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

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I. EXECUTIVE SUMMARY

Some time ago, Connecticut resident Kathleen B. found herself in a painful dilemma; both her sons were suffering from bi-polar disorder, a serious mental health disorder marked by extreme changes in mood, energy, thinking, and behavior. Mrs. B was unable to locate a psychiatrist participating in her managed care health insurance plan who was willing to treat them. Mrs. B.'s boys, then aged 13 and 15, had previously been treated by Lisa Donovan, M.D. Dr. Donovan was ending her practice, however; Mrs. B. needed to find a new physician to treat her sons. The boys, N. and B., were severely ill. They suffered radical mood swings – from a manic to a depressive state and back -- within a single day. B. was actively suicidal; he tried to hang himself in the closet of the B.'s home. The B. family was insured at the time by Health Net, one of Connecticut's largest managed care insurance plans. Mrs. B. contacted Heath Net and asked them for the names of the psychiatrists specializing in the care of children and adolescents who participated in the Health Net network of physicians. Mrs. B. needed to find a participating psychiatrist because she could not afford to pay the cost of psychiatric care without insurance help.

Health Net gave Mrs. B. a list of 90 doctors; she was told that the 90 physicians participated in the Health Net network and could treat her children. Mrs. B. began at the top of the list and attempted to contact a doctor who would care for B. and N. As she worked her way through the list, she noticed that some of the names were duplicates or even triplicates. Several of the doctors on the list were deceased. None of the remaining doctors were accepting new Health Net patients. Not one would see Mrs. B.'s sons. Luckily, when informed of the problem, Dr. Donovan agreed to continue to see B. and N. until Mrs. B. could arrange transition to a new doctor. In the end, it was several months before Mrs. B. could find psychiatric care for B. and N.

Eventually she was able to locate a physician who had just moved to Connecticut from Massachusetts. He was willing to treat one of the boys. Mrs. B. found another psychiatrist willing to provide care, but he declined to participate with Health Net or any other health care plan. Mrs. B. was forced to pay this doctor out-of-pocket for the cost of her son's care.

Eventually Mrs. B. testified at the Connecticut State Legislature about her difficulty arranging psychiatric care for her sons. Mrs. B.'s testimony put the public on notice about serious problems with the delivery of the psychiatric care needed by children and adolescents in our state.

Richard Blumenthal, Attorney General of the State of Connecticut, and Jeanne Milstein, Connecticut Child Advocate, issue this joint report addressing the availability of mental health care to Connecticut children. This report incorporates the information received from a survey (*see* Appendix at A-1) of Connecticut child and adolescent psychiatrists, and is part of the ongoing investigation of the Attorney General and the Child Advocate of the mental health care available to Connecticut children.

A. SURVEY RESULTS

Taken as a whole, the returned surveys show that many children have lost access to quality psychiatric care. The psychiatrists who responded to our survey are angry about what they see as unfairly low reimbursement rates, and punitive and burdensome coverage determination procedures. Many child and adolescent psychiatrists, almost half of the total in the survey, refuse to participate with any of Connecticut's seven largest managed care plans.[1] The doctors agree that managed care companies have forced many psychiatrists to abandon quality, relationship-based psychiatric care in favor of practice inappropriately focused solely on the use of prescription

[1] Aetna U.S. Healthcare; Cigna Healthcare of CT.; Health Net; Anthem BlueCross and BlueShield of CT.; ConnectiCare; Oxford Health Plans; United Healthcare.

drugs. The managed care companies force this change by reducing reimbursement to cover only a brief visit, perhaps 15 minutes, necessary to quickly assess and re-prescribe medication, and by denying coverage or requiring voluminous documentation for the longer visits associated with relationship-based psychiatric care.

The returned surveys have also yielded the following, more specific, information:

1. According to the survey responses, a shortage of child and adolescent psychiatrists available to treat insured patients results in substantial and potentially dangerous delays in a significant number of cases for new patients with "urgent" problems.
2. Responding psychiatrists generally rate managed care plans as poor or below average in fairness of reimbursement, bureaucratic "hassle," and support of quality care.
3. Responding psychiatrists assess the present managed care system as "much worse" than the previous "fee-for-service" financing system, expressing their subjective opinions in the absence of objective criteria.
4. Most of the responding doctors with advanced certification in child and adolescent psychiatry decline to participate in managed care.
5. The number and geographic location of responding participating and non-participating psychiatrists suggest that Connecticut now has two parallel child and adolescent psychiatric care systems: one-half of the system consists of psychiatrists participating and paid by managed care; the other half of the care delivery system consists of doctors who refuse to participate. These

non-participating psychiatrists are supported mainly by patients paying high fees out of their own pockets with only limited contributions from managed care plans.

6. The survey responses indicate that managed care companies avoid paying for much of the care needed by these enrollees by driving many experienced and qualified child and adolescent psychiatrists out of managed care. Parents enrolled in managed care are often forced to seek care from non-participating doctors because they cannot find a participating physician able to treat their child or because their child requires more than the less expensive medication-focused care that managed care companies will cover.
7. Some managed care plans have significantly misstated the participating providers available to treat the children and adolescents enrolled in their plans. These plans have misled families into believing that their plans' provider networks have sufficient psychiatrists available to meet their needs.
8. In short, managed care has abandoned its responsibility to reimburse doctors for much of the psychiatric care needed by Connecticut's children and adolescents.

B. CONCLUSIONS AND RECOMMENDATIONS

The results of this survey, both the data collected and the written remarks of child and adolescent psychiatrists, show that countless children and adolescents are receiving inadequate psychiatric treatment, or no treatment at all. Although some patients may be adequately served by psychiatric care focused on the use of medication, a significant proportion of children and adolescents may need treatment that is more intensive, and more expensive, than therapy restricted to the use of drugs. Loss of access to this type of care, what psychiatrists call "relationship-based

psychiatric care," has been happening out of public sight. Using low reimbursement rates and bureaucratic hurdles to discourage the delivery of relationship-based care, managed care companies appear to be forcing many Connecticut child and adolescent psychiatrists out of managed care, making it increasingly difficult for many middle income children and adolescents to have adequate access to psychiatric care or to receive the relationship-based treatment that was formerly the standard of care. For many young people, the psychiatric care available appears to be either drugs, or nothing.

Many psychiatrists have recognized these changes. Their deep regret and indignation is expressed unequivocally, so that one doctor can write that managed care is "...bilking patients, hospitals and doctors of millions, billions and trillions for a cheap product, not consistent with our values, our best interest, or our expanding knowledge and capabilities" (Survey #40).

Several practical measures would do much to improve access to quality care:

1. Managed care companies must be required to accurately inform enrollees concerning the child and adolescent psychiatrists participating in their networks. The plans must police and oversee their provider panels so that enrollees can rely on the accuracy of participating provider lists.

2. Plans must be required to canvas participating providers regularly to determine those providers who are actually available to see enrollees seeking to begin treatment. This information must be made easily available to enrollees so that they are not required to telephone their way through the provider list only to be told that participating psychiatrists are not participating after all, or are not seeing new patients.

3. Managed care plans must take steps to insure that children and adolescents with urgent care needs can be seen by participating doctors without delay. These companies cannot be

permitted to abdicate their responsibility for operating plans that work, where patients with immediate need for care can secure immediate attention.

4. Managed care companies should be required to pay psychiatrists fees that are reasonably related to the time required to deliver relationship-based care when needed, and to cease abusive coverage determination practices, so that doctors enroll in, and continue on managed care provider panels. In addition, reimbursement to child and adolescent psychiatrists should be adequate to encourage treatment for patients who need more than medication alone.

Based on the information we have received, the managed care companies serving our state are breaking their promises, implicit in their contracts with employers and enrollees, to make available participating physicians ready and able to deliver the medically necessary psychiatric care needed by the children and adolescents enrolled in their plans. The crucial choices controlling access to this care can no longer be left to the managed care industry. The Connecticut General Assembly must adopt measures to ensure that our children receive the medically necessary psychiatric care they deserve.

II. INTRODUCTION

Richard Blumenthal, Attorney General of the State of Connecticut, and Jeanne Milstein, Connecticut Child Advocate, issue this joint report addressing the availability of child psychiatric care. This report incorporates information received from a survey of Connecticut child and adolescent psychiatrists, and is part of the ongoing investigation by the Attorney General and the Child Advocate of the mental health care available to Connecticut children.

Over the past several years, advocates at the Office of the Attorney General and the Child Advocate have received many complaints from parents describing their difficulty arranging psychiatric care for their children. Typically, parents will explain that their family is covered by a managed care health insurance plan obtained through their place of employment. Faced with a child's need for the care of a psychiatrist -- for severe depression, for example -- the parents search for a psychiatrist who will accept their insurance and treat their son or daughter. Repeatedly, parents report that they cannot find a participating psychiatrist to treat their child.

We have also received complaints from parents who were dissatisfied with what they describe as hurried and infrequent psychiatric visits focused solely upon the use of prescription medication. For example, single parent D.C. of W., Connecticut, recently told us that her daughter C. had been adopted from an eastern European country and suffered from reactive attachment disorder, bipolar disorder, oppositional defiance disorder, and impulse disorder. Mrs. C. looked for a child psychiatrist who could effectively treat her daughter. Mrs. C. sought to identify an expert physician by seeking referrals from other professionals in the field. The psychiatrists recommended, however, had waiting lists or were not accepting new patients at all.

Eventually, Mrs. C. was able to secure the services of an in-network psychiatrist to treat her child. This doctor could see the child one time per month at most. Often two or three months

would elapse between visits. The psychiatrist confined his treatment to the short visits necessary to re-prescribe medication because managed care companies would not compensate him for the longer visits associated with difficult cases requiring complex medication management or relationship-based care. Mrs. C. was very dissatisfied with the intensity and thoroughness of this doctor's care. The physician was not able to monitor the medications and evaluate their side-effects since he saw Mrs. C's daughter so infrequently. Mrs. C. told us that in a complicated case such as that presented by her child, a 15 minute visit one time per month was completely inadequate and ineffective.

Psychiatrists have also complained, often vehemently, about the pressures and constraints of managed care health insurance plans that the doctors say reduce the quality and the quantity of the care they can provide their patients. These psychiatrists say that managed care companies have reduced reimbursement to a level that covers only the brief visits necessary to re-prescribe medication. Doctors who attempt to bill for the longer visits associated with the appropriate treatment of more complex and difficult cases find that coverage is denied by the managed care company, or the company subjects the doctor to a punitive roadblock of repetitive requests for medical documentation and justification..

To investigate the availability of child and adolescent psychiatric care in Connecticut, the Attorney General and the Child Advocate decided to survey psychiatrists specializing in the care of children and adolescents to determine whether managed care companies have misstated the psychiatric care available under their plans, obstructed access to care, or lessened its quality. The survey was also intended to gather information on whether some managed care companies do a better job of supporting quality care than others (*see* Appendix at A-1).

III. OVERVIEW OF MANAGED CARE

A managed care plan provides for the delivery of healthcare services to people who enroll in the plan ("enrollees") in exchange for monthly premiums paid by enrollees and/or their employers. The managed care companies that operate managed care plans arrange for services to be delivered to enrollees by physicians, hospitals, and other care "providers." A crucial component of any managed care plan is the "behavioral health" benefit. Behavioral health care includes mental health and substance abuse services.

Managed care is "managed" because it closely reviews care -- both prospectively and retrospectively -- to determine whether the services involved are medically necessary and are included in the array of covered services. For example, a psychiatrist may have to submit information to the plan and obtain prior authorization before the doctor is permitted to deliver care to a patient. If the psychiatrist does not obtain prior authorization, the plan will deny coverage. The plan may also use retrospective review, where the psychiatrist delivers care to an enrollee and then submits a bill and supporting documentation to the plan. The plan may grant coverage, request additional information, or deny coverage. A coverage denial will, in some cases, force the psychiatrist to absorb the cost of the care.

The burden of managed care -- its procedural "hassles," the threat of lost income to the physician if coverage should be denied, and the fact that managed care, by reducing reimbursement to a level that covers only the short visits necessary to re-prescribe medication and by denying coverage to doctors who attempt to bill for the longer visits associated with the treatment of difficult cases, coerces doctors to focus solely on the use of prescription medication -- is a central theme in the survey results described in this report.

Crucial to the operation of managed care is the concept of physician "participation" on the plan's panel of "participating" care providers. A physician participates with a plan, and becomes part of the plan's "provider panel," when he or she signs a provider agreement with the plan agreeing that the participating physician will treat plan enrollees, charge the enrollees a specified co-insurance amount, and then bill the plan directly for reimbursement.

The participating doctor agrees to accept the amounts set out in the plan's fee schedule as payment in full. With the exception of co-insurance or deductible, a participating physician may not bill an enrollee for the cost of care. In exchange for agreeing to participate in the plan, the doctor is listed as a participating provider in the plan's printed and on-line directories. These are the main tools enrollees use to identify participating providers. Because the physician is participating, enrollees in the plan will seek out care from that doctor. Theoretically, at least, the doctor who participates in a plan will accept a lower reimbursement amount (as compared to the unregulated fee a non-participating doctor may charge a patient paying "privately" with his or her own money) in exchange for the opportunity to treat and bill for a high volume of plan enrollees.

A physician who chooses not to participate in a given plan may charge any fee to which the patient will agree. The non-participating physician is not required to accept the plan's reimbursement as "payment in full," and does not collect co-insurance. Instead, if the managed care plan has an "out-of-network" benefit, the plan will pay the psychiatrist a fee, often set at 80% of the reasonable and customary amount for the care at issue. The patient must pay the difference, often substantial, between the plan's reimbursement and the doctor's charge.

A psychiatrist may elect not to participate in managed care plans when he or she is able to treat a sufficient number of patients and bill them privately so that plan participation is not an economic necessity.

Because of the high cost of psychiatric care, many enrollees must seek care from participating physicians so that their liability for the cost of care is limited to deducible and co-insurance. Only relatively affluent patients are able to pay their share of the high charges assessed by non-participating psychiatrists.

When the plan does not have an "out-of-network" benefit, no plan coverage at all is available for the services of the non-participating physician, and the patient or family must pay the entire fee out-of-pocket. Cigna Healthcare of Connecticut, for example, has 237,477 Connecticut residents enrolled in its managed care plans. Of these enrollees, 53,609 have no out-of-plan benefits. They must find participating psychiatrists willing to treat their children, pay 100% of the high fees of out-of-network doctors, or see their children go without care.

A central focus of this report is the availability of participating psychiatrists. Because of the high cost of care received from non-participating doctors, if an enrollee is unable to locate a psychiatrist participating in the enrollee's managed care plan, that enrollee will, in many cases, be forced to go without medically necessary care.

IV. THE SURVEY

The survey instrument was developed with the assistance of Connecticut psychiatrists, including leadership of the Connecticut Council of Child and Adolescent Psychiatrists, and the New Haven Private Practice Community, as well as David I. Gregorio, PhD., MS, director of the graduate program in public health at the University of Connecticut Health Center in Farmington, Connecticut.

The survey form contained seventeen questions. It solicited information concerning psychiatric training and the geographical location of practice, and asked doctors to indicate the

plans, if any, in which they participated. It called for psychiatrists to rank the seven major managed care plans in Connecticut according to a range of criteria linked to the availability and quality of psychiatric care. The doctors were also asked to indicate why they had chosen not to participate in particular managed care plans. In addition, doctors were requested to compare the current managed care system to the financing system that existed before managed care, and they were requested to express their agreement or disagreement with the assertion that managed care has forced many child and adolescent psychiatrists to abandon the ongoing relationship-based psychotherapy that is the central component of quality psychiatric care.

To select the psychiatrists to be surveyed, we enlisted the help of managed care plans and psychiatrists. Because the survey is intended in part to highlight differences between psychiatrists participating on the provider panels established by managed care companies with psychiatrists not participating, we sought to identify a broad cross-section of psychiatrists specializing in childhood and adolescent psychiatry, both those participating in managed care plans and others not participating. Accordingly, we obtained from the seven managed care plans the lists of participating psychiatrists whom the plans have designated as available to treat children and adolescents. We also obtained a list of the membership of the Connecticut Council of Child and Adolescent Psychiatrists, Connecticut's principal professional organization for this specialty. We combined the eight lists into one non-duplicated list of 526 physicians either designated by managed care plans, or self-designated, as specializing in the treatment of children and adolescents.

On September 15, 2006, we sent a survey to each of the 526 psychiatrists on the master list, together with a cover letter from the Attorney General and the Child Advocate explaining the purpose of the survey and requesting cooperation (*see* Appendix at A-5). These physicians were

assured of confidentiality pursuant to Conn. Gen. Stat. §46a-14n(a). Officers of the Connecticut Council of Child and Adolescent Psychiatrists and the New Haven Private Practice Committee also wrote to the psychiatrists on the list and urged them to complete and return the survey.

By December 12, 2006 we had received 179 completed survey returns, 34% of the 526 responses we solicited. Our technical advisors tell us this response rate is typical for surveys sent to health care practitioners. Although it is possible that psychiatrists more critical of managed care were more likely to return their surveys, we believe that the information we have received points to real problems adversely affecting the lives of Connecticut children.

With the help of Professor David Gregorio and his associate Holly Samociuk at the University of Connecticut Health Center, the survey responses were entered into a computer program that permitted us to create reports of the survey results. We prepared three principal reports: first was a report showing the responses of all 179 responding physicians (Report 1). (Appendix at A-6).

The second report shows the survey results divided to show data for the physicians who were identified by at least one of the seven managed care companies as participating in their plan (Report 2-A), versus those physicians who had not been designated as participating by any plan (Report 2-B). (Appendix at A-16, and A-24, respectively).

Finally, we prepared a third report focusing on the accuracy of the participating provider lists supplied to us by the seven Connecticut plans (see page 23).

V. THE SURVEY FINDINGS

A. PSYCHIATRISTS HARSHLY CRITICAL OF MANAGED CARE.

The survey instrument urged respondents to "[u]se the area below if you wish to add more information or express your views more fully." Forty-five physicians accepted this invitation and augmented their survey responses with written remarks. Several respondents covered a whole page, or more, with detailed observations about the effect of managed care on child and adolescent psychiatry. The number of the comments, and their angry eloquence, were unexpected. They have supplied a rich vein of information that has added greatly to the findings of this study. Moreover, the complaints of the psychiatrists who expressed their opinions in writing were strikingly consistent with the data collected in the body of the survey.

The forty-five comments touched repeatedly on several main themes:

1. Responding psychiatrists say they have been forced to abandon psychotherapy in favor of medication.

Twelve doctors asserted that managed care forces psychiatrists to abandon relationship-oriented child and adolescent therapy and restrict care to the use of medication. One doctor observed that "[m]ost children require much more than a prescription in order to make gains...." This physician argued that low reimbursement, the fact that managed care companies will not pay enough to compensate doctors for longer visits, "... forces child psychiatrists to see patients for shorter sessions and to focus on medication rather than the much needed bond between child and doctor" (Survey Return #166). Another physician maintained that with the current managed care system:

> A number of mds had been tempted to abandon psychotherapy in favor of pure med management by differential reimbursement. This narrows patient options to a few dedicated clinicians, and a variety of half-trained supporting non-mds. Meanwhile stigma has decreased so total demand is greater for fewer well-trained psychotherapists

(md and non-md). The result is many children taking multiple drugs without significant effect and getting not even an evaluation of their family structure and strictures, the world they face.

(Survey Return #60).

Several psychiatrists complained about having their care decisions ignored by untrained insurance company workers, "[u]nsophisticated twenty year olds with a list of criteria are making decisions...."[2]

2. Many responding psychiatrists believe that low pay and harassment by managed care companies have made quality psychiatric care impossible.

We received eleven comments complaining about low managed care reimbursement rates. Another ten comments focused on the "hassle" factor: excessive paperwork, redundant information requests, and "lost" claims. One veteran psychiatrist told us that "I quit my practice of thirty years because of current payment and management climate. ... at the height of my ability to be of help, I left."[3] Another doctor remarked that "MC [managed care] has truly killed psychiatry as a profession. ... I get paid [about] $90 [for a] 45 – 50 [minute] session to deliver meds and psychotherapy. My private fee is $170 for this. Can you blame us for getting away from mc?"[4]

[2] "Unsophisticated twenty year olds with a list of criteria are making decisions about the care of children with complex psychiatric and behavioral disorders that only we as child psychiatrists are coming to diagnose and treat effectively, e.g. bipolar disorder. Because money is the bottom line of insurance companies [,] psychiatrists who are "in network" and are required to fill out OTR's {Outpatient Treatment Reports} are being coerced into prescribing medications well before they might otherwise in order to obtain more sessions. This is a major reason not to be on a [participating physician] panel" (Survey Return #79).

[3] "I quit my practice of thirty years because of current payment and management climate. I am not accepting new patients means that I am not willing to accept the loss of respect, freedom and compensation of pre-managed care. I can now only work for institutions that will buffer me from dealing with the insurance (payment and contracting) morass. At the height of my ability to be of help, I left" (Survey Return #27).

[4]MC [managed care] has truly killed psychiatry as a profession. Emphasis has been on [a] psychiatrist as a fifteen minute session medication prescriber. One can make a decent mc/psychiatry living. I get paid [about] $90 [for a] 45 – 50 [minute] session to deliver meds and psychotherapy. My private fee is $170 for this. Can you blame us for getting away from mc? (Survey Return #34).

3. Many responding doctors believe that managed care companies are acting in bad faith, and are motivated by a dishonest desire to suppress coverage for medically necessary care.

Several physicians expressed their belief that managed care companies are essentially dishonest, aiming to make money by cheating patients and doctors. "The actual goal of insurers has been to deprive children of services through every possible ruse" (Survey Return #155). Some doctors focused on the conflict of interest inherent where a managed care company stands to make money by denying services: "Any health system based on a third party making money by cutting benefits and [increasing] paperwork and not participating in care is unbelievable!!" (Survey Return #167). The attitude of many responding psychiatrists towards managed care companies may be summed up by the expression of one particularly frank physician: "I hate insurance companies – Big Fat Liars!!" (Survey Return #104).

4. Most doctors responding say that access to quality care has been diminished.

The child and adolescent psychiatrists who responded to our survey questionnaire were also concerned about the diminished quality of psychiatric care available to children and adolescents under managed care. One physician wrote:

> Insurance companies appear to be preventing access to care by not having adequate clinicians on their panels, both in terms of quality and quantity of clinicians. In my private practice world, it is impossible to be on panels as the paperwork and telephone time is exhaustive and non-reimbursable, the reasonable & customary payments are arbitrary and not adequate, treatment decisions are made by individuals within the insurance companies that have never seen the children and/or families; and even if they had seen the patients, often they do not appear to have adequate training to make such decisions. . .based on my experience (and that of others), it appears as if the vast majority of Americans who rely most heavily on insurance-i.e., the middle class -- are excluded from adequate access to quality care for their children because of the insurance companies.

(Survey Return #120).

A striking example of the access-limiting effect of managed care is seen in the remarks of a psychiatrist who candidly admits that he excludes from access to his care patients whose claims the doctor believes will cause him difficulty with managed care companies: "As a solo practitioner I try to carefully screen who I take so as not to take families and patients who will drain excess energy due to insurance hassles" (Survey Return #135).

The thoughtful letter composed by one child and adolescent psychiatrist aptly summarizes the views of many of the doctors who commented in writing:

> ...as I noted in some of my responses, I had stopped working with all insurance companies because of the numerous issues involved in doing so. I simply don't have the time or patience to go through their various, often bizarre policies in order to get reimbursement. Most of my colleagues in this area have been forced to follow suit. I have, however, worked closely with many of my patients to help them get reimbursement. It has been baffling at best. Among the various "excuses" my patients are given by their carriers as to why reimbursement is either delayed or rejected are: ●The claim is lost or was never received. ●My medical license number or EIN doesn't appear on the claim (when it is pre-printed on all of my bills). ●There is no diagnosis code on the bill (when there IS a diagnosis code on the bill). ●There is no CPT code on the bill (when there IS a CPT code on the bill). ●The handwriting is illegible (my handwriting is incredibly neat). ●The patient doesn't exist. ●And the latest – the diagnosis code had "expired" (no idea really, what this means). Going through these EOB's [explanations of benefits] with my patients leaves us feeling fairly certain that the insurance companies are "just trying to make it difficult" in the hope that the patients will give up in frustration (which many of them in fact, do). To say that families in need of psychiatric care for their children are unfairly burdened financially by unfair policies of their carriers has absolutely been my experience, and I believe, is in fact a gross understatement.

(Survey Return #140).

B. DATA REPORTS

1. Report Number 1 – Consolidated report of all practicing child and/or adolescent psychiatrists responding.

We received 179 returned surveys. Of this number, 131 were from psychiatrists actually practicing child and/or adolescent psychiatry. Forty-two of the 179 doctors indicated that they

did not treat children or adolescents, and six surveys were returned with most or all of the survey questions left blank. Report Number 1 is the most general report we have included here because it combines both those psychiatrists who say they participate in one or more managed care plans, together with those psychiatrists who say they do not participate in any of the seven managed care plans. (Appendix at A-6). We discuss below several of the most important aspects of this data.

a. *Responding psychiatrists report in a significant proportion of cases substantial and potentially dangerous delays before new patients with "urgent" problems can be seen.*

The responses to survey question number 10 show that 103 respondents indicated their typical waiting time before they are able to see particular classes of patients. The replies for patients needing urgent care were particularly interesting. Of 103 physicians responding, seventeen, or **16%, said urgent self-pay patients would typically wait between 8 and 14 days** before being seen by that psychiatrist. Another 12 physicians, or **12% of the total answering, indicated that urgent self-pay patients would typically wait more than 14 days before being seen.**

Waiting times were comparable for insurance plan enrollees needing care on an urgent basis. Twelve of the 76 doctors responding, or 16%, of physicians indicated that such patients would have to wait between 8 and 14 days for an appointment, and **another 16% of** the physicians indicated such patients would have to wait more than 14 days to be seen. Thus the risk that a patient needing urgent psychiatric care will be unable to receive care within a reasonable time appears to be significant whether the patient seeks care from a participating or a non-participating doctor. This finding suggests a dangerous shortage of child and adolescent psychiatrists across the board.

b. *Responding psychiatrists generally rate managed care plans as poor or below average in fairness of reimbursement, beauracratic "hassle" and support of quality care.*

In question 15, the doctors were requested to rate the seven managed care plans according to fairness of reimbursement, coverage denials, bureaucratic hassle, and support of quality care. This question called for the doctors to express their subjective judgment, rather than use an objective standard. All seven managed care plans were rated poor or below average in fairness of reimbursement by a majority of responding physicians. Most unfavorably rated was Oxford, which was found poor or below average by 80% of the doctors.

Poor or below average ratings for "bureaucratic hassle" range from 47% (Aetna) to 67% (Oxford). Poor or below average ratings for "support of quality care" range from 33% (Health Net) to 68% (Oxford).

c. *Responding psychiatrists assessed the present managed care system as "much worse" than the previous "fee-for-service" financing system.*

Question 16 of the survey asks physicians to rank the current managed care system in comparison to the financing system existing before managed care in terms of ability to access psychiatric care, the financing available to support quality psychiatric care, the availability of fair reimbursement to providers, wasteful and obstructive procedures and paperwork, and the allowance of coding for the full range of mental health services necessary. This question calls for the doctors to express their subjective opinions, not to use particular objective criteria. For every criterion, a majority of the responding physicians rated the current managed care system "much worse" compared to the financing system existing before managed care ("fee for service" reimbursement).

d. *Responding psychiatrists say managed care has degraded the availability of quality psychiatric care.*

In question 17, physicians were asked to evaluate the following statement: "Managed care companies' emphasis on empirically tested, symptom-focused care, subject to the requirement of prior authorization of coverage, has forced many child and adolescent psychiatrists who participate in managed care plans to abandon the ongoing relationship-based psychotherapy that is the central component of quality psychiatric care." Sixty percent of the 119 physicians responding strongly agreed with this statement. Eighty percent either agreed or strongly agreed.

2. Report Number 2 – Participating versus non-participating psychiatrists.

a. *Nearly half of all responding child and adolescent psychiatrists do not participate in any managed care plan.*

Our second report (*see* Appendix at A-16, A-24) compares the responses of the practicing psychiatrists who indicated in their survey returns that they **did not** participate in any of the seven major Connecticut managed care plans with those physicians who reported that they **did** participate in one or more of the seven plans.

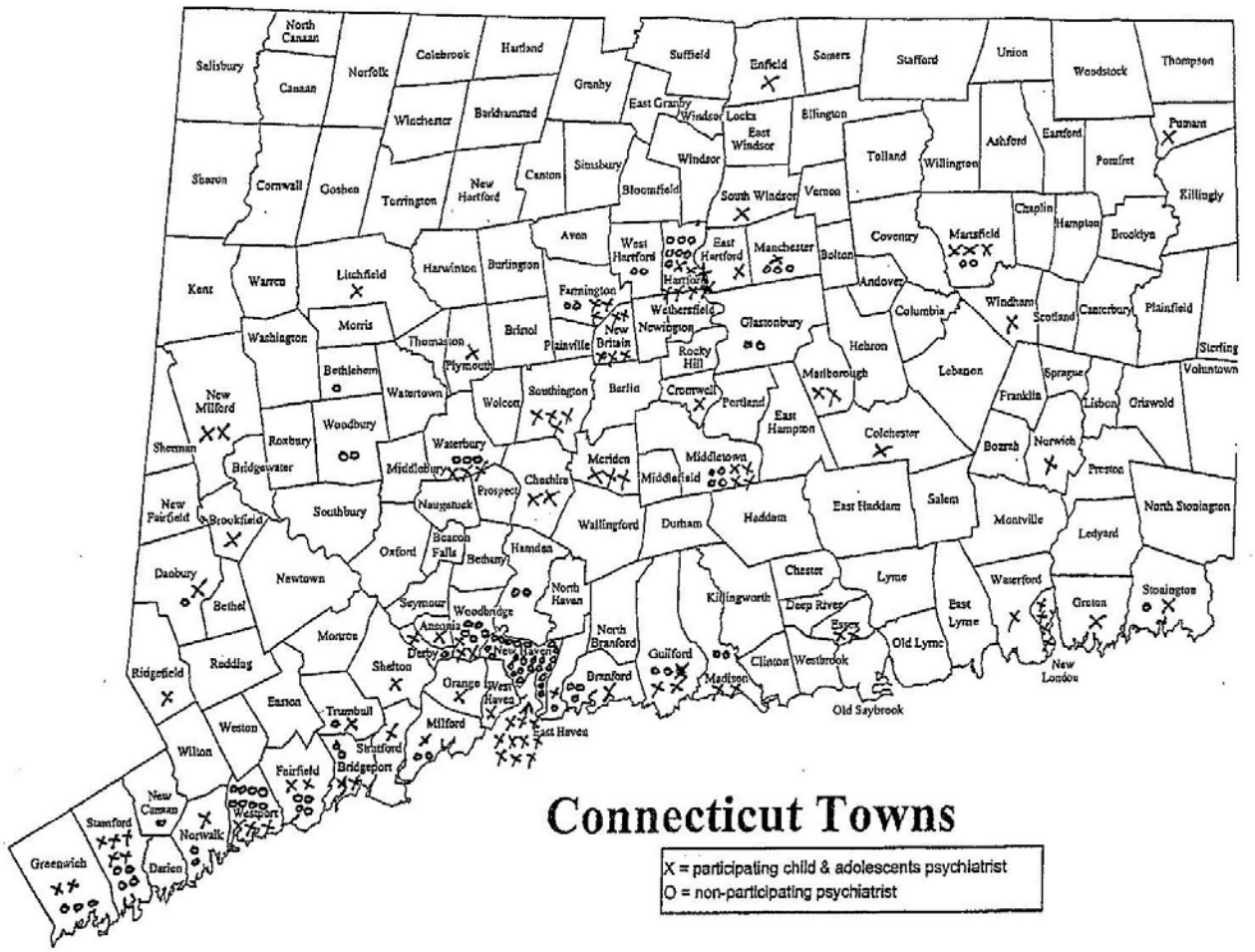
The first, and very significant revelation of this report is that non-participating physicians amounted to almost half of the total of practicing child and adolescent psychiatrists responding to the survey. Sixty-two, or 47% of the total of 131 practitioners, did not participate, compared to 69, or 53% of doctors who participated in one or more managed care plans. According to this data, nearly half of all responding child and adolescent psychiatrists are unavailable to treat managed care plan enrollees unless those enrollees are willing to pay part, or all, of the high private fees typically charged by non-participating doctors.

b. *Most of the responding doctors who have advanced certification in child and adolescent psychiatry do not participate in managed care.*

Survey question number 1 queries psychiatrists concerning their training. Some physicians have the advanced training described as "board eligible" or "board certified" in child and adolescent psychiatry. Other psychiatrists are board certified or board eligible in general psychiatry. Finally, several physicians are board certified or board eligible in pediatrics. Report number two shows that 38 of the 69 participating physicians, or 55%, are either board certified or board eligible in child and adolescent psychiatry. In contrast, 52 of the 62 non-participating physicians, or 84%, are board certified or board eligible. Consequently, non-participating physicians in our summary have a higher proportion of board certifications than participating doctors. Moreover, of the 90 doctors who report themselves to be either board certified or board eligible in child and adolescent psychiatry, 52, or 58%, were not participating. Thus most physicians either board certified or board eligible in child and adolescent psychiatry responding to our survey do not participate in any major Connecticut managed care plan.

c. *Responding psychiatrists reporting that they have been forced out of managed care have created a parallel care delivery system financed by enrollees' out-of-pocket payment.*

Judging from the responses received, participating and non-participating child and adolescent psychiatrists co-exist side-by-side in many areas of the state. The chart below is marked to indicate the practice locations of the 131 psychiatrists described in Report 2 (*see* Appendix at A-32 for this chart broken down by county):



The number and geographical location of responding participating and non-participating psychiatrists suggest that Connecticut is now operating with two parallel child and adolescent psychiatric care systems: one-half of the system appears to consist of psychiatrists participating in, and paid by managed care, while the other half of the care delivery system is apparently composed of doctors who refuse to participate in managed care. These non-participating psychiatrists are supported mainly by patients paying high fees out of their own pockets, with the addition of some managed care payment when the enrollee has “out-of- plan benefits” in his or her insurance plan.

For example, psychiatrists interviewed by telephone tell us that a typical private fee charged by a non-participating psychiatrist in the New Haven area might be $185 for a 50 minute session. If an enrollee has a managed care plan without an out-of-plan benefit, the enrollee will be forced to pay the full $185 out-of-pocket. If the enrollee's plan does have an out-of-plan benefit, the plan will typically pay the doctor about $125 per session, not much more than the plan would pay a participating physician. The enrollee will then be required to pay the psychiatrist the difference between the plan's payment and the doctor's fee – in this example, $60.

Doctors we have interviewed tell us that some psychiatrists in Fairfield County charge as much as $300 for a 50 minute session. If a family is enrolled in a managed care plan with an out-of-plan benefit, the plan might pay such a doctor $150, leaving the family liable for the $150 balance of the doctor's bill.

Plans with out-of-plan benefits are more expensive than plans with only in-plan coverage, because "richer" plans naturally require the payment of higher premiums. An enrollee of more modest means is more likely to have a less expensive plan that pays only for the services of participating psychiatrists. This enrollee, unable to locate an in-plan psychiatrist to care for his or her child, must therefore pay the non-participating doctor's whole fee in cash or dispense with care altogether. Ironically, enrollees able to afford the higher premium are more likely to purchase out-of-plan benefits. When these enrollees are forced to seek the care of a non-participating psychiatrist, at least they will receive some assistance in the form of out-of-plan coverage. Thus families who can least afford to pay for psychiatric care end up paying the most.

Patients paying privately for psychiatric care are usually enrolled in managed care plans. Managed care companies avoid paying for some or all of the care needed by these enrollees because they have succeeded in driving many experienced and qualified child and adolescent

psychiatrists out of managed care. As we have seen, responding child and adolescent psychiatrists believe they are grievously underpaid by managed care. The responding doctors resent what they see as abusive paperwork and procedures designed to defeat access to coverage and limit care to the administration of medication. The responses to our survey indicate that, when they can, many psychiatrists leave managed care so they can practice free from managed care harassment. Patients end up paying part or all of the fees charged by these out-of-plan physicians. The end result is that managed care appears to have succeeded in transferring a major proportion of the cost of child and adolescent psychiatry to enrollees who reasonably expected that their insurance would cover the care their children needed.

Report Number 2 also shows in the response to question 16 that both participating and non-participating physicians generally believe that the current managed care system is much worse than the financing system that existed before managed care.

In their response to question number seventeen, a large majority of both participating physicians (85%) and non-participating doctors (92%) agree or strongly agree with the survey's statement faulting managed care for abandoning relationship-based psychotherapy.

3. Report Number 3 –Managed care plan participation lists are inaccurate; all seven managed care plans have misstated the physicians on their participation lists. Aetna and Cigna have radically overstated the number of doctors participating in their networks.

Report Number 3 focuses on the accuracy of the participating provider lists supplied to us by the seven Connecticut plans. To determine whether the managed care plan participation claims were accurate, we compared the names on the plan lists to the responses given on the survey form by the 147 doctors whose returns we were able to identify. The identities of the doctors who submitted the other thirty-two surveys (for a total of 179 returns) are unknown to us.

To determine the actual availability of child and adolescent psychiatrists claimed by managed care plans to be participating in their provider networks, we first looked to see which of the 147 psychiatrists were listed by the plans as participating on their provider panels. We then examined the survey responses to determine, of those doctors claimed as participating by a given plan, how many doctors reported that they are not participating with that plan, are not treating children adolescents, or are retired. We also examined the survey responses to determine those doctors who say they are participating but are not currently accepting patients, or who can see patients only after a delay exceeding four weeks.

The results of this analysis are reflected in Report 3 below:

REPORT 3: Accuracy of Managed Care plan participation lists; Comparison of plan lists to information contained in surveys.

Of the 147 doctors whose returns investigators have identified:	**Aetna**	**Anthem**	**Cigna**	**Connecti-Care**	**Health Net**	**Oxford**	**United Healthcare**
1. Number of doctors who appeared on plan's participation list;	54	22	50	24	32	9	25
2. Number of doctors on plan participation list who reported that they were not participating with that plan, are not treating children or adolescents, or are retired.	31	3	26	7	6	1	6
3. Number of doctors who say they are participating but are not currently accepting patients.	6	6	6	4	4	3	5
4. Number of doctors who say they are participating but can see patients only after a delay exceeding four weeks.	4	2	3	1	1	1	2
5. Of doctors claimed by plans, how many are actually available to see patients within four weeks. (row 1 – rows 2 + 3 + 4)	13 (24%)	11 (50%)	15 (30%)	12 (50%)	21 (66%)	4 (44%)	12 (48%)

Report 3 shows that every plan claimed as participating at least one doctor who denied participation with that plan, was not treating children or adolescents, or was retired. ConnectiCare apparently misstated the participation status of 7 doctors, Health Net 6, Anthem 3, UnitedHealthcare 6, and Oxford 1.

Two managed care plans, however, appear to have radically misstated their participating doctors. Aetna claimed 31 psychiatrists, and Cigna claimed 26, who reported that they are not on that company's provider panel, are not treating children or adolescents, or are retired.

In addition, even where a plan accurately reported that a particular doctor was participating on that plan's provider network, a significant number of the responding participating doctors reported that they are not actually available to see new patients. If the number of responding participating doctors claimed by the plans is compared to the number of responding doctors who deny that they are participating, are not treating children or adolescents, are retired, or are not accepting patients or seeing patients only after a delay exceeding four weeks, the number of responding participating physicians claimed by the plans who are actually available to treat plan enrollees within a reasonable time drops, in most cases, to one half or less of the total claimed by the plans. Thus Aetna reported that 54 of the 147 sample doctors were participating on Aetna's panel of child and adolescent psychiatrists. 31 of these 54, however, denied that they were participating, were not treating child or adolescents, or were retired. An additional 10 of the 54 were participating but not accepting new patients, or seeing new patients only after a delay exceeding four weeks. Thus only 13 doctors of the original 54 claimed by Aetna, or 24%, were actually available to see plan enrollees seeking to begin treatment.

VI. CONCLUSION

The results of this survey, both the data collected and the written remarks of child and adolescent psychiatrists, show that countless children and adolescents are receiving inadequate psychiatric treatment, or no treatment at all. Although some patients may be adequately served by psychiatric care focused on the use of medication, a significant proportion of children and adolescents may need treatment that is more intensive, and more expensive, than therapy restricted to the use of drugs. Loss of access to this type of care, what psychiatrists call "relationship-based psychiatric care," has been happening out of public sight. Using low reimbursement rates and bureaucratic hurdles to discourage the delivery of relationship-based care, managed care companies appear to be forcing many Connecticut child and adolescent psychiatrists out of managed care, making it increasingly difficult for many middle income children and adolescents to have adequate access to psychiatric care or to receive the relationship-based treatment that was formerly the standard of care. For many young people, the psychiatric care available appears to be either drugs, or nothing.

Many psychiatrists have recognized these changes. Their deep regret and indignation is expressed unequivocally, so that one doctor can write that managed care is "...bilking patients, hospitals and doctors of millions, billions and trillions for a cheap product, not consistent with our values, our best interest, or our expanding knowledge and capabilities" (Survey #40).

Several practical measures would do much to improve access to quality care:

1. Managed care companies must be required to accurately inform enrollees concerning the child and adolescent psychiatrists participating in their networks. The plans must police and oversee their provider panels so that enrollees can rely on the accuracy of participating provider lists.

2. Plans must be required to canvas participating providers regularly to determine those providers who are actually available to see enrollees seeking to begin treatment. This information must be made easily available to enrollees so that they are not required to telephone their way through the provider list only to be told that participating psychiatrists are not participating after all, or are not seeing new patients.

3. Managed care plans must take steps to insure that children and adolescents with urgent care needs can be seen by participating doctors without delay. These companies cannot be permitted to abdicate their responsibility for operating plans that work, where patients with immediate need for care can secure immediate attention.

4. Managed care companies should be required to pay psychiatrists fees that are reasonably related to the time required to deliver relationship-based care when needed, and to cease abusive coverage determination practices, so that doctors enroll in, and continue on managed care provider panels. In addition, reimbursement to child and adolescent psychiatrists should be adequate to encourage treatment for patients who need more than medication alone.

Based on the information we have received, the managed care companies serving our state are breaking their promises, implicit in their contracts with employers and enrollees, to make available participating physicians ready and able to deliver the medically necessary psychiatric care needed by the children and adolescents enrolled in their plans. The crucial choices controlling access to this care can no longer be left to the managed care industry. The Connecticut General Assembly must adopt measures to ensure that our children receive the medically necessary psychiatric care they deserve.

APPENDIX