Westchester Institute *for* Human Development

https://www.wihd.org

Welcome!

Community Support Network Transition Institute 2022

Accessing Healthcare in Adulthood

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Introduction/Goals of session

Disclaimers

Questions ☺

Accessing Healthcare in ***Adulthood***

Considerations for adulthood

- Guardianship (18)
- Healthcare proxy
- https://www.health.ny.gov/publications/1430.pdf
- Medicaid as primary OR secondary
- Managed care (Health Homes/IDD)
- Dual eligibility (PHP)
- Dependent health coverage (NY – 29) https://www.dfs.ny.gov/consumers/health_insurance/cobra_and_premium_assistance

Accessing Healthcare in ***Adulthood***

Considerations for adulthood

- Post age 29 continued coverage?

Pre-existing disability + dependent on policyholder for support and maintenance = right to remain on policy subject to requirements for proof and notice

Accessing Healthcare in Adulthood

noun

1 the ability, right, or permission to approach, enter, speak with, or use; admittance:
They have access to the files.

2 the state or quality of being approachable:
The house was difficult of access.

3 a way or means of approach:
The only access to the house was a rough dirt road.

SEE MORE

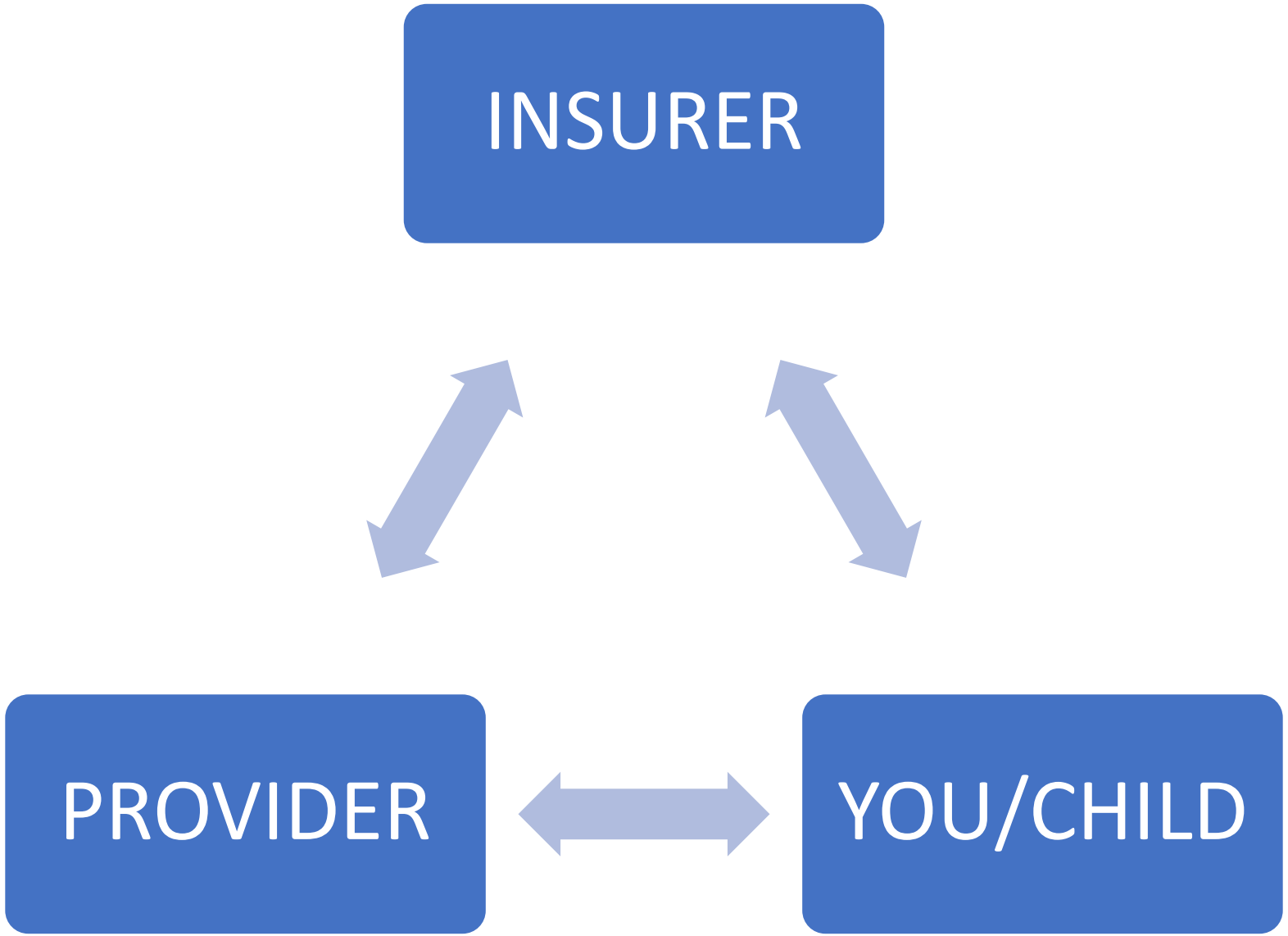
verb (used with object)

9 to make contact with or gain access to; be able to reach, approach, enter, etc.:
Bank customers can access their checking accounts instantly through the new electronic system.

10 *Computers.* to locate (data) for transfer from one part of a computer system to another, generally between an external storage device and main storage.

How do we access Healthcare?

Who are the Players?



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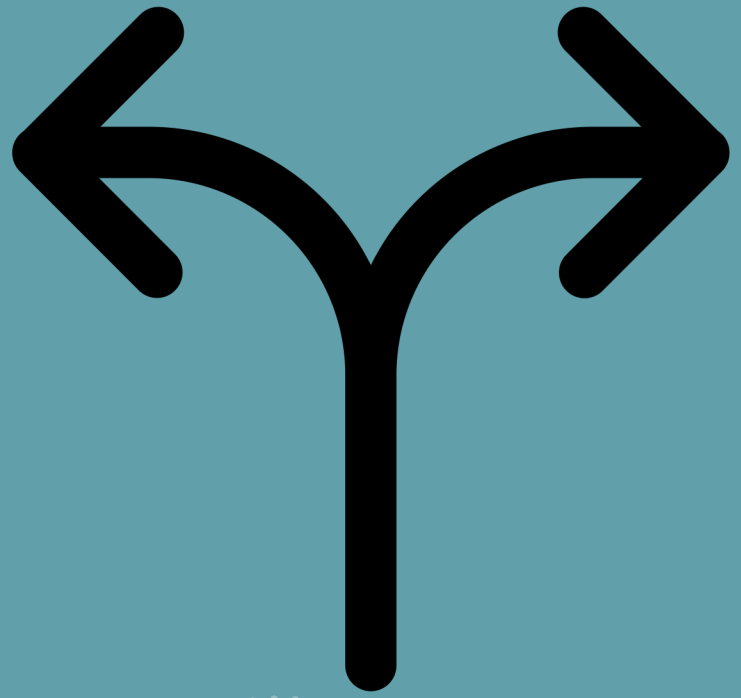
Get to know your Plan!



Important because:

- Plan Information - is the coverage I need in the plan?
- Should it be ? (essential health benefits, parity)
- Appeals and complaints procedures

GET TO KNOW YOUR PLAN

FULLY FUNDED – GROUP OR INDIVIDUAL

- Consumer protections
- Department of Insurance/Department of Financial Services
- Review the CERTIFICATE/EVIDENCE OF COVERAGE

SELF-FUNDED – ERISA/EBSA framework

- MANAGED by Insurer – “ASO” - Employment protections -
- Need to ask for DETAILED SUMMARY PLAN DESCRIPTION

OTHER PLAN TYPES – Medicaid MCOs, Self-funded non-federal govt, etc

GET TO KNOW YOUR PLAN – Medicaid

MEDICAID MANAGED CARE ("MCOs")

- Lots of public plan information
- Internal Appeals AND fair hearings
- Many plans allow for External Appeal as well but fair hearing process preserves services.

Traditional Medicaid

- Fair Hearings = entitlement
- Usually no other level of appeal

MANDATES

- *DICTIONARY DEFINITION:*

verb *[with object]*

1 give (someone) authority to act in a certain way: *other colleges have mandated coed fraternities*.
- require (something) to be done; make mandatory: *the government began mandating better car safety*.

2 *historical* assign (territory) under a mandate of the League of Nations: (as adjective **mandated**) *: mandated territories*.

- *HEALTHCARE DEFINITION:*

Making something covered as a matter of requirement not choice

MANDATES - FEDERAL

ESSENTIAL HEALTH BENEFITS – the ACA

- Emergency services
- Hospitalization (surgeries and inpatient care)
- Laboratory services
- Mental health and substance use disorder services (including behavioral health treatment such as counseling and psychotherapy)
- Outpatient care
- Pediatric services (including oral and vision care)
- Pregnancy, maternity, and newborn services (includes prenatal, childbirth, and postnatal care)
- Prescription drugs
- Preventive care, wellness services, and chronic disease management
- Rehabilitative and habilitative services and devices (to help people gain or recover skills after injury as well as amid disability or chronic conditions)

AUTISM MANDATE - NY

- Individual mandate separate from mental health provisions
- Applies to individual and fully insured large or small group plans

- Covers
  - DIAGNOSIS
  - BEHAVIORAL HEALTH TREATMENT (includes ABA)
  - PSYCHIATRIC CARE
  - PSYCHOLOGICAL CARE
  - THERAPEUTIC CARE

    Licensed or certified speech therapists, occupational therapists, social workers, physical therapists

    There are no caps on ABA coverage

PARITY

- *DICTIONARY DEFINITION:*

par·i·ty[1] | 'perədē |

noun

1 the state or condition of being equal, especially regarding status or pay: *parity of incomes between rural workers and those in industrial occupations*.
- (also purchasing parity) the value of one currency in terms of another at an established exchange rate: *the euro's parity with the dollar*.

- *HEALTHCARE DEFINITION*

Requiring mental health benefits to be overall on a par with medical or surgical ones

Compliance + enforcement

PARITY - federal

MHPAE = Mental Health Parity and Addiction Equity Act

- Original scope was expanded/enhanced by ACA – applies to all Marketplace plans
- Federal Employee Benefit Program is subject to MHPAE through executive order
- Applies to Medicaid Managed Care (”MCOs”)
- Childrens Health Insurance Program (“CHIP”)
- Some state and local government plans
- Enforcement depends on plan type

When does federal Parity not apply?

- Grandfathered plans created before 23 March 2010
- Self funded plans with fewer than 50 employees
- Certain self-funded plans on a cost basis
- Some non federal governmental plans may opt out
- Medicaid FFS plans aka “traditional” Medicaid (but state Medicaid plans & CHIP must)
- Medicare (except for costsharing for outpatient mental health services)
- Tricare/DOD plans

PARITY – NY State regulated plans*

The following is a list of key provisions:

- Coverage for *all* mental health conditions, substance use disorders and autism spectrum disorders, as defined in the most recent edition of DSM or ICD;
- Prohibits preauthorization and concurrent review of substance use disorder services during the initial 28 days of inpatient and outpatient treatment;
- Prohibits preauthorization and concurrent review of psychiatric inpatient services for persons under the age of 18 for the first 14 days;
- Prohibits prior authorization for formulary forms of prescribed medications for treatment of substance use disorders;
- Clinical review criteria applied by utilization review agents must be approved/designated by OMH or OASAS, where applicable;
- Medical necessity criteria must be made available to insureds, prospective insureds, or in-network providers upon request;
- Prohibits taking any adverse action in retaliation against a provider filing a complaint, making a report, or commenting to a government body regarding policies and practices that violate this statute;
- Requires insurers and health plans to post additional information regarding their in-network providers of mental health and substance use disorder services, including whether the provider is accepting new patients as well as the provider's affiliations with participating facilities certified or authorized by OMH or OASAS; and

* As summarized by the New York State Psychiatric Association

PARITY IN PRACTICE

Consider these at the point of service (pre-auth) OR the point of denial – ask yourself how they are applied to medical claims?

- QTL = Quantitative Treatment Limitations (= numerical, countable)
- NQTLs = Non Quantitative Treatment Limitations (eg medical management, step therapy and pre-authorization requirements)
- Autism issues = hourly, age and dollar caps, settings requirements

RIGHTS OF APPEAL

POINT OF SERVICE DENIAL

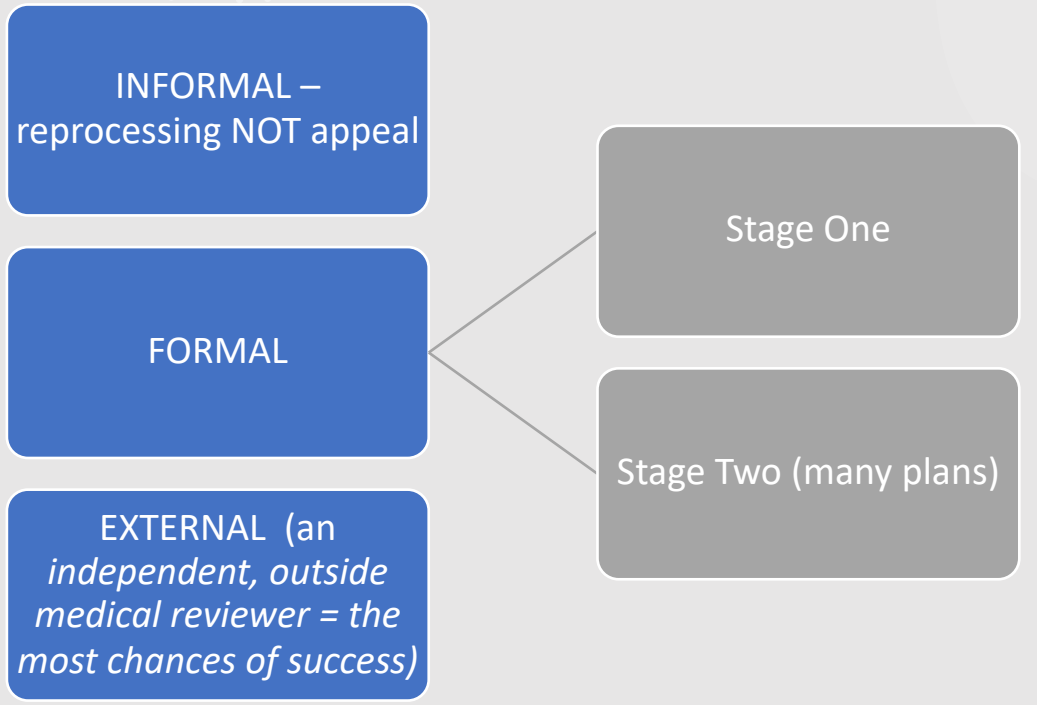
APPEAL

LITIGATION

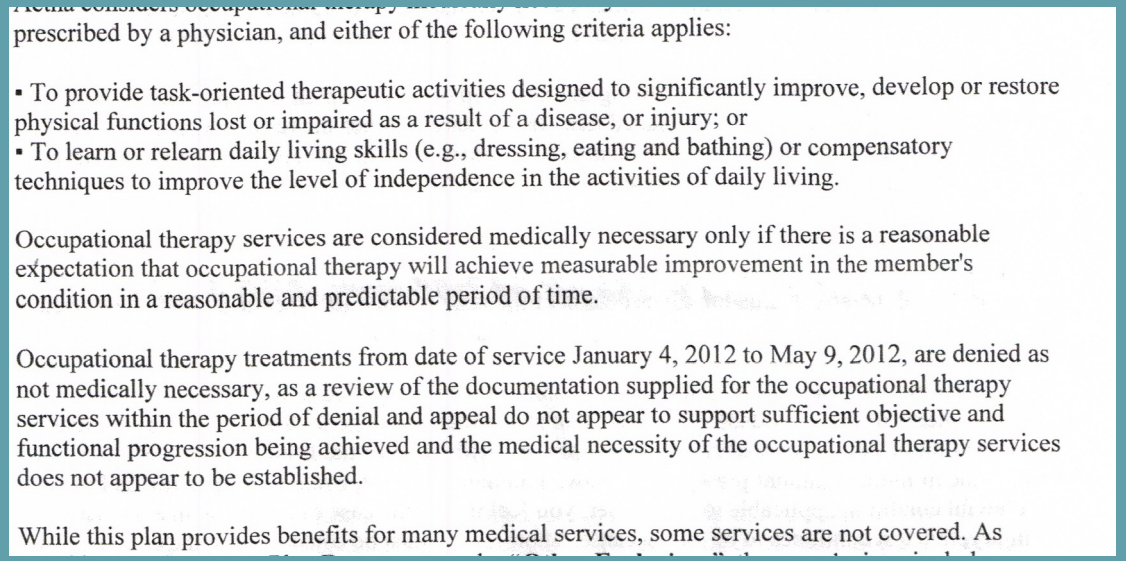
EXAMPLES OF APPEALS

- Denial of medically necessary therapies, medication, DME
- Denied request to use an out of network provider (continuity of care, single case agreement, network adequacy)
- May be pre or post service
- Expedited appeals (concurrent review)
- Visit limits, lifetime limits, dollar limits
- Denial of appropriate hours of care

RULES OF THE GAME – most Plans!



DENIAL – STAGE ONE OR TWO APPEAL



prescribed by a physician, and either of the following criteria applies:

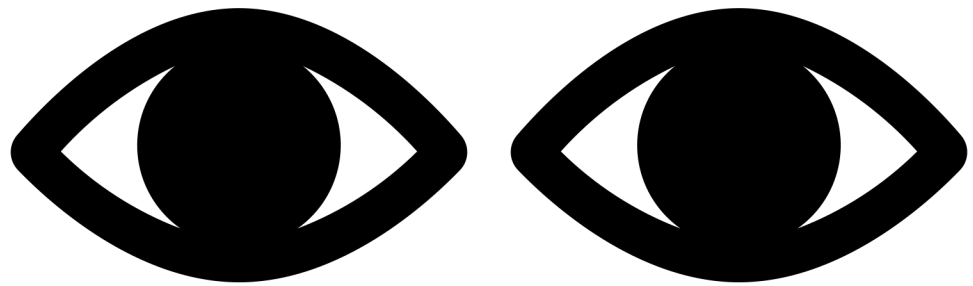
- To provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease, or injury; or
- To learn or relearn daily living skills (e.g., dressing, eating and bathing) or compensatory techniques to improve the level of independence in the activities of daily living.

Occupational therapy services are considered medically necessary only if there is a reasonable expectation that occupational therapy will achieve measurable improvement in the member's condition in a reasonable and predictable period of time.

Occupational therapy treatments from date of service January 4, 2012 to May 9, 2012, are denied as not medically necessary, as a review of the documentation supplied for the occupational therapy services within the period of denial and appeal do not appear to support sufficient objective and functional progression being achieved and the medical necessity of the occupational therapy services does not appear to be established.

While this plan provides benefits for many medical services, some services are not covered. As

- CLINICAL INFORMATION (NON-PERSONAL) – "POLICY BULLETINS"
- ARE THESE UP TO DATE?
- ARE THEY IN LINE WITH GENERALLY ACCEPTABLE STANDARDS OF CARE ("GASC"s)
- ALL PLANS - ARE THEY BEING APPLIED CORRECTLY?



EXTERNAL REVIEW

What?

Adverse Benefit Determinations involving MEDICAL JUDGMENT

- Requirements of MEDICAL NECESSITY
- APPROPRIATENESS

- HEALTH CARE SETTING
- LEVEL OF CARE
- EFFECTIVENESS of a covered benefit
- Whether it is EXPERIMENTAL
- RESCISSIONS OF COVERAGE

EXTERNAL REVIEW

How?

- Self-funded plans use approved Independent Review Organizations
- State-regulated plans –External Appeals through dfs.ny.gov

NEW YORK STATE | Department of Financial Services

New York State External Appeal

Diagnosis: Autism Spectrum Disorder

Treatment: Autism Related Treatment (including ABA)

Health Plan: Oxford

Decision: Overturned

Appeal Type: Medical necessity

Gender: Male

Age Range: 20-29

Decision Year: 2019

Appeal Agent: IPRO

Case Number: 201908-119913

SUMMARY

Diagnosis: Autism Spectrum Disorder Treatment: Applied Behavioral Therapies (ABA) The insurer denied the Applied Behavioral Therapies (ABA).The denial was reversed. This is a young male patient who was diagnosed at a very early age with developmental delays and Autism Spectrum Disorder. He had deficits in communication and was mostly nonverbal and used an IPhone to communicate with. He had ritualized and compulsive behaviors, physical and verbal stereotypies and behaviors, self-injurious behavior including hitting his hand to his forehead. It was noted that he displayed recent aggression since a reduction in applied behavioral analysis. Applied Behavioral Analysis according to the American Academy of Child and Adolescent Psychiatry is an effective behavioral treatment for autism spectrum disorder children and has been shown to significantly facilitate acquisition of language, social skills, and to improve behavior through early and sustained intervention. The American Academy of Pediatrics reports that the efficacy of applied behavioral analysis is well documented through 5 decades of work and has shown substantial sustained gains in adaptive, academic, language, social, and behavioral functioning and better reported outcomes. The National Institute of Mental Health reports that applied behavioral analysis is widely accepted as an effective treatment. The National Academy of Sciences reports that 40 years of research testifies to the efficacy of time limited focused applied behavioral analysis methods in reducing or limiting specific problem behaviors and teaching new skills to children and adolescents with autism and other developmental disorder. Multiple sources support that applied behavioral analysis is an appropriate and effective treatment behaviorally and educationally for autistic spectrum disorder individuals with social delays, language and communication delays, and difficulties in adaptive functioning. In this case, this individual had deficits in social communication and interaction, ritualized and compulsive behaviors, physical and verbal stereotypies and behaviors, self-injurious behavior, including hitting his hand to his forehead, and recent aggression since a reduction in ABA. Goals of treatment included improving communication and adaptive functioning, decreasing maladaptive behaviors, and improving independence and daily skills. He had regressed after a reduction in these services, including having aggression. He required these applied ABA services and treatment to further progress and not to regress, which has happened. This patient required intensive behavioral intervention with applied behavioral analysis therapy, and there were specific target goals and objectives to target behaviors and skills. Additional goals included improving communication skills in expressing his emotions, decreasing elopement and maladaptive behavior and stereotypies, and decreasing self-aggression, aggression and unsafe behavior. Still further goals included acceptance of nonpreferred behavior, expressing his physical and emotional status, and decreasing theft. He required intensive instruction supervision and support. It was likely that with a lower frequency of ABA services, he would further regress in functioning and behaviors. Autism spectrum disorder is a neurodevelopmental disorder that is considered permanent, and there are many associated deficits with this disorder; therefore, treatment is complex, and it is medically necessary to have ongoing treatment. It typically requires a long duration and requires intensive structured and supervised treatment, which ABA can provide. Based on the above, the medical necessity for intensive behavioral therapies is substantiated. The insurer's denial is reversed.

REFERENCES

1) The American Academy of Child and Adolescent Psychiatry. 2) The National Institute of Mental Health. 3) The American Academy of Pediatrics. 4) The National Academy of Sciences.

NEW YORK STATE | Department of Financial Services

New York State External Appeal

Diagnosis: Autism Spectrum Disorder

Treatment: Home Health Care

Health Plan: Integra MLTC, Inc.

Decision: Overturned

Appeal Type: Medical necessity

Gender: Female

Age Range: 30-39

Decision Year: 2020

Appeal Agent: IPRO

Case Number: 202007-130043

SUMMARY

Diagnosis: Developmental delay, Autism, Severe intellectual disabilities. Treatment: Home Care/Personal Care HHC - Level 2 Personal Care Services (CDPAS), per 15 minutes, 84 hours per week. The insurer denied coverage for Home Care/Personal Care HHC - Level 2 Personal Care Services (CDPAS), per 15 minutes, 84 hours per week. The denial is overturned. This is female patient with profound developmental delay, autism, and severe intellectual disabilities. The patient also has memory impairment and severely impaired decision making. The patient lives with her aunt. The aunt and 2 cousins provided care to the patient. The patient was approved for Consumer Directed Personal Assistance Services (CDPAS) 63 hours per week. The patient's aunt requested an increase of services to 84 hours per week which was denied. The Uniform Assessment System (UAS) functional assessment indicates that the patient is totally dependent for most instrumental activities of daily living (IADLs) except medications (maximal assistance), transportation (extensive assistance), and stairs (supervision). Regarding activities of daily living (ADLs), the patient needs extensive assistance for bathing, and limited assistance or supervision for most other ADLs except walking, locomotion and transfers (independent). With greater severity of intellectual disability, the ability to perform daily activities (IADLs and ADLs) is more impaired. For this patient, there is almost complete dependence on caregivers for IADLs. The patient also needs assistance or supervision with most ADLs. The patient's need for assistance with daily activities appears to be primarily due to autism and intellectual disability. As a result of the patient's functional impairment due to autism and severe intellectual disability, caregiver assistance is medically necessary for IADLs and ADLs during daytime hours, with assistance needed for some ADLs into the evening/night hours for both scheduled and unscheduled tasks. Most of the patient's care is needed from morning through evening hours, which should be covered by CDPAS 12 hours per day, 7 days per week (84 hours per week). Informal caregiver assistance is necessary for ADL care, when needed, the other 12 hours of the day. The health plan did not act reasonably with sound medical judgment in the best interest of the patient. Based on the above, the medical necessity for Home Care/Personal Care HHC - Level 2 Personal Care Services (CDPAS), per 15 minutes, 84 hours per week is substantiated. The insurer's denial is overturned.

REFERENCES

1) NYS Title 18 Section 505.28 Consumer Directed Personal Assistance Program, 7/6/2016. 2) New York Codes Rules and Regulations, Title: Section 505.14 Personal care services; 07/06/2016. 3) A clinical primer on intellectual disability, Transl Pediatr, 2020 Feb; 9 (suppl 1): S23-S35. 4) Treatment of Menorrhagia, Am Fam Physician 2007 Jun 15, 75(12): 1813-1819.

NO DATA = NO CASE

- **Summary:**

Autism Spectrum Disorder Speech Therapy This is a patient diagnosed with Autism Spectrum Disorder (ASD). He also presents with food aversion and oral motor weakness. According to a provided medical report, the patient actively participates, interacts well with family and friends, and eats solid foods at regular mealtimes. The documentation states that the patient has been in private speech therapy for years but has not been receiving speech therapy services through his school since late 2019.The documentation also states the need for ongoing speech therapy. At issue is whether the requested services are medically necessary for the patient. The health plan's determination is upheld. Language deficiencies (as in the case of the autism) can have a significant impact on several domains including the academic, social, and emotional states of the patient. Speech and language intervention has been shown clinically to be extremely effective when provided as early as possible along with intensive instruction. (1) Specifically, individuals diagnosed with autism who receive language therapy have been shown to exhibit improved functional communication abilities, which in turn, improve their social abilities, academic abilities, as well as the individual's overall quality of life. However, no documentation was provided by a speech-language pathologist, on behalf of the patient, indicating his current speech and language functioning level. Furthermore, there is no clear information of the daily impact experienced by the patient. Additional information was requested and a speech therapy initial evaluation from 2018 was provided, but there are no speech therapy records provided from 2019. In general, services for autism spectrum disorder (ASD) are considered medically necessary when developmental delays or persistent deficits in social communication and social interaction across multiple contexts have been identified when the evaluation is performed by a qualified and certified speech-language pathologist. Since there is no information relative to the patient's social communication deficits or how his oral motor weakness significantly impacts the intelligibility of his speech, a level of medical necessity cannot be professionally supported. As a result, the requested health/service treatment of speech therapy evaluation visits are not medically necessary for this patient.

TECHNICAL TAKEAWAYS

- Reprocessing or appeal?
- CHECK the EOB for easy fixes like covered person, policy dates, Dx, dates of service
- Know the NETWORK status
- ALWAYS Follow the procedure and timelines set out in a denial letter
- Make sure you have paid your initial payments
- Understand the appeal process in the Plan so you are ready
- Track claims individually - even successful appeals still have to go through the system

DRAFTING – CLEAR LANGUAGE, HEADINGS & BULLETS

- ENSURE all identifying/required information is given so there is no excuse for the insurer to reject
- NOTE all procedural failings eg lack of documents
- Enclose Letters of Medical Necessity AND quote them!
- Keep the emotion OUT – this is just about FACTS, DATA, PROGRESS
- State that the denial is against the best interests of the Insured

ENERGY AUDIT

Good Energy

Relationships with provider offices & agency staff

Keep the MD up to date

Good contacts in HR (self funded employer plans)

Great record keeping

Strategic “asks”

Wasted Energy

- Over-emotional wording
- Expecting too much of call center staff
- Rushing to meet appeal deadlines rather than being proactive

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Accessing Healthcare in Adulthood

Take back control of your healthcare!

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