# 2022 Annual Report: Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

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New York state law, Section 1. Section 33.27 of the mental hygiene law, as added by 2 section 1 of part FF of chapter 57 of the laws of 2018, requires an annual report for the independent substance use disorder and mental health ombudsman program, also known as the Community Health Access to Addiction and Mental Health Care Project (CHAMP) that summarizes the work of the program and make recommendations to address systemic issues identified through the program.

## EXECUTIVE SUMMARY

### A. Background

Community Health Access to Addiction and Mental Healthcare Project (CHAMP), a joint project of the NYS Office of Addiction Services and Supports (OASAS) and the Office of Mental Health (OMH), is a first-in-the nation substance use disorder (SUD) and mental health (MH) ombudsman program meant to increase access to services by assisting individuals in maximizing use of insurance benefits. Established in the 2018-2019 New York State Budget (Mental Hygiene Law §33.27), the project provides New Yorkers with assistance in overcoming the numerous insurance related barriers that prevent or delay access and continuity of care for New Yorkers seeking MH or SUD treatment. CHAMP serves a critical need to help people find care by providing information, assist with obtaining and/or using their health insurance coverage, investigating, referring, and resolving complaints made by or on behalf of consumers regarding their coverage, assisting with referrals, and providing resources to overcome barriers, including restricted and limited networks, insurance denials and high out-of-pocket costs. As of June 2022, CHAMP has provided services for over 5,000 individuals since the program's inception and conducted education and outreach to more than 273,00 New Yorkers. CHAMP and the Ombudsman Director have helped New Yorkers with insurance eligibility, accessing care, overcoming high costs of care, as well as assisting with insurance denials and other administrative barriers with coverage.

CHAMP collects, aggregates, and analyzes data through the cases that come through the program, and has tracked significant, ongoing, systemic barriers that prevent people from getting the SUD or MH care they need. The calls that CHAMP receives provide an understanding of the complex intersection of challenges faced by individuals with Medicaid, Medicare, and commercial health plans, as well as people who are uninsured or underinsured,

when trying to access SUD and MH care. The data collected by CHAMP since its inception four years ago has begun to map out the complexities of barriers experienced by consumers and providers and may help identify trends where systemic issues may exist to help the State evaluate policy reforms to improve access to care during a time when overdoses and suicide rates continue to rise.

The federal Mental Health Parity and Addiction Equity Act ("Parity Act"), enacted in 2008, was intended to end discrimination in accessing MH and SUD care by ensuring those services are covered by certain commercial and public insurance plans comparably to medical and surgical care. New York's Timothy's Law, which amended the State Insurance Law, was enacted even earlier, in 2006, and in subsequent years additional parity protections have been enacted in New York State, including in 2019 when federal parity protections were codified in NYS law.

CHAMP presents a unique opportunity to help resolve challenges faced by consumers and providers in real time, and to identify barriers, including systemic issues and potential violations of the Parity Act, impacting access to care. CHAMP data provides the state with critical information about on the ground experiences of consumers in New York who are trying to access MH and SUD care and the barriers they face. As CHAMP provides individualized assistance through its network of five community-based organizations (CBOs), three specialist agencies, and the helpline staffed by attorneys and counselors at Community Service Society (CSS), it is also collecting data that can be used to identify systemic issues and trends that may require intervention by state regulators or policymakers. The COVID-19 pandemic limited the ability of many behavioral health programs and staff to conduct in-person outreach events. Despite these restrictions, the CHAMP team was creative and found opportunities for further engagement through virtual outreach. This, along with a robust marketing campaign led to increased utilization of the program.

CHAMP provides insight into clients who continue to face insurance denials, and limited in-network care availability, resulting in vulnerable populations unable to access care. Vulnerable populations include specifically marginalized communities, those within the children and adolescent care system, and people in need of life-saving medications.

## B. Operating Highlights

Since its inception, CHAMP:

- Served 4,855 cases in 58 out of 62 counties in New York State
- Provided 1,075 instances of technical assistance
- Reached 273,306 people through outreach

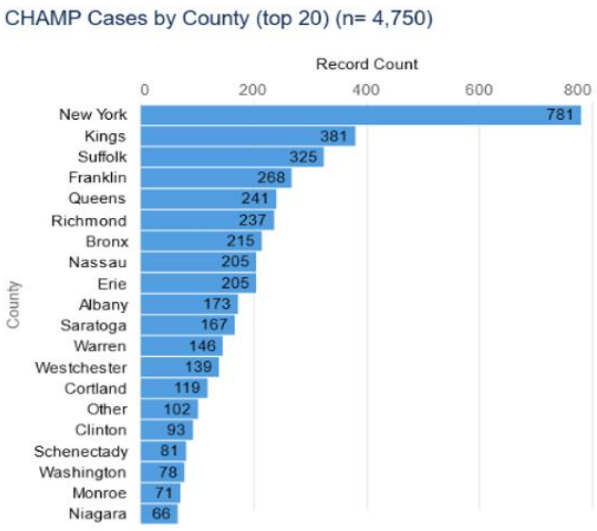
## C. Demographics

This section describes the clients who have received individual assistance from CHAMP in communities across New York State across the life of the project, including (Figure A) where CHAMP clients live, (Figure B) their age; (Figure C) their race and ethnicity, and (Figure D) primary language spoken at home.

During the reporting period, of the 4,750 clients who reported where they lived, the five counties with the most CHAMP cases were: New York (781 cases – 16.4%); Kings (381 cases – 8 %); Suffolk (325 cases – 6.8%); Franklin (268 cases – 5.6%); and Queens (241 cases – 5%).

**Figure A**

Year 1-4: CHAMP Cases by County (Top 20)



Of the 2,409 clients who reported their age during the reporting period, the highest proportion were between the ages of 27 and 45 (46%). Of the remaining clients, 3% were under the age of 19; 12% were aged 19-26; 14% were aged 46 to 54; 14% were aged 55 to 64; and 13% were over the age of 65.

**Figure B**

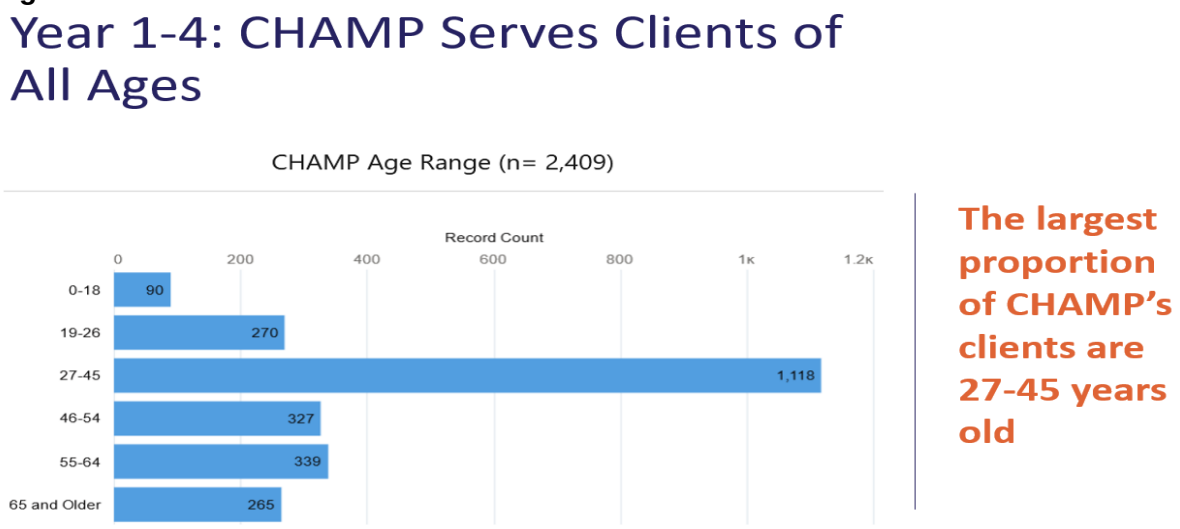
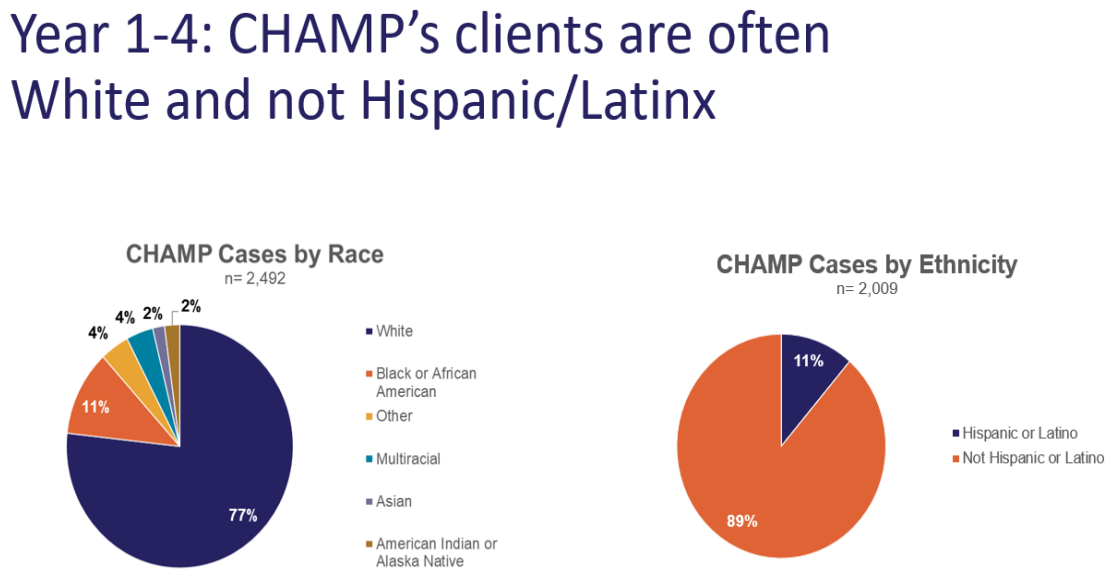



**Figure C**

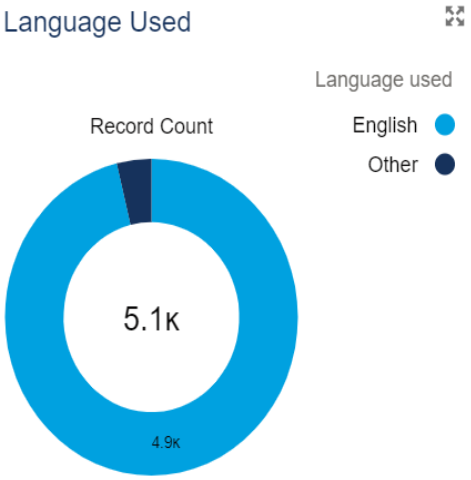



In 2021, provisional data from the Center for Disease Control and Prevention (CDC) estimated that **more than 107,000** people died of a drug overdose, with 75% of those deaths involving an opioid. The overall rise in overdose deaths is largely attributable to the

proliferation in the drug supply of illicit fentanyl, a highly potent synthetic opioid.[1] In just one year, overdose death rates (number of drug overdose deaths per 100,000 people) increased **44%** for Black people and **39%** for American Indian and Alaska Native (AI/AN) people. Most people who died by overdose had no evidence of substance use treatment before their deaths. In fact, a lower proportion of people from racial and ethnic minority groups received treatment, compared with White people.[2]

In October 2020, to better address health equity, CHAMP revised its Salesforce protocol to require all case handlers to ask clients to provide their race and ethnicity if they are comfortable doing so. Clients are not required to provide this information if they do not wish to do so, and the disclosure if this information is not a condition of receipt of services. Of the 2,492 clients who reported their race, 74% identified as White, 12% identified as Black or African American, 4% identified as multiracial, 3% identified as Asian, 1% identified as American Indian or Alaskan Native and 6% identified as another race.

**Figure D**




## CHAMP LANGUAGE AT HOME

In June 2022, CHAMP had its brochure and flyer, which have been available in English and Spanish since 2019, translated into the remaining top ten non-English languages spoken in New York State: Arabic, Bengali, Chinese (both simplified and traditional), Haitian Creole, Italian, Korean, Polish, Russian, and Yiddish. The distribution of CHAMP materials in additional languages will hopefully help CHAMP reach a broader swath of New Yorkers.

**NEEDS IDENTIFIED**

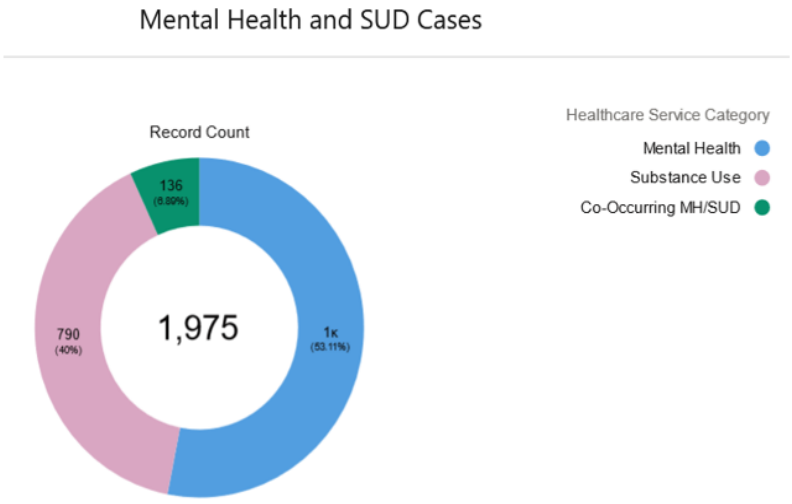
Of the 1,975 cases during years 1 – 4 where CHAMP clients reported needing assistance with care, 53% needed help with mental health care, 40% needed help with substance use disorder care, and 7% needed help with treatment for co-occurring mental health and substance use disorder needs. More specifically, the most common types of care CHAMP clients needed help with were outpatient MH care (including visits to therapists and psychiatrists) and inpatient SUD care, followed by outpatient SUD care and MH or SUD medication in a setting other than an

[1] CDC. U.S. Overdose Deaths In 2021 Increased Half as Much as in 2020 – But Are Still Up 15%. 2022. Retrieved from https://www.cdc.gov/nchs/pressroom/nchs_press_releases/2022/202205.htm.
[2] CDC. Drug Overdose Deaths Rise, Disparities Widen: Vital Signs. 2022. Retrieved from: https://www.cdc.gov/vitalsigns/overdose-death-disparities/index

Opioid Treatment Program (OTP) or Office-Based Opioid Treatment (OBOT). CHAMP clients also needed help with accessing inpatient MH treatment, residential SUD treatment, treatment at an OTP, treatment at an emergency department, and MH outpatient treatment.

Collecting information about the barriers that prevent CHAMP clients from accessing SUD and MH care helps CHAMP identify possible violations of parity or other laws relating to the protection of people with MH/SUD issues, as well as providing time-sensitive data and recommendations to state regulators on such issues to accessing life-saving care.

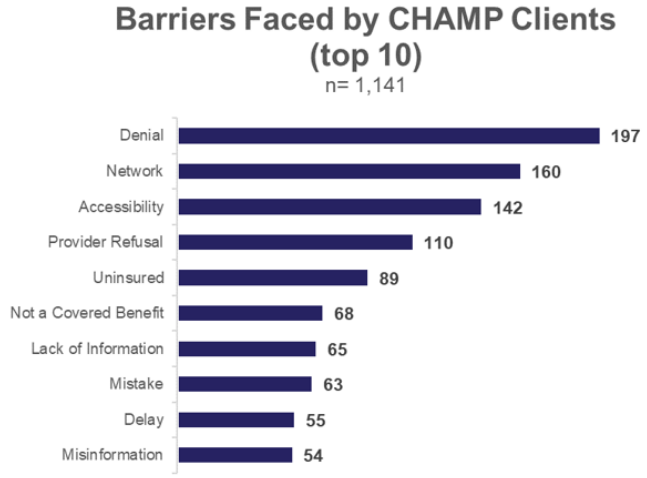
## Year 1-4: CHAMP clients need help accessing care for mental health, substance use disorders, and co-occurring MH/SUD needs




**INSURANCE ISSUES**

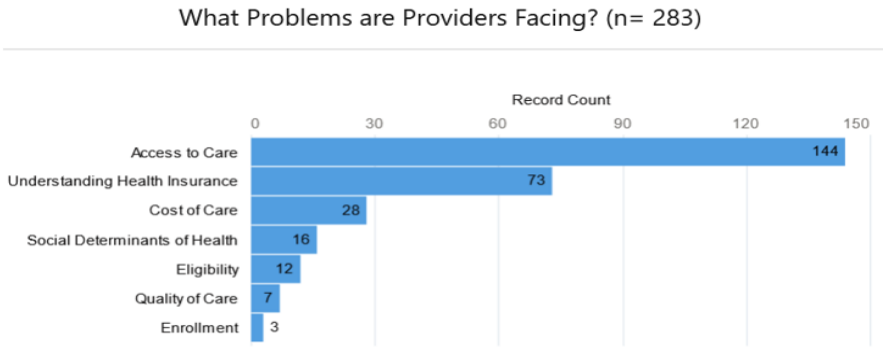
## A. SERVICES PROVIDED FOR BARRIERS FACED BY CHAMP CLIENTS/PROVIDERS

### The most common barriers faced by CHAMP clients in Years 1-4 were insurance denials, inadequate networks, and accessibility




CHAMP clients face a variety of barriers that prevent CHAMP clients from accessing SUD/MH care. Of the 1,141 clients who reported the barriers they faced, the most common were denials by insurers, difficulty accessing in-network providers, provider accessibility, providers unable to treat clients (e.g. due to their co-morbid medical issues/ co-occurring issues), and individuals who were uninsured. Other barriers include insurance plans excluding the needed service from their benefit coverage, insurer or provider mistakes, delays by insurers or providers, and insurer or provider misinformation.

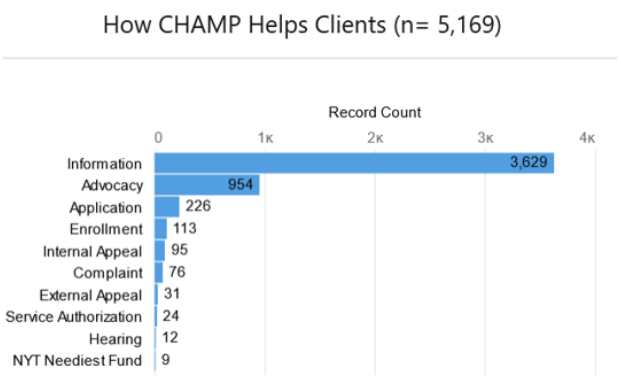
### Year 1-4: CHAMP also helps providers whose patients are facing insurance barriers—most commonly barriers to accessing care




CHAMP handled 283 cases where the client was a provider or advocate from a program. The providers and advocates served during the reporting period required help: (1) getting their patients or clients access to MH/SUD care; (2) understanding health insurance; (3) getting reimbursed for care they provided or helping patients afford the cost of care; (4) helping patients

with quality-of-care issues; (5) assisting patients or clients with social determinants of health; and (6) helping patients determine their eligibility for health insurance.

## Year 1-4: CHAMP helps clients in many ways, like providing information and advice, advocating on their behalf, and filing appeals and complaints

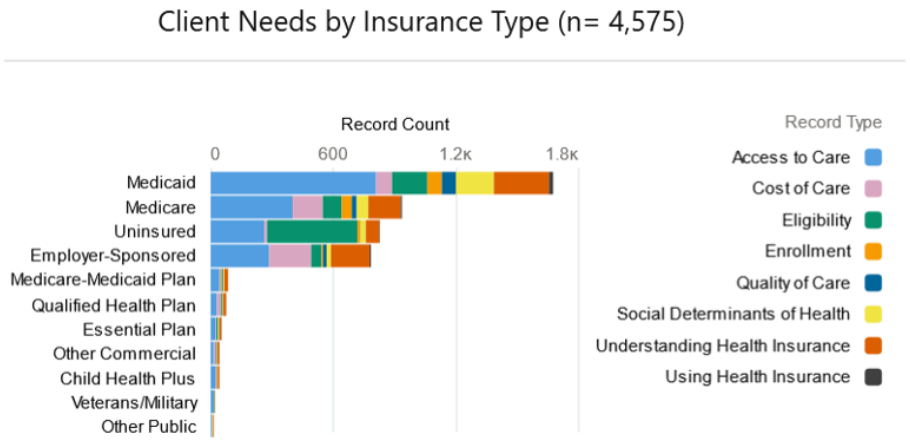



**To date, CHAMP has helped clients with 95 internal appeals, 31 external appeals, 75 complaints, and 12 hearings**

The most common services provided to CHAMP clients were giving information, orientation, and/or advice about using health insurance or accessing care (3,629); and negotiating dispute resolution (954). Other services provided to clients included: (1) filing internal appeals and external appeals filing complaints with regulators or insurers; (2) assisting with enrollment into health insurance; (3) assisting with applications; (4) helping with service authorization; and (5) providing representation or advice for fair hearings and other insurance hearings.

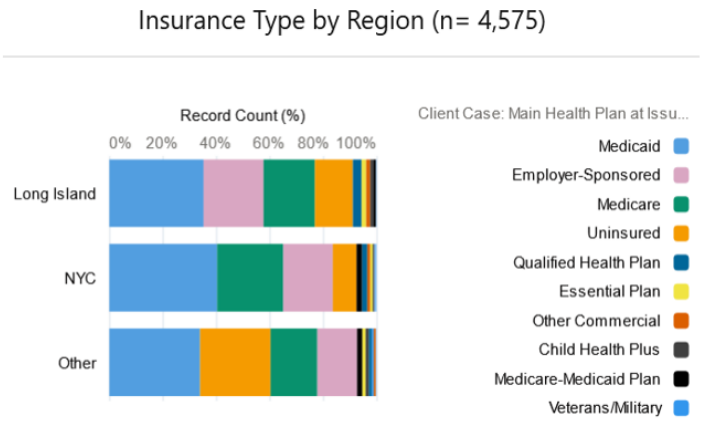
### B. TRENDS

## Year 1-4: Clients with Medicaid were more likely to experience social determinants of health, and clients with employer-sponsored insurance were more likely to experience affordability issues



CHAMP identifies trends and systemic problems in health insurance coverage of MH/SUD care. The chart above indicates that the type of insurance CHAMP clients use may include the types of issues they need help with. Clients across all insurance types need help accessing MH/SUD care. Proportionally, CHAMP clients with Medicaid are more likely to need help with social determinants of health, such as housing, food, transportation, and quality of care issues, while uninsured CHAMP clients need help with eligibility for insurance. In addition, CHAMP clients with employer-sponsored plans often need help accessing care and with the cost of care.

## Year 1-4: CHAMP clients' source of insurance coverage varies by region, with clients outside of NYC more likely to be uninsured




The above chart indicates that there may be regional differences among the CHAMP clients' source of coverage. Throughout New York state, Medicaid, Medicare, and employer-sponsored insurance were the most common types of coverage. Clients outside of NYC were more likely to be uninsured than those from New York City. The need for expanded telephone enrollments into NYSOH Marketplace coverage would benefit CHAMP clients, many of whom have urgent health care needs and who may not be able to easily travel to an in-person assister location. Seamless provision of enrollment and ombudsman services are essential to facilitating access to care for people with MH and SUD needs.

### C. CHAMP SUCCESS STORIES IN ADDRESSING INSURANCE- ACCESS TO CARE ISSUES

**(All names have been changed to protect client confidentiality)**

- **Luke's Story**: A CHAMP CBO contacted CSS for assistance helping Luke. Luke was insured by his mother's employer-sponsored plan. Luke was seeking inpatient SUD treatment but could not afford his plan's $2,000 deductible for treatment. CSS determined that Luke was eligible for Medicaid as secondary insurance and enrolled him. With Medicaid as secondary insurance, Luke was able to access treatment without the high cost-sharing of his mother's plan.
- **Hector's Story**: Hector's sister called CHAMP while Hector was hospitalized for medical issues related to his alcohol use disorder. After a previous hospitalization a month earlier, Hector had been unable to fill his prescriptions because the pharmacy said his insurance

cards were invalid. Hector and his family worried he would face the same barrier after release from his current hospitalization. CHAMP staff at CSS and Medicare Rights Center worked together to determine that Hector had Medicare and was enrolled in a Dual Advantage plan, and that he also had Extra Help. CHAMP determined that Hector's insurance cards were several years old, and that his current pharmacy did not accept Medicare. CHAMP helped Hector get new insurance cards and find an in-network pharmacy, so he was able to fill his prescriptions.

- **Sherry's Story**: Sherry was insured by Medicare, with secondary commercial insurance. Sherry traveled out-of-state for treatment at a residential eating disorder facility that accepted her commercial insurance (Medicare does not cover residential treatment). After she arrived, the facility learned that Sherry had primary Medicare and told her she would be discharged immediately – Sherry then called CHAMP. CHAMP reviewed her case and determined that Sherry's commercial insurer would cover her residential treatment only if she provided denials from Medicare. However, the facility refused to bill Medicare, claiming it was unable to do so as Medicare doesn't cover residential treatment. CHAMP clarified that the facility could in fact bill Medicare. Still, the facility did not cooperate. After significant CHAMP advocacy, the facility agreed not to discharge the client and then bill Medicare so that the client could obtain Medicare denials to provide to her commercial plan, enabling her commercial plan to cover the care.

- **Victoria's Story**: Victoria was insured by the Essential Plan and was receiving health services from a Federally Qualified Health Center (FQHC). Her primary care physician at the FQHC referred her for mental health services with a therapist employed by the same FQHC. Victoria called CHAMP when she learned that her insurance was not covering her treatment with her therapist, although she reported that her plan told her the therapist was in network. Through many phone calls, CHAMP determined that although the FQHC's physical health services were in-network with the client's plan, their mental health providers were not. CHAMP advocated with the FQHC, which agreed not to bill the client for the mental health services she had received.

- **Scott's Story**: Scott tested positive with COVID-19 in March 2020 and developed long-COVID symptoms, including mental health symptoms. Scott had insurance coverage from his recent employer via COBRA. He began seeing an out-of-network psychotherapist with expertise in long-COVID. Scott's COBRA coverage ended, and he enrolled in insurance through New York's health insurance marketplace, the NY State of Health. Scott's new plan had no out-of-network benefits. Scott asked his new plan to cover his psychotherapist, but they denied his request, stating they had in-network providers who could treat him. CHAMP filed an external appeal on Scott's behalf and won, with the independent reviewer agreeing that Scott's plan did not have an in-network provider with the training and expertise to treat him and ordered the plan to cover his treatment.

- **Indira's story**: Indira tested positive for COVID-19 while in at inpatient SUD program. When Indira contacted CHAMP, she said the program was going to discharge her to a motel the following morning due to her COVID status. Indira was afraid that if she was discharged with nowhere to go, she would not be able to continue her methadone treatment. CHAMP asked

the Ombudsman Director to facilitate a conversation with the program. The program said COVID+ patients are discharged

- because (1) the program was not set up for isolation (2) the program could not provide services to patients in isolation and cannot bill for patients held in isolation. The program told CHAMP that Indira would be able to access her medication after discharge at an OTP and return to inpatient treatment after completing isolation. When CHAMP relayed this information to Indira, she said that the program told her she would have to make her way to her local social service district on her own, request a hotel voucher and set up her isolation hotel on her own. While sick with COVID this was not possible for her. Indira faced other barriers including lack of transportation from the hotel to the OTP, and the loss of her next scheduled treatment bed. CHAMP advocated with the program and the Ombudsman Director facilitated a conversation with OASAS to address the many barriers Indira faced. The case raised novel issues around how inpatient and residential programs bill for patients who are isolating with COVID, and how to discharge patients in a seamless and supported transition. Indira received support in a timely manner around additional issues that could have prevented her from receiving needed care – including social determinants of health (housing, transportation linkages to medications, telehealth while isolating, and her return to treatment after isolation).

## RECOMMENDATONS TO ADDRESS SYSTEMIC TRENDS IDENTIFIED IN CHAMP

The New York State Council for Community Behavioral Health (The NYS Council) and the Legal Action Center (LAC) are two Specialist organizations within CHAMP, supporting the project with community outreach as well as providing technical assistance in their respective areas of expertise. The NYS Council provides consultation, training, and technical assistance on the behavioral health system and best practices for supporting CHAMP clients with SUD/MH care needs. LAC provides expert training and technical assistance to CHAMP on the Parity Act and other New York and federal insurance laws, rules and regulations and assists with preparing client complaints and appeals. LAC is the anchor organization for the New York State Parity@10 Coalition, which includes the NYS Council and 25 other MH/SUD providers, impacted individuals and advocacy organization across New York State to ensure Mental Health Parity and Addiction Equity Act (MHPAEA) is fully implemented and enforced.

The NYS Council and LAC submit an annual policy report analyzing CHAMP data that utilizes their policy expertise as one of the contractual deliverables for the program. The following section is based on their recommendations for Year 4:

### I. Recommendation for CHAMP Program: Expand outreach and engagement for communities experiencing inequities in access to care

CHAMP data highlighted the impact of the COVID-19 pandemic on MH/SUD conditions, including a surge in requests for care, and barriers to accessing care. Children, people from racial and ethnic minority groups, those with pre-existing MH/SUD conditions, and people facing financial and/or housing insecurity are among those who are likely to experience symptoms of

increased mental health illnesses during the COVID-19 pandemic.[3] In communities of color, especially among Black, Hispanic, and Asian adults, there have been higher rates of COVID-19 infections and deaths, along with greater stressors related to the pandemic. At the same time, these marginalized groups have experienced decreased access to mental health and addiction care services.[4] In the first half of 2021 in New York City, 1,233 people died from drug overdoses, a 78% increase from the same period in 2019, and a 28% increase from the same period in 2020. Overall, deaths by overdose have nearly doubled from pre-pandemic levels in New York City.[5]

CHAMP case handlers in 2021 targeted their efforts to better address health equity by requesting clients to voluntarily provide their race and ethnicity; disclosure was not a condition of assistance. In Year 4, approximately 68% of clients disclosed their race. Of that 68% that did disclose, 74% identified as White, 12% identified as Black or African American, 4% identified as multiracial, and 4% identified as "other". These data indicate a need for a strategic approach for engaging these communities to ensure that they can utilize CHAMP services for assistance in overcoming barriers to accessing MH/SUD care.

New York State continues to take measures to address health equity as a priority area. The Department of Health created the Office of Health Equity & Human Rights, and the State established the Council for Treatment Equity within the Behavioral Health Services Advisory Council, and other steps being taken by the state may lead to better outcomes and reduced racial disparities. In addition, New York submitted a request for a Health Equity 1115 Waiver Amendment for $13.5 billion over five years to address health disparities and systemic health care delivery issues both highlighted and intensified by the COVID-19 pandemic the Department of Health.

CHAMP will continue its focus on racial and health equity by intentionally distributing resources – including information about how to access CHAMP – into communities where Black, Indigenous and People of Color (BIPOC) are underserved, as well as other under-resourced communities. In addition, CHAMP will expand its current reach into underserved and under-resourced communities, by adding three additional CBOs that have expertise in MH services.

## II. Recommendation: Network Adequacy

Year 4 CHAMP data shows barriers related to clients who need geographically accessible in-network care. Network related obstacles such as difficulties in finding in-network providers accepting new patients or reasonable wait times are consistently one of the top barriers that CHAMP callers face. In Year 4, case handlers identified network adequacy as a barrier 166 times. However, it is possible that there were additional cases that may not have been identified

[3] National Institutes of Health. (n.d.). Mental Health During the COVID-19 Pandemic. Retrieved from https://covid19.nih.gov/covid-19-topics/mental-health

[4] Thomeer, M.B, Moody., M.D., Yahirun, J. (2022). Racial and Ethnic Disparities in Mental Health and Mental Health Care During the COVID-19 Pandemic. From *Journal of Racial and Ethnic Health Disparities.* Retrieved from https://europepmc.org/article/MED/35318615

[5] NYC.GOV. (22 Apr. Unintentional Drug Poisoning (Overdose) Deaths Quarter 2, 2021, New York City. Retrieved from: provisional-overdose-report-second-quarter-2021.pdf (nyc.gov)

as such, because network adequacy barriers were identified as a secondary issue in prior years.

A 2019 national study of employer sponsored plans by the actuarial firm Milliman found that New York State consumers go out-of-network for MH/SUD care at significantly higher rates than for medical/surgical care, which strongly indicates that there are inadequate networks of providers to help New Yorkers.[6] Despite this evidence, as well as CHAMP data over the last several years also showing network adequacy issues, ongoing challenges to transparency and expediency remain for those with Medicaid and commercial insurance.

In 2020, LAC and the Partnership to End Addiction published the report, *Spotlight on Network Adequacy Standards for Substance Use Disorder and Mental Health Services.*[7] The Spotlight includes a 50-state survey of network adequacy standards for mental health and SUD services and found that only seven states had quantitative network standards in three key categories: geographical distance, appointment wait times, and provider-enrollee ratios. Further, only two states adopted those metrics specifically for MH/SUD providers. Providing network adequacy standards beyond what is otherwise the national norm by developing enhanced qualitative metrics for New York state regulated commercial plans as well as Medicaid Managed Care plans that ensure robust networks of MH/SUD providers could include:

- ***Geographically accessible****: Both public and private health plans should be required to have accessible in-network providers from several categories of MH/SUD provider types within a specified distance/travel time from a member's home. These requirements should include flexibilities based on rural/urban and available transportation options. This can include (not default or prioritize) access to telehealth providers that is patient-centered. Networks should include both in-person and telehealth providers. This would include a geographic standard in non-urban areas of 30 minutes/30 miles from a patient's home or workplace.*
- ***Provider Wait-times****: The adoption of appointment wait time metrics for commercial plans for in-network MH/SUD care for both urgent and non-urgent services, like those in Medicaid Managed Care (MMC) could be considered.*
- ***Patient-to-Provider Ratios:*** *New York State already has patient-to-provider ratios in MMC for primary care, family medicine, pediatrics, and other specialties that ensure that there are an adequate number of providers per patient in a plan or region.[8] Adopting similar metrics for both MH/SUD care into commercial plan requirements may also be*

[6] Meleck, S., Davenport, S., & Grey, T.J. (2019). Addiction and mental health vs. physical health: Widening the disparities in network use and provider reimbursement. Milliman. Available at: https://www.milliman.com/en/insight/addiction-and-mental-health-vs-physical-health-widening-disparities-in-network-use-and-p. See also Pelech, D., & Hayford, T. (2019. Medicare Advantage and Commercial Prices for Health Services. Health Affairs. Available at: https://www.healthaffairs.org/doi/full.10.1377/hlthaff.2018.05226

[7] Legal Action Center. 2022. Spotlight on Network Adequacy Standards for Substance Use and Mental Health Services. Retrieved from Legal Action Center | Spotlight on Network Adequacy Standards for…

[8] NYS Dept. of Health. (n.d.) Guidelines for MCO Service Delivery Networks – Version 3.0. Retrieved from https://www.health.ny.gov/health_care/managed_care/guidelines_for_mco_service_delivery_networks-v3.0.htm

*considered. A standard of 1:1000 patients, like that in the state of Colorado, could be helpful in serving New Yorkers in need of behavioral health care.*[9]

- ***Routine compliance monitoring*** *is necessary to ensure health plan networks remain adequate to meet the needs of NYS health care consumers. Further, it is critical that provider directories are continuously updated and accurate, and easily accessible to patients. Patients should be held harmless when a provider directory is inaccurate. Requiring plans to submit quarterly, standardized, comprehensive reporting on network adequacy including patient-to-provider ratios, average wait times, changes to provider lists may be helpful.*

## III. Recommendation: Children and Adolescents Including Services for Autism Spectrum Disorders

In Year 4, CHAMP identified several ongoing barriers, also identified in previous years, that continue to impact access to mental health and addiction care for children and adolescents. Youth are often unable to access specialized mental health or addiction care, including treatment for co-occurring MH/SUD and MH, Intellectual (I), and/or Developmentally Disabled (DD) conditions. The continuum of care for children still has gaps, with few SUD programs geared toward children and adolescents. With inpatient hospital beds closing or otherwise unavailable, children are languishing in emergency departments, awaiting inpatient treatment beds, and are frequently discharged before receiving treatment. [10]

According to the 2022 *Mental Health in American Report*, the promise of the federal parity act did not resolve the number of commercial insurance plans in the United States that do not cover mental health, which increased in 2022 and resulted in 950,000 children left without needed coverage. [11]The state prevalence of untreated youth with depression ranges from 30.0% in Maine to 73.1% in Texas. New York ranks 33rd in the nation with 60.3% of youth experiencing major depressive episodes (MDE) who continue to go untreated. Even among the states with greatest access for youth, 1 in 3 youth are still not receiving the mental health services they need. [12]

For Children with Medicaid, accessing evidence-based treatment for autism spectrum disorders is still a difficult challenge. The lack of Medicaid coverage for Applied Behavioral Analysis (ABA therapy) for children with autism spectrum disorder (ASD) has been identified in previous years and remains an identified barrier to this evidence-based treatment in CHAMP Year 4 data. ABA therapy has been available to commercially insured children since 2011 but was historically excluded as a Medicaid benefit. The Department of Health (DOH) administratively added ABA therapy to Medicaid FFS as of August 1, 2021, and to Medicaid Managed Care (MMC) as of

[9] Colorado Community Health Alliance. 2021. Network Adequacy Plan. Retrieved from ACC RAE 6 Network Adequacy Plan FY 21-22.pdf (colorado.gov)

[10] CDC Fact Sheet: Mental Health Among Adolescents. 2022. Retrieved from: Mental Health Among Adolescents (cdc.gov)

[11] Mental Health in America. Access to Care Data. 2022. Retrieved from https://mhanational.org/issues/2022/mental-health-america-access-care-data

[12] Mental Health in America. Access to Care Data. 2022. Retrieved from https://mhanational.org/issues/2022/mental-health-america-access-care-data

October 1st, 2021.[13] Subsequently, ABA therapy as a service was carved out of MMC, with billing only allowable to Medicaid FFS. Finding providers is still exceedingly difficult, and CHAMP reporting suggests that children in some MMC plans are also experiencing challenges to accessing ABA therapy. While MMC plans are experienced in billing FFS Medicaid for services, and all Medicaid providers are required to also be credentialed to accept FFS Medicaid, reimbursement rates and complex billing procedures have deterred individual providers and private programs from offering ABA therapy to children with FFS Medicaid. Most providers are in settings such as special needs schools, where providers panel with MCOs or in private ASD programs that are exclusively paid by private pay and commercial insurance. Children with I/DD, receiving Office of Persons with Developmental Disabilities (OPWDD) services, are most likely to have FFS Medicaid, as OPWDD services are not carved into managed care. According to CHAMP data, there has been challenges in helping connect children to ABA services when they have FFS Medicaid.

Removing barriers to Applied Behavioral Analysis (ABA) therapy for children with autism spectrum disorder (ASD) who are Medicaid recipients by implementing and enforcing already existing policy would be helpful to those in need of these services.

## IV. Recommendation: Co-Occurring Conditions

As reported in previous years, CHAMP clients with co-occurring MH/SUD conditions continue to face barriers to needed care. COVID restrictions, a bifurcated behavioral health system, and workforce shortages resulted in CHAMP clients unable to access treatment for their MH/SUD conditions until one or the other presenting diagnosis was treated or resolved. Systems of care, including reporting requirements, funding, and staffing levels, are separate and distinct in New York, with little integration between systems to ensure the right care at the right time, across all systems.

Currently, MH/SUD programs are routinely screening for co-occurring disorders. Screening is a first step, but most programs do not have the staffing and expertise to address severe co-occurring disorders. By treating the whole person, integrated care leads to improved outcomes and increased quality of life. SAMHSA asserts that integrated screening and treatment for co-occurring disorders leads to better health outcomes and better quality of care.[14]

## V. Recommendation: Parity

CHAMP was established by the Executive and Legislature to ensure that individuals with a substance use disorder and/or mental illness receive appropriate health insurance coverage. MHL Section 33.27(a). Although the purpose of Timothy's Law, the federal Parity Act, and other recent insurance laws have been enacted to ensure that stricter requirements and standards and not imposed on coverage of MH/SUD care than on medical/surgical care, significant

[13] NYS Dept. of Health. New York State Medicaid Update – July 2021 Vol 37 – Number 9. Coverage of Applied Behavioral Analysis. Retrieved from: https://www.health.ny.gov/health_care/medicaid/program/update/2021/no09_2021-07.htm

[14] TIP 42: Substance Use Treatment for People with Co-Occurring Disorders. March 2020. Retrieved from: TIP 42: Substance Use Treatment for Persons With Co-Occurring Disorders | SAMHSA Publications and Digital Products

challenges remain for health care consumers understanding and accessing their rights under these various complex insurance laws. Similarly, consumers often lack access to detailed plan information to determine if their health plan is following the law.

Information shared in the Year 3 policy report focused on the New York Department of Financial Services public searchable database of external appeals. CSS analyzed the rates that appeals were overturned or upheld for MH/SUD services and compared those with overturn rates for medical/surgical appeals. They also identified plans of concern with particularly high overturn rates of MH/SUD appeals when compared to medical/surgical appeals. Disparities such as these constitute "red flags" indicating plans may be in violation of the federal parity law.

The searchable database is regularly updated to include the outcome of external appeals. For calendar year 2021, disparities between the appeal overturn rates for MH/SUD care as compared to medical/surgical care are ongoing. See table below:

| | Mental Health | SUD | Gastrointestinal | Cardiac |
|---|---|---|---|---|
| **Overturn- Full** | 184 (66%) | 94 (53%) | 284 (32%) | 408 (43%) |
| **Overturn-Part** | 10 (4%) | N/A | 17 (2%) | 11 (1%) |
| **Upheld** | 82 (29%) | 82 (47%) | 571 (65%) | 528 (56%) |
| **TOTAL** | 276 | 176 | 872 | 947 |

In the two medical diagnoses randomly chosen (gastrointestinal and cardiac), the outcomes of the external appeals were upheld more than overturned, but for both MH/SUD the external appeals more often overturned insurer denials than upheld them. The high overturn rates, especially for mental health care necessitates a further inquiry into whether plans are applying factors and evidentiary standards for making claim denials for MH/SUD care (versus medical / surgical care) inequitably or more stringently. Further inquiry can help determine whether an adverse benefit determination regarding MH/SUD care indicates that standards may have been applied inappropriately and whether extensive advocacy has assisted in assuring that the claim has been paid correctly for services rendered.

New York State has taken several steps toward better parity enforcement in recent years, including implementing parity compliance regulations that require public and private health plans to develop internal parity compliance programs and monitoring reports submitted to DFS as required by the 2018 Parity Reporting Act. The Office of Mental Health has synthesized these reports into a database where certain activities can be sorted by commercial health plans.[15]

DFS is also utilizing Parity Reporting Act data to conduct MHPAEA testing. Most recently, DFS issued penalties of over $2.6 million, with an additional $473,565.90 in restitution to consumers, to Aetna Life Insurance Company, Oscar Insurance Corporation, and Wellfleet New York Insurance Company. The three commercial insurers failed to comply with federal and state cost-

[15] NYS Office of Mental Health. Mental Health SUD parity Data 2019-2020. Available at: https://omh.ny.gov/omhweb/bho/parity.html

sharing requirements in accordance with MH/SUD parity. The press release and consent orders are available on the DFS website.[16]

Additionally, the New York State Department of Health (DOH) and OMH conducted MHPAEA testing of 19 distinct nonquantitative treatment limitations (NQTLs) to access MH/SUD parity compliance of the State's Medicaid Managed Care Organizations (MCOs). The 19 NQTLs were divided into three phases and tested via two series of focus surveys. The first series of focus surveys, Phase I and II, resulted in a total of 30 citations, while the second series of focus surveys, Phase III, resulted in a total of 61 additional citations for all MCOs. The citations issued can be found on the DOH website.[17] The State released the *Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report: New York Medicaid Managed Care, Alternative Benefit Plan, and Children's Health Insurance Program* report[18] outlining the findings of the MHPAEA testing. The State is continuing to monitor parity compliance through future surveys and monitoring.

Lastly, OMH and DOH have observed disproportionately high rates of inappropriate administrative claims denials for Medicaid behavioral health services that ultimately impede providers' ability to get paid properly and therefore may create access issues for consumers. According to the DOH and OMH websites, 45 citations including Statements of Deficiencies (SODs) and Statement of Findings (SOFs) were issued based on failure to properly oversee behavioral health vendors who pay claims for behavioral health services, inappropriately denying claims for no prior authorization when prior authorization is not required, and failure to pay behavioral health claims correctly and timely.[19]

This available data, compared with CHAMP data, could be further scrutinized. For instance, the Parity Reporting Act data and the DFS external appeals database indicate that plans continue to violate the parity act and other insurance laws. Ensuring that they are continuously engaging in an in-operation review of plan activities to determine whether the plans are applying their standards appropriately might prove useful. The recent Medicaid Parity Compliance Analysis[20] indicates that the state is beginning to do just that. A key starting place may be to look at the plans that regularly have their determinations overturned on external appeal. Monitoring plans that have already been identified as engaging in practices that violate parity to ensure they

[16] NYS Dept. of Financial Services. Acting Superintendent Adrienne A. Harris Secures $3/1 million for New Yorkers following Mental Health and Substance Use Disorder Parity Compliance Review. Dec. 14, 2021. Retrieved from https://www.dfs.ny.gov/reports_and_publications/press_releases/pr202112141

[17] NYS Dept. of Health. Mental Health Parity and Addiction Equity Act (MHPAEA) Focused Surveys. May 2022. Retrieved from https://www.health.ny.gov/health_care/managed_care/reports/focused_surveys/mental/index.htm

[18] NYS Dept. of Health, NYS Office of Mental Health, NYS Office of Addiction Services and Supports. Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report. March 2022. Available at: https://omh.ny.gov/omhweb/bho/docs/nys-mhpaea-report.pdf

[19] NYS Office of Mental Health. Focused Survey Citations. (n.d.) Available at https://omh.ny.gov/omhweb/bho/focused-surveys.html. See also www.health.ny.gov/health_care/managed_care/reports. See also https://www.health.ny.gov/health_care/managed_care/reports/focused_surveys/behavioral/index.htm.

[20] NYS Dept. of Health, NYS Office of Mental Health, NYS Office of Addiction Services and Supports. Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report. March 2022. Available at: https://omh.ny.gov/omhweb/bho/docs/nys-mhpaea-report.pdf

maintain compliance with similar requirements for other plans throughout the state may also be helpful.

## VI. Recommendation: Medicare

In Year 4 of CHAMP, 22% of all cases were for clients with Medicare who were seeking access to MH and/or SUD care. A staggering 93% of Medicare beneficiaries 65+ with an SUD received no treatment, nor do the one in three Medicare beneficiaries with a MH condition.[21] However, Medicare has major barriers to care due to not being subject to the Parity Act and including substantial coverage limitations for necessary services including a lifetime limit on inpatient psychiatric or SUD care, and no coverage of residential MH/SUD treatment.

In one such CHAMP case, an individual insured by Medicare with secondary commercial insurance had to go out-of-state to receive treatment at a residential eating disorder. When the facility learned she had Medicare, the client was immediately discharged. CHAMP determined that her secondary commercial insurance could be used, but they would only allow coverage once Medicare officially denied coverage. However, the facility refused any attempt to bill Medicare because they knew that Medicare does not cover residential treatment. After significant advocacy from CSS and MRC, the facility agreed not to discharge her and to bill Medicare so that her commercial plan would cover the service upon Medicare's denial.

This case highlights the many barriers that individuals seeking MH/SUD experience, and the impact advocacy provided by CHAMP had on the outcome of the client. If the client did not have secondary insurance, she would have been unable to access services unless she paid out of pocket. Limits on inpatient care such as this case could be a parity violation, if the parity law applied to Medicare, as would the limit on scope of services (residential treatment).[22] Therefore, applying parity to Medicare could have the effect of making these and other services available.

## VII. Recommendation: Consumer Transparency

In prior years, CHAMP identified the need to increase consumer transparency to enable individuals to better understand their rights with regards to MH/SUD coverage in their public or private insurance plans. Easy access to web-based information that is consumer-friendly and that goes beyond necessary information about parity rights and other insurance laws could be very helpful to increasing consumer transparency. The second highest identified need for all CHAMP clients, 19% of CHAMP Year 4 callers, needed help understanding their health insurance. The same percentage of callers identified that need in Year 3, who were often unaware of their rights or health plan obligations for providing appropriate levels of coverage.[23]

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[21] Parish, W.J, Mark, TL, Weber. 2022. Substance Use Disorders Among Medicare Beneficiaries: Prevalence, Mental and Physical Comorbidities, and Treatment Barriers. From: *American Journal of Preventative Medicine.* Retrieved from https://www.sciencedirect.com/science/article/abs/pii/S0749379722001040

[22] Legal Action Center, 2022. The Path to Parity: Applying the Parity Act to Medicare to Improve Access to Substance Use Disorder and Mental health Care. Retrieved from: Path-to-Parity-MAPP-2022.06.14.pdf (lac.org)

[23] Parity@10 Consumer health Knowledge and Experience Survey, Feb. 3, 2019. Available at Consumer-Health-Insurance-Knowledge_ExperienceSurvey-Report-030719.pdf (parityat10.org)

New York has made progress in more robust monitoring and enforcement activities, but without consumer education, these problems will persist.

The federal parity act requires health plans to provide members with relevant plan information (i.e. medical necessity determinations or explanations of denials) up on request. Similarly, the Employee Retirement Income Security Act (ERISA) the federal law that applies to many employer-sponsored health plans, further requires health plans to provide members with information used in the development of non-quantitative treatment limitations (NQTLs).[24] The New York State Parity Compliance Regulations implemented in 2021 require insurers to provide information about any improper practices (i.e. violations) discovered to any affected member within 60 days of discovery, and any information about those violations.[25]

The purpose of these requirements is to help consumers understand their health insurance, appeal any determinations, and potentially seek remedies for any harms caused by plan determinations that have delayed or denied appropriate care. CHAMP Year 4 data has documented several instances that clients struggled to obtain such required documents. In one such case, CHAMP assisted a client with requesting disclosures about NQTLs and improper practices, specifically citing the federal and state statute and regulation. However, the plan deferred the request by suggesting it was unclear. Failure to provide this information is a parity violation, yet CHAMP data indicates the problem is ongoing. Other CHAMP clients have received boilerplate denial statements that include no relevant clinical rational for an adverse determination as required by law. New York Insurance law specifically requires adverse determination notices to include the clinical rationale, for without such language, an individual may be unable to make an appeal or complaint. It could be beneficial to consumers to have easy access to educational materials and web-based information about patients' rights to coverage for MH/SUD care on New York state agency websites that are easy to read and in multiple languages. Plans could also be required to submit their policies for providing plan disclosures, including a requirement to standardize disclosure materials across all plans. There could also a template request form made available to consumers that insurers are required to respond to.

## OPERATIONAL ACTIVITIES

A. **Budgets and Subcontracting**: CSS and the Ombudsman Director work with CHAMP Specialists and CBOs to explain the budget process, distribute budget templates, reviewing draft budgets from each agency and provide feedback, and submit budgets for approval. CSS also processes budget modification requests from the CHAMP Network. The Ombudsman Director oversees the work of CSS with Specialists and CBOs on deliverables and execute sub-contracts with each CBO and Specialist. Finally, CSS processes monthly invoices from each CBO and Specialist during each 12-month reporting period.
B. **Reporting and Data**: CSS submits annual reports to OASAS. CSS also submits to OASAS 11 monthly reports, three quarterly reports, and miscellaneous reports at the request of the Ombudsman Director. Annual reports are accompanied by a PowerPoint slide deck.

[24] US Department of Labor. (n.d.) Retrieved from ERISA | U.S. Department of Labor (dol.gov)
[25] 11 NYCRR Part 230. Retrieved from Mental Health and Substance Use Disorder Parity Compliance Program Certification | Department of Financial Services (ny.gov)

C. **Onboarding:** CSS onboards new CHAMP staff members at CSS and CBOs. All CBO CHAMP staff are required to complete a CHAMP Certification training program. CSS's Finance Department also processes budget modifications for each staffing change.
D. **Materials/Marketing:** CSS provides materials for review and approval to the Ombudsman Director on all CHAMP outreach and marketing materials, including a CHAMP trifold, one-pager, network map, and PowerPoint template. CHAMP's trifold and one-pager was translated into additional languages so that they are now available in the top 10 non-English languages spoken in New York State. CSS also used its in-house printing shop to print copies of CHAMPs trifold and one-pager and mailed the materials to all CHAMP CBOs and Specialists for use in outreach. In addition, CHAMP promotional materials for outreach were distributed throughout the network and included pens, hand sanitizers, magnets, stress balls, post-it notes, pill organizers, and tabletop banners. A CHAMP ad campaign ran between July and September 2022. The ads targeted areas of NYS with diverse racial and ethnic populations to ensure CHAMP is reaching as many New Yorkers as possible. In Year 5, CHAMP ads will run in selected local Bronx newspapers, the Poughkeepsie Journal, the Albany Times Union, and New York City buses and subways.

CHAMP is grateful for the opportunity to partner with OASAS and OMH, to provide high-quality health insurance consumer assistance to New Yorkers throughout the state with MH/SUD issues, as well as their families, providers, and advocates. Through its network of Specialist and CBO partners, and a live-answer Helpline, CHAMP is advocating for New Yorkers in the communities where they live and work.