



Community Health
Access to Addiction &
Mental Healthcare Project

Office of
Mental
Health

Office of Alcoholism
and Substance
Abuse Services

Getting the most from your insurance benefits

RPC/CHAMP Webinar – May 9, 2019

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Ombudsman Program**

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Community Behavioral Healthcare**

Menu

- Defining the Issue
- Common Terms
- The problem, the solution, CHAMP
- Do New York State Laws apply to my insurance?
- What MH and SUD is covered by Commercial Insurance?
- What is in network vs. out of network?
- What is Utilization Review?
- What is an appeals process?
- Common Questions
- Resources





Overdose
does not
discriminate

STIGMA=DEATH

Stigma – Impact

- MH/SUD Stigma = shame and poorer treatment outcomes (Perlick, Rosenheck, Clarkin, Sirey et al., 2001).
- Negative public perceptions
 - people with MH/SUD are unpredictable and dangerous
 - SUD/MH conditions (eating disorders; depression) are self-inflicted



Stigma - Impact

- Suicide rate
 - increased by 28.8 percent between 1999 and 2016
(*CDC, 2017*)
 - 2nd leading cause of death among 13-19 yr olds
 - 4th leading cause of death among 35 – 54 yr olds
 - 2/3 of suicides – individuals never received help
- Stigma + lack of information = no treatment = death



Common Terms

- **Appeal** – the process where an insurer's decision to not cover a service is reviewed
- **Cost sharing** – this is money the covered person has agreed to pay when receiving services or prior to insurance taking effect, e.g. copayment, coinsurance or deductible.
- **Covered** – Insurance will pay for services
- **Network** – Providers who are contracted with an insurer to provide services at a mutually agreed upon rate
- **Utilization review** – An insurer or their agent looks at a service to determine if it is medically needed and appropriate, including review of medical records, clinical consultations, before, during or after services are rendered.



What's the problem?

- History of discrimination of SUD/MH community by health insurers
- 2015 Milliman study found in NY:
 - Individuals forced to go **out-of-network** for MH/SUD care more than for medical/surgical care
 - MH/SUD providers **paid less** than medical/surgical providers for exact same procedure codes
 - Disparities worsened from 2013 to 2015
- 6 Settlements by NY Attorney General against NY plans (2014-2016) found widespread parity violations



What's the problem?

- Commercial Insurance versus Medicaid Insurance Access
 - Kaiser study = adults with SUD w/ Medicaid 2X more likely to access treatment than those with commercial insurance
 - Weissman study in *Psychiatric Services* = less access to care among adults with serious mental health with private vs. Medicaid
- CHA data shows:
 - # of clients w/ SUD + doubled since 2013
 - SUD clients 5X more likely to need help appealing service denials (25% of SUD clients vs. 5% for all others)
 - These cases can involve complex parity issues
 - Consumers and Providers lack knowledge of SUD treatment and insurance coverage



What's the solution?

- Federal and state laws passed to address these problems:
 - 2006: NY Timothy's Law (mental health parity)
 - 2008: federal Mental Health Parity and Addiction Equity Act
 - 2010: Affordable Care Act (expanded parity, EHBs)
 - 2014: NY laws in response to opioid crisis addressing UR program requirements
 - 2016: more NY laws in response to crisis: no PA for bedded treatment, access to MAT, OASAS to designate level of care tool (LOCADTR)
 - 2019: no PA for MAT; no PA/CUR for 28 days for IP/OP; 1/day co-pay; co-pay = PCP visit; enhanced parity enforcement/reporting; ER protocols for MAT; predatory broker protections; OMH review/approve medical necessity criteria; no PA adolescent MH inpatient



2019 Insurance Law Changes

- Review and approve medical necessity criteria **by OMH** and modify tools that are not clinically appropriate
- Immediate access to **medically necessary** ALL SUD treatment and no review **for 28 days**.
 - Provider must notify insurer and patient of discharge plan/specify if services are in place/readily available
 - Requires periodic consultation at or just prior to 14th day
- Prevents prior authorization for formulary forms of MAT
- Requires insurers to cover naloxone prescribed or dispensed to insured
- Extends Ambulatory Patient Group (APG) rates through March 2023



2019 Insurance Law Changes

- Co-payments for SUD/MH OPT = doctor's visit (SUD = large group only)
- Limits co-payments to 1/day (large group only)
- Insurers can limit in-network to NYS OASAS licensed, certified or authorized
- Require out of state providers to be licensed by their own state and accredited.
- Limit Medicaid managed care court-ordered treatment to NYS OASAS programs when possible
- Enhanced network adequacy reporting by insurers and enforcement by DFS/DOH



2019 Insurance Law Changes

- Prohibit retaliation by insurers against providers who complain of parity violations
- No prior authorization for adolescent MH inpatient treatment
- Enhanced MH/SUD parity law compliance by providing consumers w/more detailed information regarding their compliance analysis
- NYS parity protections for MH/Autism services/updates
- Hospitals must have protocols for MAT (bupe) induction in ED and/or linkages to subsequent care with community MAT providers



2018: CHAMP

- NYS Legislature created a statewide Ombudsman program to help consumers & providers with health insurance coverage for MH / SUD services
- Program overseen by OASAS in consultation with OMH
- OASAS & OMH contracted with Community Service Society (CSS), working with Legal Action Center (LAC) and NYS Council for Community Behavioral Health (NYS Council) to run the program
- Program named CHAMP (Community Health access to Addiction and Mental healthcare Project)
- **CHAMP HELPLINE – 888-614-5400**
- OMBUDS email – Ombuds@oasas.ny.gov



CHAMP

- Community Service Society (CSS) operates several independent statewide health insurance assistance programs serving 100,000 New Yorkers annually
- CSS health insurance assistance programs work
 - Hub and spokes
 - Central Hub – CSS
 - Spokes—4 Specialists: Legal Action Center (LAC), NYS Council for Community Behavioral Health (NYS Council), Medicare Rights Center, Legal Aid Society
 - Spokes— 5 CBOs: Adirondack Health Institute (North); Community Action of Staten Island (NYC); Family and Children’s Association (LI); Family Counseling Services of Cortland County (CNY); Save the Michaels of the World (WNY)
 - All payers & uninsured



CHAMP

- **Helpline – 888-614-5400**
- **CBO oversight/support**
- **Sentinel trends**
- **Training & TA**
- **Complex cases/appeals**
- **Outreach/engagement**
- **Community education**
- **Casework (appeals/access to care)**



CHAMP

Do You Need Help Accessing Addiction or Mental Health Care?

Community Health Access to Addiction and Mental Healthcare Project (CHAMP) can help you:

- ▶ **KNOW** your insurance rights
- ▶ **FIGHT** insurance denials for mental health and addiction care
- ▶ **CHALLENGE** insurance barriers & discrimination
- ▶ **GET** the most from your coverage
- ▶ **RECEIVE** fair reimbursement
- ▶ **LEARN** about options for low-cost care for the uninsured
- ▶ **AND MUCH MORE!**

Services Are Free & Confidential

So you can access treatment for mental health & substance use disorders, including medication.

Call our Helpline (888) 614-5400

Helpline Hours: Monday-Friday, 9 a.m. – 4 p.m.



Community Health Access to Addiction & Mental Healthcare Project

Office of Mental Health

Office of Alcoholism and Substance Abuse Services

How do I know if a plan is covered by NY State laws?

New York regulated insurers:

<https://myportal.dfs.ny.gov/web/guest-applications/ins.-company-search>



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What plans are not covered by NY State laws?

Two Circumstances not covered:

1. Self-Funded or ERISA (Employee Retirement Income Security Act) plans – Employer/employment group designs benefit package to meet group needs while also controlling costs, instead of purchasing coverage from a health insurance plan
 - Federally regulated;
 - Not subject to state laws/regulations;
 - Employer may hire third party to handle day to day operations of the benefit administration;
 - Not ERISA – State and local government plans, church plans. Municipal Corporations are subject to NYS laws.
2. Policy is issued outside of New York State – (large multi-state or national businesses). Policy might come from another state and be subject to that state's insurance laws.



SUD Specific Coverage Requirements

Licensed/certified, or otherwise authorized SUD services for diagnosis and treatment of SUD:

- **Bedded Care**
 - Detoxification; Rehabilitation 819.2(a)(1), 820.3(a)(1) Residential Stabilization and (2) Residential Rehab Elements, and Part 817 Residential Rehabilitation Services for Youth (RRSY).
- **Outpatient Care**
 - Partial hospitalization; Intensive Outpatient; Counseling; in community services; Medication administered in OASAS programs (Buprenorphine, Methadone, Naltrexone).
 - 20 family visits for individuals covered under the policy (SUD outpatient services benefit).
- **Medications**
 - Detox; Maintenance / OD Reversal; Tapering ; No prior authorization for formulary forms



In Network vs. Out of Network

- **In Network** - a program or facility that has a contract with your plan to provide services to you:
 - Relevant for no prior authorization rules for In Patient/Out Patient SUD
 - 30 minutes/miles – network standards
- Plans can limit coverage to those providers they contract with*
- **Out Of Network** – no contract - Out of Network laws – supposed to prevent surprise bills



Am I entitled to coverage of care from an *Out Of Network (OON)* facility?

- Coverage is based on the contract; Subject to plan's deductible
- If Plan: 1. Covers BH services, and 2. covers **OON** for Medical/surgical then they need to cover for BH;
- Generally some only provide coverage for ER services that are appropriately licensed;
- May require prior authorization; failure to obtain PA may mean you will have a higher cost share because reimbursement will be less.
- May require appeal process;
- During PA and/or appeals process explain why the **OON** service is different and more beneficial than what is available in network and more beneficial than the in network services.



What to ask about *Out Of Network* (*OON*) care?

- Was there a significant wait for in network services?
- Was there a facility that could meet the patients needs, e.g. co-occurring disorders, or other specific population?



What if my insurer won't cover care at an out of network facility?

- Complete your insurance claim form and submit it along with the SUD/MH health provider's invoice to get reimbursed.
- If you are unsure about your health plan's claim procedures for out of network providers, contact your insurance company



What is “Medical Necessity”?

Sample language:

- health care services that a health care provider, exercising prudent clinical judgment, would provide to a patient. The service must be:
 - For the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms
 - In accordance with the generally accepted standards of medical practice
 - Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease
 - Not primarily for the convenience of the patient, health care provider, or other physicians or health care providers



Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)

- Web-based decision tree developed by OASAS;
- Used by all New York State OASAS licensed programs;
- The only tool designated by OASAS for utilization review determinations.



What is Utilization Review?

- Reviewing a service to determine if it is clinically needed and therefore should be covered - medical necessity.
- For SUD: **L**evel of **C**are for **A**lcohol and **D**rug **T**reatment **R**eferral (**LOCADTR**)
- There are several types of UR and each has its own time frames:
 - Pre-Authorization
 - Concurrent Review
 - Retrospective Review
 - Formulary Exception
 - Step Therapy Overrides



UR: Pre-Authorization

- Pre-authorization – before you receive the services
 - Standard 3 days
 - Urgent – 72 hours
 - Court Ordered – 72 hours, special form
 - No PA for in state, in network OASAS programs



UR: Concurrent Review

- Concurrent – looking at a service you are currently receiving to see if you need to keep receiving that service
 - Standard: 1 business day
 - Urgent: if 24 hours before expiration of previously approved treatment – within 24 hours
 - INPATIENT SUD: If 24 hours before discharge – will decide within 24 hours, and will pay during any subsequent internal or external appeals process.
 - If after 24 hours, decision will be within 72 hours



UR: Retrospective Review

- Retrospective – Looking back at a service already received
 - 30 Calendar days
- If a Decision is made without speaking to the provider; request a reconsideration or “peer to peer review” which will occur within 1 business day.



Additional Rules for Medications

- “Prescribed within FDA approved administration and dosing guidelines.”
- Tiering – some plans have different levels of medications with increasing patient cost sharing arrangement:
 - Insurers do change tiers – if re-tiering so that will cost you more, they have to notify you;
 - Tiering cannot be based solely on money.
- If generic becomes available two possibilities:
 - 1 you will pay more for the brand name; or
 - 2 the brand name might be removed from the formulary completely and not be covered – if removed they will give you advance notice;
 - You CAN request a formulary exception.



Medications

- Step Therapy protocol for medications;
 - Sequence for medications that you can access for a medical condition:
 - Must use evidence based clinical reviewed criteria to make this decision – Ask for it if they say “no.”
 - You can ask for a step therapy override.
- Formulary Exception
 - This is where the medication you need is not on the insurers formulary;
 - If your request for such medication is denied – **you can do an external appeal specific to SUD medications in 24 hours**



What is an Appeal?

- **You are asking for the insurer to reconsider their decision that something was not medically necessary and therefore will not be covered (adverse determination):**
 - **Internal** - the insurer has a different clinical peer reviewer look at the request and decide if their decision was correct (upheld) or incorrect (overturn).
 - **External** – You request an outside entity to review the clinical information and plan decision by submitting an External Appeal application to the Department of Financial Services.



What is an Appeal?

- **Who can request an appeal?**
 - Provider,
 - Patient or
 - A designee.
- **Who makes the decision?**
 - A clinical peer reviewer
 - A physician or
 - Someone with same/similar specialty as the provider.



Internal Appeal?

- **Time frames:**
 - **Prior authorization** – 15 days if two levels of appeal; 30 days if only one;
 - **Retrospective** – 30 days if two levels of appeal; 60 if only one level;
 - **Expedited – Concurrent** – access to reviewer within 1 business day; decision w/in 72 hours of receipt of appeal or 2 business days
 - **Inpatient SUD** – within 24 hours of receipt of appeal request



What is an External Appeal?

- **Standard** – 4 months after you get a “final adverse determination”. You can and should give additional information. Work with your provider to give the external reviewer a complete and well explained picture of the treatment episode.
 - Decision comes within 30 days of receipts of completed application. If additional documents are needed, the External reviewer gets 5 more business days.
 - Formulary exception process 72 hour. If insurers decision is overturned, the plan will cover the medication for as long as the person is taking it, including refills.



What is an External Appeal?

- **Expedited**

- Decision within 72 hours of receipt of completed application. –
Places health in jeopardy, SUD Inpatient. Reviewer will call you and the plan
- Expedited Formulary exception process – 24 hours



FAQ 1: Can the insurer ask for all patient records every time?

No, the requests have to be reasonable. It cannot be a standard practice to ask for the whole chart for every claim.



FAQ 2: Am I only allowed to have 28 days of treatment?



FAQ 3: What is a predatory broker?



**A free airplane ride
might not be right**



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Coverage of Services provided by a CASAC:

- Coverage must include care rendered in an OASAS certified facility, *“even if rendered by a provider who would not otherwise be reimbursed under the policy.”* **11 NYCRR Part 52.24**



RECOVERY TAX CREDIT

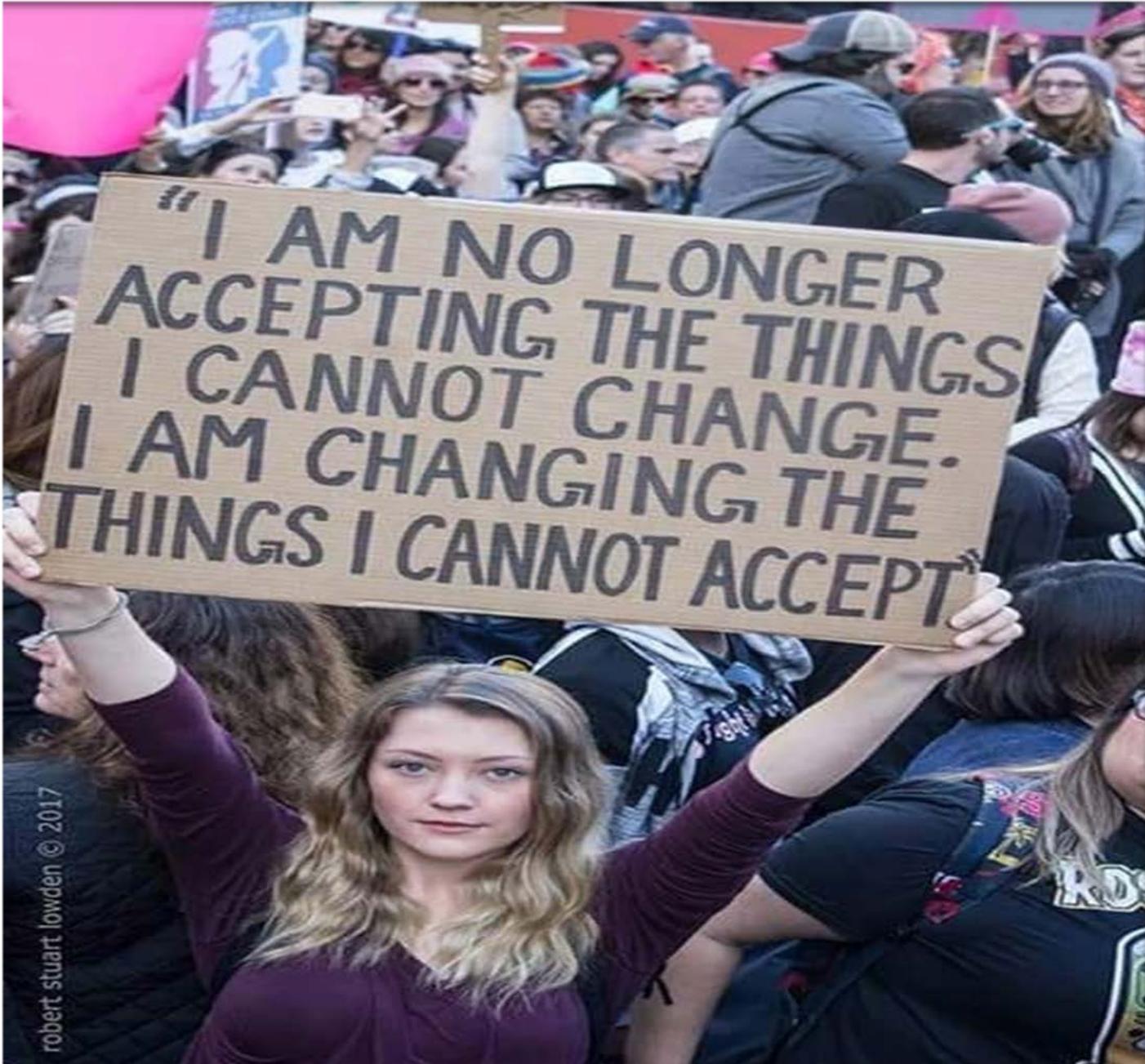
- 1st in the nation tax credit for employees who hire individuals who are in recovery from SUD.
- Program managed in conjunction with the Department of Taxation and Finance
- The tax credit will be provided to eligible employers for each eligible individual who has worked a minimum of 500 hours not to exceed \$2000 in a taxable year.
- A total of \$2 million has been provided for this program.



“The antidote to heroin is not [just] naloxone, it is also [connection and] community.”

Sam Quinones





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Resources

- **Find Addiction Treatment**
<https://findaddictiontreatment.ny.gov/>
- **ATC Directory:**
<https://www.oasas.ny.gov/atc/directory.cfm>
- **CHAMP Helpline / email:**
888-614-5400 / ombuds@oasas.ny.gov



Resources

NYS Office of Mental Health Program Directory

<https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages>

Mental Health Information for Children, Teens, and Families

<https://www.omh.ny.gov/omhweb/childservice/>

Substance Use Disorder Resources for Adolescents and Youth

<https://www.oasas.ny.gov/treatment/adolescent/index.cfm>



Resources

OnTrackNY (NY's First Episode Psychosis Program)

<https://www.ontrackny.org/>

Suicide Prevention Lifeline

<https://suicidepreventionlifeline.org/talk-to-someone-now/>

1-800-273-8255

Crisis Text Line

<https://www.crisistextline.org/>

Text "Got5" to 741-741

Youth Power! (Youth Peer Advocacy)

<http://www.youthpowerny.org/>



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Thank you for joining us:

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