report on the number, type and level of care of in-network providers, as well as those who applied for inclusion and those who have left. In order to accurately assess the behavioral healthcare system in Connecticut, this recommendation would be even more impactful if the additional data above was required to be broken down geographically as well. Not only will this serve to provide a more granular view of the system's coverage, but it will serve as an important measure of each carrier's network of providers.

4) I fully support Recommendation 3 that requires carriers to provide detailed behavioral health utilization review data.

5) One the Study's key recommendations was the development of a single, unified behavioral health treatment locator. If properly developed and implemented, this tool has the potential to revolutionize the way that consumers and providers seek and receive care. If accurate and current data concerning the availability of behavioral health providers across all levels of care and payors was easily accessible, significant inefficiency in the system could be mitigated, enabling much more proficient discharge planning as patients transition between levels of care, more effectively utilizing available provider and facility resources, and minimizing both unreasonable delays for appointments for some providers and unfilled appointments for others. One additional recommendation would be that the locator include not only whether there are available appointments or beds and what payors are accepted, but also availability by level of care. It would also be helpful to

consumers to have standardized billing practices for all behavioral health providers in the state.

6) The recommendations that leverage the expertise and infrastructure of state agencies whose missions require that they navigate Connecticut's behavioral healthcare system represent an excellent addition to this plan. Recommendation 8, which would require DCF funded providers to maintain data concerning commercial payor's coverage of in-home treatment models, could go further, and require more detailed data about the utilization determinations, as well as long term outcomes of each child, based on the treatment that they received.

The clarity and insight into the behavioral healthcare system in Connecticut that this Study brings is certain to be an invaluable resource as we continue to strive to develop the most effective, efficient and compassionate reforms for our citizens and state. OHA looks forward to continuing to partner with the Committee, as well as other stakeholders, both civil service and public, to realize significant and sustainable change in Connecticut's mental health system.

Victoria Veltri
State Healthcare Advocate