S T A T E O F N E W Y O R K

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I N S E N A T E

May 23, 2014

Introduced by Sens. SEWARD, HANNON, MARTINS, RITCHIE, BOYLE, BALL, BONACIC, CARLUCCI, FELDER, GALLIVAN, GOLDEN, GRIFFO, LANZA, LARKIN, LAVALLE, LITTLE, MARCELLINO, MARCHIONE, MAZIARZ, NOZZOLIO, O'MARA, RANZENHOFER, ROBACH, SAVINO, VALESKY, YOUNG -- read twice and ordered printed, and when printed to be committed to the Committee on Insurance -- reported favorably from said committee and committed to the Committee on Rules -- committee discharged, bill amended, ordered reprinted as amended and recommitted to said committee

AN ACT to amend the insurance law and the public health law, in relation to requiring health insurance coverage for substance abuse disorder treatment services and creating a workgroup to study and make recommendations

THE PEOPLE OF THE STATE OF NEW YORK, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 30 to read as follows:

(30) (A) EVERY POLICY THAT PROVIDES MEDICAL, MAJOR-MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE SHALL INCLUDE SPECIFIC COVERAGE FOR DRUG AND ALCOHOL ABUSE AND DEPENDENCY TREATMENT SERVICES PURSUANT TO THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AND APPLICABLE STATE STATUTES WHICH REQUIRES PARITY BETWEEN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AND MEDICAL/SURGICAL BENEFITS WITH RESPECT TO FINANCIAL REQUIREMENTS AND TREATMENT.

(B) DETERMINATION OF COVERAGE FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES BY A HEALTH PLAN SHALL BE MADE THROUGH A MEDICAL MANAGEMENT REVIEW PROCESS WHICH:

(I) UTILIZES A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE ABUSE COURSES OF TREATMENT TO SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUBSTANCE ABUSE TREATMENT; AND

(II) UTILIZES ONLY CLINICAL REVIEW CRITERIA CONTAINED IN THE MOST RECENT EDITION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S PATIENT PLACEMENT CRITERIA OR OTHER RECOGNIZED AND PEER REVIEWED CRITERIA OR

EXPLANATION--Matter in ITALICS (underscored) is new; matter in brackets [ ] is old law to be omitted.

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COMPENDIA DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT. ANY ADDITIONAL CRITERIA SHALL BE SUBJECT TO THE APPROVAL OF THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND SUPERINTENDENT.

(C) THE LOCATION OF COVERED TREATMENT PURSUANT TO THIS SECTION SHALL BE SUBJECT TO THE INSURER'S REQUIREMENTS RELATING TO THE USE OF PARTICIPATING PROVIDERS, INCLUDING THOSE PROVIDERS LOCATED OUTSIDE OF THE STATE.

(D) WHERE AN INSURED'S HEALTHCARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING CARE OF TREATMENT RELATING TO A SUBSTANCE USE DISORDER WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE INSURED, ALL INTERNAL AND EXTERNAL APPEALS OF UTILIZATION REVIEW DETERMINATIONS SHALL BE CONDUCTED ON AN EXPEDITED BASIS, AS SET FORTH IN SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER AND IN PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

(E) IN THE EVENT OF AN ADVERSE DETERMINATION FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES, THE HEALTH PLAN SHALL CONTINUE TO PROVIDE COVERAGE AND REIMBURSE FOR ALL SUCH SERVICES UNTIL THE INSURED HAS EXHAUSTED ALL APPEALS, BOTH INTERNAL AND EXTERNAL, OR OTHERWISE NOTIFIES THE HEALTH PLAN IN WRITING THAT HE OR SHE HAS DECIDED TO NOT MOVE FORWARD WITH THE APPEALS PROCESS.

(F) FOR PURPOSES OF THIS SECTION: "SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES" SHALL INCLUDE, BUT NOT LIMITED TO, HOSPITAL AND NON-HOSPITAL BASED DETOXIFICATION, INCLUDING MEDICALLY MANAGED, MEDICALLY SUPERVISED AND MEDICALLY MONITORED WITHDRAWAL, INPATIENT AND RESIDENTIAL REHABILITATION, INTENSIVE AND NON-INTENSIVE OUTPATIENT TREATMENT, AND OUTPATIENT OPIOID TREATMENT PROGRAMS.

S 2. Subsection (l) of section 3221 of the insurance law is amended by adding a new paragraph 19 to read as follows:

(19) (A) EVERY GROUP OR BLANKET POLICY DELIVERED OR ISSUED FOR DELIVERY IN THIS STATE WHICH PROVIDES MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE SHALL INCLUDE SPECIFIC COVERAGE FOR DRUG AND ALCOHOL ABUSE AND DEPENDENCY TREATMENT SERVICES PURSUANT TO THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AND APPLICABLE STATE STATUTES WHICH REQUIRES PARITY BETWEEN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AND MEDICAL/SURGICAL BENEFITS WITH RESPECT TO FINANCIAL REQUIREMENTS AND TREATMENT.

(B) DETERMINATION OF COVERAGE FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES BY A HEALTH PLAN SHALL BE MADE THROUGH A MEDICAL MANAGEMENT REVIEW PROCESS WHICH:

(I) UTILIZES A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE ABUSE COURSES OF TREATMENT TO SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUBSTANCE ABUSE TREATMENT; AND

(II) UTILIZES ONLY CLINICAL REVIEW CRITERIA CONTAINED IN THE MOST RECENT EDITION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S PATIENT PLACEMENT CRITERIA OR OTHER RECOGNIZED AND PEER REVIEWED CRITERIA OR COMPENDIA DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT. ANY ADDITIONAL CRITERIA SHALL BE SUBJECT TO THE APPROVAL OF THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT.

(C) THE LOCATION OF COVERED TREATMENT PURSUANT TO THIS SECTION SHALL BE SUBJECT TO THE INSURER'S REQUIREMENTS RELATING TO THE USE OF PARTICIPATING PROVIDERS, INCLUDING THOSE PROVIDERS LOCATED OUTSIDE OF THE STATE.

(D) WHERE AN INSURED'S HEALTHCARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING CARE TO TREATMENT RELATING TO A SUBSTANCE USE DISORDER WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE INSURED, ALL INTERNAL AND EXTERNAL APPEALS OF UTILIZATION REVIEW DETERMINATIONS SHALL BE CONDUCTED ON AN EXPEDITED BASIS, AS SET FORTH IN SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER AND IN PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

(E) IN THE EVENT OF AN ADVERSE DETERMINATION FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES, THE HEALTH PLAN SHALL CONTINUE TO PROVIDE COVERAGE AND REIMBURSE FOR ALL SUCH SERVICES UNTIL THE INSURED HAS EXHAUSTED ALL APPEALS, BOTH INTERNAL AND EXTERNAL, OR OTHERWISE NOTIFIES THE HEALTH PLAN IN WRITING THAT HE OR SHE HAS DECIDED TO NOT MOVE FORWARD WITH THE APPEALS PROCESS.

(F) FOR PURPOSES OF THIS SECTION: "SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES" SHALL INCLUDE, BUT NOT BE LIMITED TO, HOSPITAL AND NON-HOSPITAL BASED DETOXIFICATION, INCLUDING MEDICALLY MANAGED, MEDICALLY SUPERVISED AND MEDICALLY MONITORED WITHDRAWAL, INPATIENT AND RESIDENTIAL REHABILITATION, INTENSIVE AND NON-INTENSIVE OUTPATIENT TREATMENT, AND OUTPATIENT OPIOID TREATMENT PROGRAMS.

S 3. Section 4303 of the insurance law is amended by adding a new subsection (oo) to read as follows:

(OO) (1) A MEDICAL EXPENSE INDEMNITY CORPORATION, A HOSPITAL SERVICE CORPORATION OR A HEALTH SERVICE CORPORATION WHICH PROVIDES MAJOR MEDICAL OR SIMILAR COMPREHENSIVE-TYPE COVERAGE SHALL INCLUDE SPECIFIC COVERAGE FOR DRUG AND ALCOHOL ABUSE AND DEPENDENCY TREATMENT SERVICES PURSUANT TO THE FEDERAL PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008, AND APPLICABLE STATE STATUES WHICH REQUIRES PARITY BETWEEN MENTAL HEALTH OR SUBSTANCE USE DISORDER BENEFITS AND MEDICAL/SURGICAL BENEFITS WITH RESPECT TO FINANCIAL REQUIREMENTS AND TREATMENT.

(2) DETERMINATION OF COVERAGE FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES BY A HEALTH PLAN SHALL BE MADE THROUGH A MEDICAL MANAGEMENT REVIEW PROCESS WHICH:

(I) UTILIZES A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE ABUSE COURSES OF TREATMENT TO SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUBSTANCE ABUSE TREATMENT; AND

(II) UTILIZES ONLY CLINICAL REVIEW CRITERIA CONTAINED IN THE MOST RECENT EDITION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S PATIENT PLACEMENT CRITERIA OR OTHER RECOGNIZED AND PEER REVIEWED CRITERIA OR COMPENDIA DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT. ANY ADDITIONAL CRITERIA SHALL BE SUBJECT TO THE APPROVAL OF THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT.

(3) THE LOCATION OF COVERED TREATMENT PURSUANT TO THIS SECTION SHALL BE SUBJECT TO THE INSURER'S REQUIREMENTS RELATING TO THE USE OF PARTICIPATING PROVIDERS, INCLUDING THOSE PROVIDERS LOCATED OUTSIDE OF THE STATE.

(4) WHERE AN INSURED'S HEALTHCARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING CARE OR TREATMENT RELATING TO A SUBSTANCE USE DISORDER WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE INSURED, ALL INTERNAL AND EXTERNAL APPEALS OF THE UTILIZATION REVIEW DETERMINATIONS SHALL BE CONDUCTED ON AN EXPEDITED BASIS, AS SET FORTH IN SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS CHAPTER AND IN PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS CHAPTER.

(5) IN THE EVENT OF AN ADVERSE DETERMINATION FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES, THE HEALTH PLAN SHALL CONTINUE TO PROVIDE COVERAGE AND REIMBURSE FOR ALL SUCH SERVICES UNTIL THE INSURED HAS EXHAUSTED ALL APPEALS, BOTH INTERNAL AND EXTERNAL, OR OTHERWISE NOTIFIES THE HEALTH PLAN IN WRITING THAT HE OR SHE HAS DECIDED TO NOT MOVE FORWARD WITH THE APPEALS PROCESS.

(6) FOR PURPOSES OF THIS SECTION: "SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES" SHALL INCLUDE, BUT NOT BE LIMITED TO, HOSPITAL AND NON-HOSPITAL BASED DETOXIFICATION, INCLUDING MEDICALLY MANAGED, MEDICALLY SUPERVISED AND MEDICALLY MONITORED WITHDRAWAL, INPATIENT AND RESIDENTIAL REHABILITATION, INTENSIVE AND NON-INTENSIVE OUTPATIENT TREATMENT, AND OUTPATIENT OPIOID TREATMENT PROGRAMS.

S 4. Section 4902 of the insurance law is amended by adding two new subsections (c) and (d) to read as follows:

(C) WHEN CONDUCTING MEDICAL MANAGEMENT OR UTILIZATION REVIEW FOR PURPOSES OF DETERMINING HEALTH CARE COVERAGE FOR SUBSTANCE USE DISORDERS, A UTILIZATION REVIEW AGENT SHALL USE A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF SUBSTANCE USE DISORDER COURSES OF TREATMENT TO SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUBSTANCE ABUSE TREATMENT. IN ADDITION, A UTILIZATION REVIEW AGENT SHALL UTILIZE ONLY CLINICAL REVIEW CRITERIA CONTAINED IN THE MOST RECENT EDITION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S PATIENT PLACEMENT CRITERIA OR OTHER RECOGNIZED AND PEER REVIEWED CRITERIA OR COMPENDIA WHICH ARE DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT. ANY ADDITIONAL CRITERIA SHALL BE SUBJECT TO THE APPROVAL OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER OF HEALTH AND THE SUPERINTENDENT.

(D) WHERE AN INSURED'S HEALTH CARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING SUBSTANCE USE DISORDER TREATMENT WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE INSURED, INTERNAL AND EXTERNAL APPEALS OF UTILIZATION REVIEW DETERMINATION WILL BE CONDUCTED ON AN EXPEDITED BASIS, AS SET FORTH IN SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE AND IN PARAGRAPH THREE OF SUBSECTION (B) OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS ARTICLE.

S 5. Subsection (c) of section 4903 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

(c) A utilization review agent shall make a determination involving continued or extended health care services, additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the insured or the insured's designee, which may be satisfied by notice to the insured's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient

hospital admission OR REQUESTS FOR TREATMENT FOR SUBSTANCE USE DISORDER, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subsection, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending. PROVIDED THAT A REQUEST FOR TREATMENT FOR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW PURSUANT TO THIS SUBSECTION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT IS PENDING.

S 6. Subsection (b) of section 4904 of the insurance law, as amended by chapter 237 of the laws of 2009, is amended to read as follows

(b) A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving (1) continued or extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider or home health care services following discharge from an inpatient hospital admission pursuant to subsection (c) of section four thousand nine hundred three of this article or (2) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the insured's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section four thousand nine hundred fourteen of this article as applicable. PROVIDED THAT THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER NOTIFIES THE UTILIZATION REVIEW AGENT OF ITS INTENT TO FILE AN EXTERNAL APPEAL IMMEDIATELY UPON RECEIPT OF AN APPEAL DETERMINATION AND A REQUEST FOR AN EXPEDITED EXTERNAL APPEAL FOR TREATMENT OF SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED WITHIN TWENTY-FOUR HOURS OF RECEIPT OF AN APPEAL DETERMINATION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR SUCH TREATMENT WHILE A DETERMINATION BY THE EXTERNAL REVIEW AGENT IS PENDING.

S 7. Section 4902 of the public health law is amended by adding two new subdivisions 3 and 4 to read as follows:

3. WHEN CONDUCTING MEDICAL MANAGEMENT OR UTILIZATION REVIEW FOR PURPOSES OF DETERMINING HEALTH CARE COVERAGE FOR SUBSTANCE USE DISORDER, A UTILIZATION REVIEW AGENT SHALL USE A HEALTH CARE PROVIDER WHO SPECIALIZES IN BEHAVIORAL HEALTH AND WHO HAS EXPERIENCE IN THE DELIVERY OF

SUBSTANCE USE DISORDER COURSES OF TREATMENT TO SUPERVISE AND OVERSEE THE MEDICAL MANAGEMENT DECISIONS RELATING TO SUBSTANCE ABUSE TREATMENT. IN ADDITION, A UTILIZATION REVIEW AGENT SHALL UTILIZE ONLY CLINICAL REVIEW CRITERIA CONTAINED IN THE MOST RECENT EDITION OF THE AMERICAN SOCIETY OF ADDICTION MEDICINE'S PATIENT PLACEMENT CRITERIA OR OTHER RECOGNIZED AND PEER REVIEWED CRITERIA OR COMPENDIA WHICH ARE DEEMED APPROPRIATE AND APPROVED FOR SUCH USE BY THE COMMISSIONER OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER AND THE SUPERINTENDENT OF THE DEPARTMENT OF FINANCIAL SERVICES. ANY ADDITIONAL CRITERIA SHALL BE SUBJECT TO THE APPROVAL OF THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES IN CONSULTATION WITH THE COMMISSIONER AND THE SUPERINTENDENT OF THE DEPARTMENT OF FINANCIAL SERVICES.

4. WHERE AN ENROLLEE'S HEALTH CARE PROVIDER DETERMINES THAT A DELAY IN PROVIDING SUBSTANCE USE DISORDER TREATMENT WOULD POSE A SERIOUS THREAT TO THE HEALTH OR SAFETY OF THE ENROLLEE, INTERNAL AND EXTERNAL APPEALS OF UTILIZATION REVIEW DETERMINATIONS WILL BE CONDUCTED ON AN EXPEDITED BASIS, AS SET FORTH IN SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED FOUR OF THIS ARTICLE AND IN PARAGRAPH (C) OF SUBDIVISION TWO OF SECTION FOUR THOUSAND NINE HUNDRED FOURTEEN OF THIS ARTICLE.

S 8. Subdivision 3 of section 4903 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

3. A utilization review agent shall make a determination involving continued or extended health care services, additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider, or home health care services following an inpatient hospital admission, and shall provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within one business day of receipt of the necessary information except, with respect to home health care services following an inpatient hospital admission, OR REQUESTS FOR TREATMENT FOR SUBSTANCE USE DISORDER, within seventy-two hours of receipt of the necessary information when the day subsequent to the request falls on a weekend or holiday. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. Provided that a request for home health care services and all necessary information is submitted to the utilization review agent prior to discharge from an inpatient hospital admission pursuant to this subdivision, a utilization review agent shall not deny, on the basis of medical necessity or lack of prior authorization, coverage for home health care services while a determination by the utilization review agent is pending. PROVIDED THAT A REQUEST FOR TREATMENT FOR SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED TO THE UTILIZATION REVIEW AGENT PURSUANT TO THIS SUBDIVISION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR SUBSTANCE ABUSE OR DEPENDENCY TREATMENT SERVICES WHILE A DETERMINATION BY THE UTILIZATION REVIEW AGENT IS PENDING.

S 9. Subdivision 2 of section 4904 of the public health law, as amended by chapter 237 of the laws of 2009, is amended to read as follows:

2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:

(a) continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of

continued treatment prescribed by a health care provider home health care services following discharge from an inpatient hospital admission pursuant to subdivision three of section forty-nine hundred three of this article; or

(b) an adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within one business day of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within two business days of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process pursuant to section forty-nine hundred fourteen of this article as applicable. PROVIDED THAT THE INSURED OR THE INSURED'S HEALTH CARE PROVIDER NOTIFIES THE UTILIZATION REVIEW AGENT OF ITS INTENT TO FILE AN EXTERNAL APPEAL IMMEDIATELY UPON RECEIPT OF AN APPEAL DETERMINATION AND A REQUEST FOR AN EXPEDITED EXTERNAL APPEAL FOR TREATMENT OF SUBSTANCE USE DISORDER AND ALL NECESSARY INFORMATION IS SUBMITTED WITHIN TWENTY-FOUR HOURS OF RECEIPT OF AN APPEAL DETERMINATION, A UTILIZATION REVIEW AGENT SHALL NOT DENY, ON THE BASIS OF MEDICAL NECESSITY OR LACK OF PRIOR AUTHORIZATION, COVERAGE FOR SUCH TREATMENT WHILE A DETERMINATION BY THE EXTERNAL REVIEW AGENT IS PENDING.

S 10. The superintendent of the department of financial services shall select a random sampling of substance abuse treatment coverage determinations and provide an analysis of whether or not such determinations are in compliance with the criteria established in this act and report its finding to the governor, the temporary president of the senate, and speaker of the assembly, the chairs of the senate and assembly insurance committees, and the chairs of the senate and assembly health committees no later than December 31, 2015.

S 11. 1. Within thirty days of the effective date of this act, the commissioner of the office of alcoholism and substance abuse services, superintendent of the department of financial services, and the commissioner of health, shall jointly convene a workgroup to study and make recommendations on improving access to and availability of substance abuse and dependency treatment services in the state. The workgroup shall be co-chaired by such commissioners and superintendent, and shall also include, but not be limited to, representatives of health care providers, insurers, additional professionals, individuals and families who have been affected by addiction. The workgroup shall include, but not be limited to, a review of the following:

a. Identifying barriers to obtaining necessary substance abuse treatment services for across the state;

b. Recommendations for increasing access to and availability of substance abuse treatment services in the state, including underserved areas of the state;

c. Identifying best clinical practices for substance abuse treatment services;

d. A review of current insurance coverage requirements and recommendations for improving insurance coverage for substance abuse and dependency treatment;

e. Recommendations for improving state agency communication and collaboration relating to substance abuse treatment services in the state;

f. Resources for affected individuals and families who are having difficulties obtaining necessary substance abuse treatment services; and

g. Methods for developing quality standards to measure the performance of substance abuse treatment facilities in the state.

2. The workgroup shall submit a report of its findings and recommendations to the governor, the temporary president of the senate, the speaker of the assembly, the chairs of the senate and assembly insurance committees, and the chairs of the senate and assembly health committees no later than December 31, 2015.

S 12. This act shall take effect immediately.