Report On Improving Access To Psychiatric Care For Privately Insured In Howard County, MD

Funded by Howard County Government through Howard County Mental Health Authority (HCMHA)

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OVERVIEW

Howard County Government provided funding in the FY 2017 budget to the Howard County Mental Health Authority (HCMHA) to address concerns regarding individuals with private insurance having difficulty getting access to mental health/substance use/behavioral health care. Although this issue seems to be with mental health/substance use/behavioral health care in general, for our purposes we focused on psychiatric outpatient care. There were complaints of a low number of psychiatrists taking new patients and the lack of providers paneled with private medical insurance. The challenges faced by individuals with private insurance accessing care may result in not seeking the care they need or paying out-of-pocket. The financial strain of paying out-of-pocket can in itself be a hindrance to seeking treatment.

In May of 2017, the HCMHA completed a County-Wide Behavioral Health Needs Assessment and FY 18-22 Strategic Plan that included feedback from multiple stakeholders including: consumers, family members, and advocacy groups. One of the top three areas of need identified in this assessment process was "Increased Affordable and Accessible Behavioral Health Providers that take insurance and offer convenient hours and locations (especially Psychiatrists)".

Obtaining information to examine this identified need was addressed in three ways – directly from local psychiatrists (via informal interview and/or surveys), meeting with representatives of the Maryland Insurance Administration (MIA), and meeting with representatives of major insurance companies. The information obtained will be discussed separately in the following sections.

Psychiatrist interviews

Contact information for a total of 69 psychiatrists in Howard County was collected from various sources (HCMHA, Maryland Psychiatric Society, and American Psychiatric Association). We were able to obtain feedback from 23% of the psychiatrists listed. The age range of the respondents was 51 to 82 years old. The years of professional experience ranged from 21 to over 40 years. 78% of the respondents were associated with a solo practice.

- Of the responses, 67% reported that they accepted private insurance of some type.
- Of the psychiatrists who are currently not accepting private insurance, 71% reported that they accepted private insurance in the past and subsequently dropped insurance panels. (If you include the individual who was once previously contracted/salaried by a clinic that did accept insurance prior to starting their own independent practice the percentage increases to about

86%).

- 88% of the respondents related that they were accepting new patients in some capacity. The estimated waiting time for a first appointment ranged from two weeks to two months. The discrepancy between this high percentage rate and the perception that practices are not accepting new patients may be because some practices are limiting referrals (i.e. accepting patients only from limited referral sources, limiting the number of new patient intakes per month).
- Of interest, 57% of the psychiatrists who were not accepting private insurance continue to see patients with Medicare. Many of the patients aged into Medicare while receiving care and some psychiatrists felt a responsibility to serve this population.

By vast majority, the underlying reason why practitioners were not accepting insurance was essentially financial. Both psychiatrists who accepted insurance and those who did not were concerned about the reimbursement rates and the challenges of receiving payment. [Attachment 1 is an unofficial list of the reimbursement allowable of various insurance companies obtained from a clerk at a billing service.] When discussing financial aspects, it encompasses not only the low reimbursement rate payment amounts but the overhead associated with taking insurance (i.e. someone to do the billing, having an EHR to help facilitate billing, the cost of maintaining the system) and running a practice. The other major deterrent is not wanting to deal with the "hassles" (a word that came up a lot) of dealing with the insurance companies. The "hassles" frequently described included delayed payments, errors in computer systems, payment glitches, documentation, bureaucratic tangles, and pre-authorizations/pre-certifications (and further payment not guaranteed with pre-authorizations). Some respondents conveyed being demoralized by documentation and devalued by the companies. There were also concerns of insurance companies indirectly dictating care (i.e. unable to do therapy because it pays nothing). It appears, reimbursements do not encourage other types of treatment besides 15 minute medication checks. In addition, some psychiatrists felt that a lot of what they do is "uncodeable". The feeling is that insurance companies do not reimburse for services performed. One person put it succinctly "without insurance, now it's straight forward – see people, get paid".

When discussing, how to possibly entice psychiatrists to become involved with insurance panels, the response was unanimous to improve reimbursement rates, followed closely and intertwined with simplifying the process. Dealing with the insurance companies was described as an adversarial process. This would have to change if there is to be any progress. There is the belief that the goals are not the same. "We are not a team – with insurance, cost not care is the focus". "Healthcare is not a productivity model – at least it should not be."

It was noted that it would probably be particularly difficult to convince psychiatrists to panel with insurances in this area because financially patients can pay (and some prefer to pay) out-of-pocket.

A barrier that was identified in general (not only for individuals with private insurance and not just in the area) was the shortage of psychiatrists. This is a nationwide issue. Although Howard County has a higher percentage of psychiatrists than many areas, psychiatrists are busy and practices are full.

A surprising item that recurrently came up as a perceived barrier for patients with private insurance obtaining care was “phantom panels”. Phantom panels are inaccurate insurance lists or websites/rating sites. This can lead to confusion and frustration for people seeking help. Since this population may be suffering from low motivation and/or impaired functioning, any hurdles could increase chances of them abandoning following through with their pursuit to obtain treatment.

There also seems to be a cultural shift with the new graduating psychiatrists. Two of the psychiatrists that provided feedback have been trying to recruit to their practices (one with the intent to eventually sell the practice to the new comer) and has not found anyone interested. It seemed that the younger psychiatrists were more interested in salaried positions rather than an income based on the fee for service model.

Although most of the psychiatrists providing feedback were not optimistic about the chances of recruiting more psychiatrists to accept insurance, many did have ideas that may help the problem of access to care, which are listed below:

- Develop a large group without walls (virtual group) therefore all with the same tax ID. This could lead to having more power to bargain with insurance companies. Privia Medical group is an example of this model.
- Indicating copayments on the insurance cards (i.e. PCP & specialist copay is on most cards) which may simplify the process.
- Increase more out-of-network benefits and Health Savings Accounts (HSA) which could make it easier financially for members to afford care.
- A system where patients carry cards with a magnetic strip or chip and could store medical information. This would cut down on administrative costs.
- Regarding faster access, developing an intermediate stop gap transitional process from ER or inpatient until individuals are able to obtain an appointment with a longer-term provider.
- Multidisciplinary groups or integrative care may be the future. Currently, most of these types of groups do not have a mental health component.
- Discussed some type of list serve that providers can utilize to share available openings to take patients, which may cut down confusion and/or frustration.
- It may be more enticing to become paneled if insurance companies are willing to pay for blocks of time used exclusively for insured patients (therefore providers get paid for reserved times whether patients are seen or not).

Another area reviewed was the utilization of Electronic Health Records (EHR). Most of the psychiatrists responded that they did not use an EHR (76%). The most frequently given reason was expense. Some going so far as to relate that they would not engage in this system even if it was provided for free – elaborating about the hidden costs of having an EHR. Examples of these hidden costs include installing the system, planning, training, initial data entry (time), maintaining the system, technical support (either contracting with a service or hiring staff), and security programs. Those that did use an EHR obtained it to assist with billing or electronic prescriptions.

Maryland Insurance Administration (MIA)

The Maryland Insurance Administration (MIA) is an agency whose goal is to provide efficient, effective service to both consumers of insurance products and the insurance industry. The primary role is to protect consumers from illegal insurance practices. Their responsibilities include (but are not limited to) protecting Maryland consumers by regulating the state's insurance companies and producers, as well as, investigating the complaints consumers have about their insurance coverage.

The meeting with MIA representatives revealed –

- MIA jurisdiction does not apply to employer self-funded plans. Self-funded plans are those where the employer pays for the individual's medical expenses, rather than contracting with a health plan to do so.
- Federal programs (such as Medicare, Medicaid, and Federal Employee Health Benefit Program) also fall outside of their jurisdiction.
- MIA jurisdiction (Maryland law) generally does not apply to insurance policies issued in other states. [This may be of growing importance in light of possible changes to health care with the current administration.]
- MIA is finalizing a Mental Health Parity and Addictions Equity Act (MHPAEA) survey/study regarding equity between mental health/substance use/behavioral health and medical somatic care, as well as, access to care. A copy will be sent when it is available.
- MIA responsibilities do not extend to issues regarding reimbursement rates
- The Council for Affordable Quality Healthcare (CAQH) is involved with credentialing. MIA is involved with reinforcing the credentialing process.
- If MIA is contacted about a mental health/substance use/behavioral health emergency, the insurance company has to respond to the complaint within a two hour window. MIA life and health insurance complaints line phone numbers are 410-468-2244, 410-468-2340, or 800-492-6116.
- Providers can file complaints with MIA on behalf of patient. This is not considered a HIPAA or confidentiality violation.

Insurance Forum

Feedback was obtained from representatives of major insurance companies in two forums. The insurance companies included Kaiser, Aetna, BCBS/Carefirst/Magellan, and Beacon.

With regards to efforts being made by insurance companies to recruit psychiatrists and improve access to mental health/behavioral health care:

BCBS/Carefirst/Magellan – Carefirst Platinum Program was started a year ago and offers a 15% higher allowable reimbursement rate. 38 behavioral health groups have signed including the following groups from Howard County: MSA, Joshi & Merchant, Congruent, Kolmac Clinic, Hope House, Oasis, Columbia

Counseling Center, Psych Associates of Maryland, and Safe Harbor Christian Counseling. CareFirst is also trying to ease access to care through programs such as My Care link up (which helps find appointments for members), Magellan Healthcare Provider Group program (MHPG provides care coordination; 80 members), Telehealth services are being expanded to include mental health (not necessarily psychiatry), and working on embedding therapists in pediatric and primary care settings. Single case agreements can be authorized under certain circumstances (i.e. specialty service not covered, if an in-network provider is not located within a reasonable distance from the member) with out-of-network providers.

Kaiser – relates it is always recruiting including hosting recruitment events in other cities. They offer positions with competitive salaries (not reimbursement based) and good benefit packages. Their system is designed to try to keep treatment within their network. They try to keep to in-network providers for same/next day appointments. Medical necessity may change this and member could be referred out to a contracted provider. They have crisis counselors available in-person, by phone, and via video.

Aetna – recognizes that there are psychiatry shortages across the board. In an attempt to improve access for behavioral health, there is recruitment of Internal Medicine physicians that are addiction certified. There is also recruitment of Nurse Practitioners. Aetna encourages members to use a linkage team for in-network and out-of-network providers. Some cases can be approved for billing as in-network if the linkage team is unable to adequately place the member with a suitable provider. If the wait is too long for an in-network provider, the team will first make contact as a reminder about contract obligations. If outside of Geo Access Standards (consumer's distance from provider's location), a single case agreement can be approved via the in network rate.

Beacon – Medicaid participants can only see Medicaid providers. There are no single case agreements.

There did not seem to be a concise answer regarding what factors go into determining reimbursement rates/allowables. BCBS/CareFirst was able to say there were more leveled rates for Preferred Provider Organization (PPO) and Health Maintenance Organization (HMO). Also, Care Coordination with Mental Health Provider Group (MHPG) deductibles are waived. Beacon rates are set through a standardized system. This is based on state structures and parity. It collaborates with Behavioral Health Administration (BHA) and other states with service grids.

They were not able to provide information on how Maryland's mental health/substance use/behavioral health reimbursement rates compare to other states or to other disciplines in Maryland.

The credentialing process (i.e. length) was identified as an issue in getting interested psychiatrists paneled with insurance.

- BCBS/CareFirst/Magellan remarked that presently, credentialing can take up to 200 days. Part of this may be due to their credentialing process being a two tier system. The first team approving for Magellan and HMO. The second team approving for PPO and Federal Employee Program (FEP) entities.

- Kaiser reports credentialing ("on boarding") takes approximately two to three months before a provider can start seeing patients.
- Aetna conveyed that credentialing usually occurs within 30-90 days. They use the Council for Affordable Quality Healthcare (CAQH), a nonprofit organization which houses a universal database for credentialing and re-credentialing (CAQH ProView). Sometimes delays are caused with issues in the process. Contract negotiations or change in status (i.e. group to solo practice) can also impact participation status. Aetna is looking at processes to ensure area improvements. They are trying to determine better ways to provide information up front about the credentialing process. They are looking not only at individuals and groups but also facilities. [It should be mentioned that issues with the CAQH system were mentioned by several of the psychiatrists interviewed. Some of the issues mentioned included inaccuracies in the data, cumbersome program, and difficulties in updating information or correcting errors.]
- Beacon's credentialing is handled through Maryland Medicaid. Beacon recognizes that the process is too long, but relates that their rates help to entice providers to endure the process. Some providers have stated that the population is too transient – many no shows.

Some common trends regarding denials for reimbursements –

- BCBS/CareFirst/Magellan – claims are not meeting medical necessity; inadequate information being provided. There can be administrative denial for a member who utilized an unlicensed facility.
- Kaiser has a team designated to ensure that documentation is accurate in order to reduce the number of denials.
- Aetna has a special investigations unit which is proactive with obtaining more information from the vendor and ensuring what is documented in the EMR lines up with verbal reports. Errors in the claim submissions overall – when claims do not always match pre-certification. Claims that require pre-certification include: Intensive outpatient, Partial Hospitalizations, Inpatient treatment, ECT, Neuropsychological testing, etc.
- Beacon – Pre-certification services not obtained, notes not completed, members not going to a Medicaid provider.

In concluding our meeting with the insurance company representatives, their ideas on how access to care for those that are privately insured seeking mental health/substance use/behavioral health services could be improved was discussed. There was agreement with the need to utilize creative, innovative ideas integrating technology. Telepsychiatry, as a modality, was brought up by more than one representative. It was deemed this could be particularly helpful with involuntary ER evaluations/admissions. Aetna is currently offering video screening over secure network (in NJ, PA). Kaiser anticipates video capabilities within mental health/substance use/behavioral health later this year. Increasing reimbursement rates and forming partnerships (i.e. helping to form groups, integrative care) was also discussed. Offering referral connect with specialty services will increase access to mental health/substance use/behavioral health care. A core idea was to somehow recruit incoming physicians into the field of psychiatry to address the shortage of psychiatrists.

CONCLUSIONS

In the course of examining the concerns about access to care for individuals with private insurance, two key issues were identified. One key issue being the difficulty of access to psychiatric care in general - regardless of insurance, no insurance, or willingness to pay out-of-pocket. This is felt to be due to the shortage of psychiatrists. A recent article in Psychiatric News (by Aaron Levin; 4/14/2017) said there is currently a 6.4% national shortage in the psychiatry workforce – this means the number of psychiatrists would need to increase by 2,800 to meet current demands for psychiatric care. The second key issue is the lack of psychiatrists participating with insurance plans for those who desire to use their insurance benefits.

The consensus is that access to mental health/substance use/behavioral health care is an issue (not only in Howard County). Unfortunately, there does not seem to be an apparent straight forward solution. It is a complex, multifactorial problem. The resolution for this challenge may be at a healthcare system/cultural level. To make headway, a change in the health care paradigm will be required.

AFTER ACTION

It is the hope that this document highlights some key problem areas, identifies the root causes and effects, and identifies some actionable recommendations for possible investigation/implementation. In FY 18, recommended action steps for the second year of the HCMHA's private insurance consultant are:

1) Consultant will assist consumers with private insurance seeking mental health/substance use/behavioral health services to navigate system of care and better access services. Consultant will provide monthly tracking reports which will include (but not be limited to) the following collected data:

*Number of Consumers Served
*Consumer Demographic Information
*Number successful in accessing what service and why
*Number unsuccessful in accessing what service and why
*Number of insurance industry contacts
*Number of new services or specialty codes added by which insurance company
*What insurance companies were receptive and why
*Any mental health parity issues resolved or unresolved and why
*The Number of contacts with any existing or new provider resulting in new capacity or willing to open to new clients and why

2) Explore the implementation, with the goal to operationalize, the following suggestions for access improvements resulting from Psychiatrists, Maryland Insurance Administration and Insurance Companies interviews. Those targeted for FY 18 are:

*Develop a List Serve for Central Access System to streamline referrals to psychiatrists

*Educate Howard County Residents on Maryland Insurance Administration Services and how to access those services
*In partnership with Providers and Insurance Companies, explore ways to reduce the error rate on claim submissions, reduce time to credential Providers, and work on the rate reimbursement system
*Create Workforce Development Plan for the expansion of the psychiatry workforce in Howard County
* Follow-up regarding request of public records pertaining to number of complaints to MIA.

3) Develop Advocacy Plan for working with Insurance Industry for appropriate behavioral health insurance reimbursement codes and rates, making sure specialists and specialized treatments are covered and accessible and that in-patient hospitalization and crisis services as recommended by the individual's treating physician is considered as part of the covered plan of care.

4) Create a network with insurance companies, advocacy organizations, and the Maryland Insurance Administration to address and resolve the issue of adequate providers on insurance panels for behavioral health treatment to assure that individuals can be seen within a reasonable timeframe.

5) Engage in Outreach activities to encourage all providers of behavioral health services (including nonprofits) to bill and collect from insurance companies in order to expand the local network of available resources.

6) Meet with Howard County Government to examine its own insurance programs in regard to behavioral health parity.

7) Create a small work team to partner with HCMHA Private Insurance Consultant in FY 18 to move selected result areas in the right direction and in a timely manner.

Attachment 1

Unofficial Reimbursement Allowable

Insurance Company	90792	99212	99213	99214	90833	90836
Aetna	$110.00		$45/$46	$70.80	$55/$40	$60.00
BCBS/Magellan	$155.08		$78.16	$114.94	$54.79	$90.94
BCBS Federal	$155.08		$78.16	$114.94	$54.79	$90.94
Cigna	$157.34		$54.96	$86.06	$40.00	$60.00
Kaiser						
United Health Care	$110.00	$40.00	$40.00	$53.00	$40.00	$60.00
Beacon MEDICAID	$154.71		$50.95	$108.04	$50.05	$92.76
Medicare	$147.06	$44.99	$74.94	$112.29	$67.50	$85.22

CPT Codes

90792 – Psychiatric Interview with Medical Services
99212 – Office Visit Established Patient 10 minutes
99213 – Office Visit Established Patient 15 minutes
99214 – Office Visit Established Patient 25 minutes
90833 – Psychotherapy with E/M code (16-37 minutes)
90836 – Psychotherapy with E/M code (38-52 minutes)