

**Agenda**  
**Treatment and Coverage of Substance Use Disorders and Mental Illness Working Group**  
**PA 99-0480**

**Locations**

Department of Insurance Office Springfield  
320 W. Washington St.,  
4th Floor, Springfield, Illinois 62767

Department of Insurance Office Chicago  
122 S Michigan Ave,  
19th Floor, Chicago, Illinois 60603

**Call-in Information**

312-535-8110  
Code: 806 801 498

- I. Welcome
- II. Introductions
- III. 2019 ACA Open Enrollment Overview
- IV. Feedback from Committee Testimony
- V. Next Steps/ Discussion
- VII. Adjourn





**WORKING GROUP**  
**TREATMENT & COVERAGE OF SUBSTANCE ABUSE DISORDERS & MENTAL ILLNESS**  
**MEETING MINUTES**

Illinois Department of Insurance  
 Meeting Minutes of House Bill 1, Public Act 099-0480  
 Working Group Regarding Treatment and Coverage of Substance Abuse Disorders and Mental Illness  
 Open Meeting  
 Tuesday, November 6, 2019  
 1:30 p.m. to 3:00 p.m. CST

**Video Conference location:** Illinois Department of Insurance Video Conference Room at  
 122 S. Michigan Ave., 9th Floor, Chicago, Illinois 60601.

**Video Conference location:** Illinois Department of Insurance Conference Room at 535 W. Jefferson Street, 5<sup>th</sup> floor,  
 Springfield, Illinois 62767.

<b>Working Group Members</b>		Present Y/N	CHI/ SPI
Robert Muriel	Director, Illinois Department of Insurance	Y	
Brian Gorman	Director of Outreach, Illinois Dept. of Insurance	Y	
Laura Pellikan	Exec. Director, Illinois Dept. of Insurance	Y	
Ryan Gillespie	Dep. Director, Health Products, Illinois Dept. Of Insurance	Y	
Sara Stanberry	Health Products Advisor, Illinois Dept. of Insurance	Y	
Kate Morthland	Policy Advisor, Illinois Dept. of Insurance	Y	
David Applegate	Dir. Of State Policy, Kennedy Forum	Y	
Renee Popovits	Principal Attorney, Popovits Law Group	Y	
Rafael Rivera	Dep. Director, Prevention Services, Illinois Dept. of Human Services	Y	
Kathleen Monahan	Illinois Dept. of Human Services	Y	
Stephine Becker	Assoc. Director of Healthcare Justice, Shriver Center	Y	
Jud DeLoss	General Counsel, Illinois Association of Behavioral Health	Y	
Sara Howe	CEO, Illinois Association of Behavioral Health	Y	
Blanca Campos	Community Behavioral Healthcare Association	Y	

**MEETING MINUTES**

- Call to Order.  
 The Director for the Illinois Department of Insurance, Robert Muriel, called the semiannual meeting of the Mental Health and Substance Use Disorder (MHSUD) Working Group to order at 1:35 p.m.
- Introductions.  
 Director Muriel welcomed all attendees, clarified the structure of the meeting. Working Group members, and Illinois State Department staff introduced themselves in Chicago and Springfield.
- Approval of the November 27, 2018 MHSUD Working Group Meeting Minutes. A motion to approve the minutes was made and seconded once a couple of attendance errors were mentioned that needed to be corrected to reflect they were in attendance at the last meeting. The minutes were approved and entered into the record.
- Brian Gorman introduced Kathleen Monahan.

Presentation by Kathleen Monahan, update to the State of Illinois Opioid Action Plan (SOAP)

- Last update was two months ago, today's presentation will summarize updates
- Shared some background on the main pillars of SOAP, including priorities and strategies.
- **Strategy 1** - PMPnow, the Illinois Prescription Monitoring Program, which requires all prescribers possessing an Illinois controlled substances license to register with the program, allows providers to access information more easily regarding their patients' prescription history. Searches by providers continue to increase and the program has been improved to allow providers access to information more easily due to integration with patients' electronic health record (EHR) information. 622 healthcare systems are now connected to PMPnow and 71,000 prescribers are now registered and the numbers have been steadily increasing.
- The increase in search numbers mentioned above were presented in a graph which shows that number of PMP searches has increased from 4.5 million to 6.5 million. This is due in part to the program's improvements which includes allowing users to access the information more quickly, without having to go through a second portal. These improvements to access have resulted in more providers using the PMPnow system.
- **Strategy 2** – To reduce high risk opioid prescribing through provider education and guidelines. UIC did a study to see whether technical assistance and education would modify providers' behavior. Resulted in one less opioid prescription, per month, per provider was dispensed after they were exposed to the training. Another tactic included the PMP Review Committee sending letters to prescribers that were outside the bounds of the norm for prescribing opioids. The number of high dose opioid prescriptions per 100,000 decreased by 25% over the three and half years of the study. The number of patients that were dispensed an opioid prescription per 100,000 decreased substantially by 30 percent.
- **Strategy 3** – To increase the accessibility of information and resources. IDOI created an Access to Care and Treatment Program (related to behavioral health parity law). IDOI delivered presentations to people in every Illinois county, reaching over 4,500 individuals. The Department of Health worked with the Broadcasters Association to get PSA's about the Good Samaritan Law throughout central and southern Illinois in 2018-19. It was a very successful campaign that reaching over half a million individuals a month.
- Other public awareness campaign included the Illinois Help Line. The Help Line has been very successful and the company who provides the services are constantly working on quality improvement and making updates to information so that people who call in are being directed to an appropriate provider. Stats as of this week show that the line has had over 18,000 calls in a year and a half with over 48,000 visits to the website from over 36,000 unique individuals.
- Video campaign called "Help is Here" with the tagline "Recover Belongs in Illinois." This campaign features individuals with lived experience talking about their recoveries. Campaign includes shorter versions of the videos and a Facebook ad campaign that is ongoing – results aren't in yet on how campaign is doing. By the end the calendar year (December 2019) the Help Line is going to have texting and chat capabilities.
- **Strategy 4** – Increase the impact of prevention programming in communities and schools. The Department of Public Health expanded Naloxone education in school districts and IDPH has been training school nurses and coordinating school Naloxone access and increasing school-based prevention programming. Cross agency work going on with IDHS/SUPR, IDPH and the Illinois Board of Education.
- **Strategy 5** – Strengthening data collection, to identify opportunities for intervention. IDPH received a grant to leverage syndromic surveillance data which is up and running

on the IDPH Opioid Dashboard. This dashboard can help predict hotspots along with an overdose map function, but the information is about a year behind due to coroners' reports to verify some of the overdoses. IDPH is implementing the Overdose Mapping application Program (ODMAP) for use by law enforcement agencies in rural Illinois receiving Naloxone.

- Opioid Data Dashboard – Kathleen highly recommended that working group members visit the dashboard site because it's continually being improved and becoming more interactive.
- **Strategy 6** – Increase the access to care for people with opioid use disorder. This strategy is probably the biggest aspect of work that SUPR does. HFS and Medicaid not cover all three forms of medically assisted treatment (MAT). The Emergency Opioid and Addiction Treatment Access Act (also known as the Prior Act Bill) was passed in January 2019 - people no longer need prior authorization for treatment for outpatient methadone treatment (OMT). Federal CMS approved IDOI request to change the essential health benefits so that insurance companies have to remove barriers for people who need treatment for opioid use disorders. Illinois may be the only state where this has happened.
- There is an ongoing effort to reduce the number of MAT deserts, where it's difficult for people to find access to treatment. Back in March of 2018 there were 1.8 million Illinois residents that were living in counties with no access. As of October, 2019 that number has been reduced to approximately 847,000 Illinois residents. Presently, half a million Illinois residents have access to at least one of those medication assistance treatments. Map was shared that showed with counties don't have a facility or provider that is prescribing treatments. This map is not interactive but the Opioid Dashboard does allow users to access a layered map where people can see what provider is offering what of the three MATs. A lot of work is being done, including a monthly and quarterly internal dashboard, to reduce the number of Illinois MAT deserts and the number of people who don't have access to MATs. Other projects that are dedicated to this work include "Hospital Warm Handoff" and "Hub and Spoke" that has five geographic sites that try to treat some of the people who have limited access.
- Pregnant women, newborns and post-partum women are a special population that all SAMSA grantees are supposed to pay particular attention to and prioritize. The Illinois Perinatal Quality Collaboration (ILPQC) has an MNO initiative that are 101 hospital participate in. They also work with DCFS to refer pregnant or post-partum women who are identified as positive for opioids. There is a pregnant and post-partum women with OUD project, run by Lisa Cohen, that certifies doulas to be peer recovery coaches. The Peer Recovery Coaches with lived experience seem to be the best assistance for the mothers that need help. The certification process for peer recovery coaching is a challenge for the grant because the certifications are multi-layered and time consuming. Another big challenge for pregnant women who might not choose assistance through this program is stigma. Women who have an opioid use disorder don't want to be judged or fear they won't be treated fairly. Four sites are part of this pilot program.
- HFS has a DocAssit Consultation Program to provide training and support for Medicaid providers serving pregnant and postpartum women with substance use disorders.
- There is a very robust technical assistance program for new providers who are prescribing any of the three MAT prescriptions and they focus on special populations in their training.
- **Strategy 7** – Increase the Capacity of Deflection and Diversion, about people who are incarcerated and people on probation. This information is from other agencies. The Administrative Office of Illinois Courts (AOIC) has implemented several training

initiatives for judges to address OUD. ICJIA also administered two deflection/diversion grants to nine grantees. These grants help law enforcement to develop and implement deflection programs that offer immediate pathways to SUD treatment as an alternative to involvement in the criminal justice system. In general, the criminal justice population is a big part of SUPR's focus for the next couple of years.

- **Strategy 8** – Increase the number of first responders and community members who are trained and have access to Naloxone. This is another robust program, which includes 121 programs enrolled in Drug Overdose Prevention Programs (DOPP), over 54,000 people have been trained to administer naloxone, 53,463 naloxone kits have been distributed, resulting in 3,226 overdose reversals have been reported to SUPR. The statewide standing order for naloxone allows all pharmacies enrolled in DOPP to provide naloxone to people without a prescription.
- A comment was mentioned about report from 18 months ago where they were talking about collecting the data on the reversals that have been reported. That data had some skewed racial information that they were going to look into. The report showed that far more Caucasians were administered the Naloxone treatment than minorities. A concern was raised and Kathleen was asked to look at that data and share any information about the statistics and what is happening. The group wants to understand what the disparities are so that they can help address the issue. Rafael responded that part of the challenge with the recorded naloxone data is that they collect the information from forms that need to be filled out. Law enforcement people are more likely to fill out the forms. Family members and bystanders are less likely to fill out a form and return it to be counted in the data. So, they aren't collecting all the information. SUPR is continuously collaborating with IDPH to look at their overdose data because they have more information that is recorded through EMS encounters and hospitals. This helps both groups can look at more data. For those people who are reporting on overdoses that were prevented tends to be their syringic exchange programs and similar programs where they have contact with people who are currently using Naloxone or know about that network. It may be that the only way the government can analyze the data is the overdose rates and the reported deaths (the opposite of the reversal) to see if that is having an impact on the minorities communities. May need to look at the data differently because the state is trying hard to serve all communities to know what the data is saying. Currently, when someone is getting Naloxone from a pharmacy there is no recording back mechanism. It was suggested that it would be great to find a way to close the loop with the pharmacy distribution in order to collect more information (such as a way to text information back about use and if it was successful. With the syringe exchange program, when someone comes in asking about harm reduction products we can ask "since the last time you were here, did you use the Naloxone?" And then try to collect information that way.
- Some data shows that to reduce the overdose stats it makes more sense to get as much Naloxone out into the community and not worry so much about the reporting of reversals. It's an easy product to use and it doesn't cause harm.
- **Strategy 9** - Decrease the number of overdose deaths after an at-risk individual's immediate release from a correctional facility. The reported information is from other agencies. IDPH and Corrections partnered to do community expos to assist parolees and probationers to try and help their re-integration into the community and to provide naloxone and naloxone training. Other initiatives include a pilot project that provides SUD services for Medicaid members involved with the criminal justice system who are offered treatment as an alternative to incarceration. Cook County Jail has a medical detox unit. There are a number of initiatives that were just funded in Cook County to

work with Cook County Jail and the populations that we are trying to reach and offer naloxone training if not medication assisted treatment. The Jail AMAT program which connects people who are incarcerated that are about to be released within 30 days to discuss their options regarding naltrexone and what the jail is willing to allow for the providers to work with. SUPR has been pushing to get all three forms of medication assisted treatment and naloxone within different jail systems. There are a number of jails being supported from a number of funds where the providers go in and connect with someone who has an opioid use disorder and know they are at high risk for overdose once they are released from incarceration. So they work with these individuals by giving them a naltrexone injection and then a follow up treatment with the same provider in an effort to make a connection while they are in jail.

- IDPH's final data for 2018 showed a 1.6% decrease from 2017 to 2018. It's the first time there has been a decrease in deaths in five years. This decrease points to the fact that a combination of all the above efforts are making an impact. However, non-fatal opioid overdoses have not decreased. New challenges require that new initiatives to address the disparity in those who are dying.
- IDPH data – A graph was shared that shows the percentage of opioid overdose deaths and the percent change/drop in 2018. It was noted that there was a significant decrease in the number of deaths in the second quarter of 2017 and the group was wondering what changed during that timeframe. Rafael mentioned that there was a change in format or recording that probably resulted in the lower numbers.
- Another graph was shared that shows the growing disparities in opioid overdose deaths. The number of African American deaths continue to increase. The number of Hispanic deaths has been pretty level but has seen a slight increase. These increasing numbers for minority deaths is really a challenge for the state.
- Additional numbers were shared about non-fatal opioid overdoses including hospitalizations and emergency department visits. There was less of an increase in hospitalizations and ED visits compared to the previous year.
- Heroin overdose hospitalizations increased in 2017 but stayed the same in 2018. Hospitalizations due to overdoses involving opioids other than heroin decreased by 10% in 2018.
- A graph was shared that showed the number of naloxone administrations per encounter. This graph that shows that a person could receive two or even three naloxone administrations in one encounter. This means that the first administration didn't work but a second or third attempt is made because they think the person can be saved. This number is increasing over time and this is because of the strength of the heroin and synthetic fentanyl.
- Resources/websites were shared to find out more information and where some of the information from the report came from. Kathleen highly recommended the Opioid Data Dashboard and SUPR monthly reports that show the federal funded programs and number of people treated in each program.
- Proposed recommendations include: Address the growing racial and social disparities of the opioid crisis, look at harm reduction strategies and how they can be expanded through state funds, collaborate with law enforcement to identify strategies to curtail drug trafficking activities; increase the Helpline use including chat and text features; and create a comprehensive single state website which has been discussed before and is a continued recommendation.

- Questions and comments during the presentation and after.
  - In the technical assistance that is provided for new providers who are prescribing any of the three MAT prescriptions, does it share best practices and are they the same as the best practices the MCOs are adopting, (referred to a bill that DHS worked on that included prior authorization that includes a notification and continued stay reviews). It would be helpful to know if providers are being trained on it, and are the insurance companies and MCO's are approving the Medicaid reimbursement for these services?
 

**A:** The assistance that DHS is providing is specific to the programs that are within SUPR, so they don't crossover into what MCOs might be doing but DHS is constantly having conversation with HFS and trying to improve these services where they could benefit from the education.

Response to answer above: "It doesn't do any good to train providers on something if the primary source of reimbursement is going to limit the actual services that are being rendered. So there has to be some sort of joint education, and it's a shame we don't have someone here from the insurance industry because they should know about this in order to make a difference. The state has worked hard to expand coverage with all three forms of MAT and educate providers but if the money doesn't follow the clinical stuff, it's not going to happen.
  - A question was asked related to a report from 18 months ago where information was shared about the collection of the data on the overdose reversals that have been reported. That data showed some skewed racial information that they were going to look into related to far more Caucasians being administered the Naloxone treatment than minorities. A concern was raised and Kathleen was asked to look at that data and share any information about the statistics and what is happening. The group wants to understand what the disparities are so that they can help address the issue. Rafael responded that part of the challenge with the recorded naloxone data is that they collect the information from forms that need to be filled out. Law enforcement people are more likely to fill out the forms. Family members and bystanders are less likely to fill out a form and return it to be counted in the data. So, they aren't collecting all the information.
  - How is SUPR targets their efforts in training for Naloxone training? Do you go by hot spots areas or where you see the most overdoses?
 

**A:** There are funded providers to cover certain areas. Depending on the funding source, such as the Illinois Preventing Drug Overdose which covered the six highest rated overdose counties. Five providers were funded to cover the county. Law enforcement was trained and then it expanded beyond that to bystanders and institutions. With the SOR money, a number of public health departments in some of the other 96 counties who covered multiple counties. The designated public health departments were responsible for any requests for services or training from those other counties.
  - Because Medicaid doesn't cover people who are incarcerated, as you are talking to patients about their options, at what point do the MCOs get involved and trying to get them Medicaid coverage and does it matter what MCO they choose in order to get that Medicaid assisted treatment? Rafael said he didn't know the answer. He said that he knows their providers screen for Medicaid eligibility once they are released and they are supposed to be helping them. It was suggested that this process might be something to look at more closely because once a person starts MAT and then they are released from jail and if they need to get on Medicaid, they need to be educated on picking the right plan so that the plan they choose, supports the medication they need. Otherwise, it's an



opportunity for relapse. Kathleen mentioned that the Dept. of Corrections has a pilot program in two locations where they are working at least 30 days before someone is released to get them on Medicaid with the purpose that they will be linked to a provider. The plan is to expand this pilot program within the next year across the Department of Corrections. Some Hub and Spoke locations are also working directly with local county jails in some of the hardest hit counties. It was also mentioned that there are a number of enrolment assistors across the state that are willing to help and go into jails and be that type of connection between the provider and the individual. It means making that connection in each local community. All the qualified health centers have application assistors that are willing to do that work.

- A comment was made that there are some consent decrees that the department hadn't been complying with and there is over a 120,000 backlog cases of Medicaid eligibility. Hoping the department has some sort of fast track for those coming out of jail because they are such a vulnerable population because of the resulting recidivism rates would far outweigh the interventions that need to be done. It seems prioritizing this would be a good thing for the Federal consent decree that the state has been defaulting on.
- Has there been any consideration from legislation that would allow some of the federal funds that would allow some flexibility to address the resurgence of meth and other drugs.

A: The DHS has noticed an increase through the helpline of people seeking assistance for meth as well as cocaine. The numbers are not as dramatic as the opioid crisis. The data seems to be localized and they are gathering data to see what regions are most affected (mainly region 4, above the delta region). They have some increases and they are trying to gather enough data to see what they can do about assistance but they have not guidance from the feds to use any of the opioid money to use it any differently.

- Renee - The purpose of this group is to help consumers to understand and access services and the hotline was created under HB1 to deal related to education, and as she hears about the success of the opioid help line, wondering if there can be an integration of some of the things that IDOI and HFS is supposed to be doing under HB1 and build it off the existing help line. Consumers might not think to go to DOI, their first thing is that they need help. They might need help with treatment, reimbursement, or something else. Is there a way to either populate these types of questions within one overall help line, such as a one-stop shop? Since the help line is showing great success, why don't we try moving over some of the mental health and substance use disorder information, to the same help line for the parity coverage?
- A: Brian answered that he didn't think it was an out of bounds idea. All of us who work on the policy implementation side and those who work on consumer education and outreach are learning as we go along. The reality is that the DOI generally occupies the states about getting covered in a qualified health plan. There is a compliance element to the plans that are offered throughout the Marketplace and on the individual market and ultimately if a consumer feels that their rights under Illinois law have been violated, we provide a vehicle for that consumer to seek relief. So that is how these services differ, and why it's currently structured. There would need to be a wrap around element to how DHS and Medicaid clients and private insurance products all work together should be a goal for everybody in the state.
- Not suggesting that there shouldn't be outreach, or not to have a complaint hotline but think we could all do a better job of getting the information to the consumers about their rights. Are there other front doors to get consumers that information?
- A: Yes. Having this group and the fact that these conversations are happening, which didn't exist before the statutory requirements, which require us to work together will

allow this work to continue. Related to the ACA, two federal grants around the number of different market reforms, two of those forms are awareness of essential benefits and better understanding of mental health parity. Part of the work product that was created was using those dollars working on our drug formulary on the compliance side and the Accessing Care and Treatment booklet related to mental health and substance use disorder. The printed work product was a smaller palm card, that instructed people how to use their insurance. We are going to work with our other partners – last year we provided these resources to legislators’ offices, in addition to 35 presentations regarding access to coverage of treatments. In the next month and a half to be doing some paid advertising using federal resources on mental health parity in television, radio and digital formats. We requested an extensions to use some remaining funds to highlight the benefits of QHPs and the idea of mental health parity and the protection. We are using the open enrollment period to help amplify those message points.

- Sara Stanberry suggested some recommendations related to the language about behavioral health based on her experience speaking with insurers and MCOs that they use the terminology differently. Consumers understand that behavioral health means both mental health and substance use disorder but Insurance companies and MCO’s consider “behavioral health” as only mental health coverage. Sara suggests that moving forward we need to be consistent and mention both MH and SUD in our documents and messaging. Sara also suggested that we make sure consumers understand what it means.
- Question about issue Renee has with providers when care is denied at the SUD level and they have to figure out what entity is the right one to appeal to. Consumers don’t understand if their health plan is a federal plan, or a self-funded plan or whether or not the state has any jurisdiction. Is there anything that can be done in Illinois to help people understand what kind of plan they have? Or something on their insurance card that shows what kind of plan it is such as “this is a fully funded plan,” or “this is a state or county plan” and for information, call this number. Until that happens, people won’t pursue their rights. Brian mentioned that an additional challenge includes the low level of consumers’ health insurance literacy across the state that compounds this challenge.
- Blanca commented that it would be helpful if the plans that cover mental health and substance use disorder benefits included this information in their summary of benefits. Brian mentioned that we look to our colleagues in other states for best practices and how they handle regulatory elements and consumer assistance but they also face some of the same challenges as Illinois.
- The question was asked if insurance companies have to follow any requirements that they need to mention mental health and substance use disorder coverage in their documentation. Sara Stanbury confirmed that mental health parity is a process that insurance companies are required to follow and they are required to show their benefit levels to their customers and those benefits are reviewed by the IDOI to make sure they are in parity with their medical/surgical benefits. Because parity is an internal practice and not a benefit, it’s not a written policy.
- Stephanie Becker asked if the Accessing Care and Treatment booklet available on the IDOI website. Brian said the PDF exists but he needs to include some disclaimers because it’s a federal paper product.
- Jud DeLoss commented that there is a document within the booklet that is an authorization for protected health information that would not satisfy any law in respect to substance use disorder and substance abuse. And he would be more than happy to contribute and assist with the requirements.

- Another comment, part of the work group that the Kennedy Forum leads as well as IDH, the Parity Implementation Coalition. The work group put together a checklist on those things that might be required to be satisfied under SB-682, the Prior Authorization Bill and the Update to the Illinois Parity law 1707. The checklist includes deadlines and deliverables and I think one of the main focuses of this working group is to ensure those steps are carried out and Jud offered to share this checklist as a tool to help guide discussions in addition to the information that was shared in the presentation.
  - Renee mentioned another checklist when HB-1 was first passed that was put together by her law firm and the Kennedy Forum that references an annual report that is supposed to be coming out of this working group by the end of this year. Renee offered assistance to help with the report and asked if there was anything the group could start drafting. Renee also has the original annual report from 2017 as a reference that she could share. Brian introduced Kate Morthland and mentioned she would be person leading that report. Brian said Renee could send him a copy of the 2017 report and he could pass it on.
  - There was mention of another data working group her firm and the Kennedy Forum are supposed to be convening
  - with technical assistance from the IDOI and HFS. They are waiting on one more appointment from the Governor that they expect soon. This working group has some upcoming deadlines that are coming up but they have been working to extend those deadlines. There are key pieces in here that the work group will work on to develop some formats for reporting that ultimately DOI and HFS will utilize as they are reviewing plans.
- The next meeting is scheduled in four months, March 11, 2020 at 1:30 pm in the Department of Insurance in Chicago and Springfield. The group was supposed to convene twice per calendar year but a meeting earlier in the year did not happen. The focus of the meeting could be working on the annual report and what is needed. Once the data work group is convened it would be helpful to do an update on what is happening with the group. The data work group will include providers MCOs and insurers.
- Adjourned at 3:05 pm



Insert Date, 2020

Illinois Attorney General Attorney  
Health Care Complaint Section  
[healthcare@atg.state.il.us](mailto:healthcare@atg.state.il.us)

Re: **Denied Coverage for Substance Use Disorder Treatment**

Dear Illinois Attorney General Office:

My name is [insert your name]. I needed treatment for my substance use disorder so I went to [Insert name and address of treatment center] on [Insert dates of treatment or date of assessment but admission denied]. My insurance plan/managed care organization (MCO) whose name is [insert name of MCO or health plan] denied or limited my care.

PLEASE CHECK ALL THAT ARE APPLICABLE My insurance plan/MCO told me and/or my treatment provider that:

- I am not eligible for coverage, yet I have Medicaid coverage
- My treatment was not considered medically necessary
- I did not need residential level services or my plan does not cover residential services
- I needed to fail first in outpatient services
- My plan does not cover treatment for marijuana addiction
- My plan does not cover court ordered services
- I do not need additional days of care, no further days will be authorized yet I know I need further care and the clinical staff have recommended additional services
- I must be stepped down to a lower a level of care yet I am not ready
- I need to be placed on medicated assisted treated treatment and given outpatient services
- Other please explain:

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I appreciate your assistance investigating these limits on my health insurance coverage. You have my permission to contact me for further information and to contact the plan to obtain facts about my treatment and these limitations and/or denials. I can be reached at the following:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Parent Name and Phone if Minor: \_\_\_\_\_

I also enclose a signed consent form giving my treatment provider permission to talk with you and share necessary treatment information to allow you to pursue this investigation on my behalf. I also authorize you to keep me and the treatment provider informed about your progress in getting me coverage for the treatment services I need.

With appreciation,

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Patient Signature

Enclosure: Signed Consent for Release of Information