Testimony Notes - Prior Auth Process - Angela Camp

Uploaded by: Angela Campbell

Position: FAV

Senate Bill 308/House Bill 305: Health Insurance – Utilization Review – Revisions

POSITION: SUPPORT

- Good afternoon. My name is Angela Campbell, and I am a certified professional coder and the supervisor of the prior authorization department in the Sandra and Malcolm Berman Cancer Institute at GBMC.
- We have 10 providers in the practice specializing in oncology and hematology.
- To support these providers, we employ 5 full-time staff who work to obtain prior authorizations for treatment necessary for the care of our patients.
- Over the years, we have seen the process grow more cumbersome with more medications and treatments requiring prior authorizations.
- Each day, my staff and I submit requests through the electronic prior authorization systems used by insurance carriers. On average, we submit about 50 requests per day among our three infusion centers.
- I can assure you that it is not an easy process, and the solution to addressing denials and delays is not for physicians to simply use these systems. These systems are often part of the problem.
- There is no single portal or uniformity among the electronic prior authorization systems used by insurance carriers.
- One of the hardest issues is trying to determine where to go to even begin the process.
- While there may be some overlap in vendors, each carrier has its own portal for submission of requests.
- There are different portals used for medications than there are for other health care services. Within one insurance carrier's portal, there may be additional portals for specific types of authorizations, such as oncology, cardiology, genetic testing, or radiology.
- Often, it feels that we are sent in circles trying to get to the correct portal or vendor.
- When we submit a prior authorization request, the questions and information requested are different with each carrier portal. Often the information requested is not relevant to the patient's diagnosis or treatment and takes additional staff time to complete.

- When the authorization request is submitted, only about 50% are automatically approved. The remaining requests are denied or pended for additional information.
- Because the portals don't interface with our EHR, when medical records are requested, these records must be printed, scanned, and then uploaded to the portal or faxed depending on the direction given by the carrier. This printing, scanning, uploading, and faxing takes considerable staff time.
- We often experience situations where a treatment will be denied or delayed because of missing information, such as a lab report, even though we submitted the information, but the carrier's staff are not familiar with reading the records or treatment plans, which then necessitates a series of phone calls between us and the carrier.
- To conclude, the most frustrating aspect of this process is the fact that, most of the time the medication or other health care service, is ultimately approved but only after considerable staff time is spent working through the process which can take days or even weeks, which causes patient's stress and anxiety, especially when it affects the timing of the patient's treatment plan.
- Thank you for listening, and I hope that you act favorably on this legislation.

APTA MD Testimony 2023 - Support - Senate Bill 308

Uploaded by: Daniel Shattuck

Position: FAV

APTA Maryland

February 15, 2023

The Honorable Melony Griffith, Chair
Senate Finance Committee
3 East, Miller Senate Office Building
Annapolis, Maryland 21401

RE: Senate Bill 308 – Health Insurance – Utilization Review – Revisions- **SUPPORT**

Dear Chair Griffith,

We represent over 1,800 members and our mission is to foster excellence in the profession of physical therapy by advocating, educating, and promoting best practices to improve the human experience of the diverse society we represent and serve.

APTAMD is part of a coalition to improve patient centered care through legislation titled: ***Health Insurance – Reform Utilization Review Techniques***

Health insurance carriers engage in a process known as "utilization review," which is a system where the carrier reviews a practitioner's request that a patient receive a certain health care service to determine if the service is medically necessary. The two most common types are "prior authorization," which is requesting approval in advance from the carrier and "step therapy," where the patient must try and fail on other medications (often less expensive) before "stepping up" to another medication.

SB308 will improve the prior authorization process by adding transparency, aligning standards, and increasing accountability of the insurers.

The 2021 Report on the Health Care Appeals and Grievances Law (released December 1, 2022) reports that carriers rendered 81,143 adverse decisions (e.g., denials of health care services based on the carrier's decision that the health care service was not medically necessary rather than the judgment of the treating practitioner).

In 2022, the Maryland Insurance Administration (MIA) modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation), 72.4% of the time on filed complaints, up from 70.5% in 2021. This means that in more than 7 out of 10 cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service.

The 2021 American Medical Association conducted a survey on the impact that prior authorizations have on physicians and patients and found that:

- 93% of the time physicians reported delays in access to necessary care.
- 82% of the time physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.
- 73% of the time physicians reported that criteria used by carriers for determining medical necessity is questionable - 30% of the time physicians reported that it is rarely or never evidence-based and 43% only sometimes evidence-based.

APTA Maryland Ph. 800.306.5596 Fax 877.622.0960 aptamd@aptamd.org

APTA Maryland
A Chapter of the American Physical Therapy Association

This legislation would reform prior authorization by:

1. Require evidence-based, peer reviewed criteria as the standard of care developed by an organization that works directly with health care providers or a professional medical specialty society.
2. Mandate that a physician which made or participated in the adverse decision notify the insured's physician or health care practitioner prior to making the adverse decision and be available to discuss the basis for the denial and the medical necessity of the health care service rather than deny care and then allow for a peer-to-peer meeting after the fact.
3. Study how to standardize electronic systems across all carriers (rather than each carrier having their own system) with the same data points and using a single point of entry, such as CRISP.
4. Study the feasibility of implementing a "gold card" standard in Maryland, which would exempt health care practitioners who meet certain standards from prior authorization standards.

The Data –Ultimate Outcome of Physical Therapy Denied Claims

■ *13.08% of filed physical therapy claims are denied*
■ *66.14% of denied physical therapy claims are appealed*
■ *52.34% of appealed physical therapy claim denials are overturned*

The National American Physical Therapy Association (APTA) conducted a survey on administrative burden from Dec 2018-Jan 2019. APTA members report that medically necessary physical therapist services are delayed — ultimately impacting patients' clinical outcomes — because of the amount of time and resources they must spend on documentation and administrative tasks. The volume of these tasks also leads to dissatisfaction and burnout. APTA urges policymakers and third-party payers to advance policies that streamline documentation requirements, standardize prior authorization and payer coverage policies, and eliminate unnecessary regulations.

- 85.2% of providers agree or strongly agree that administrative burden contributes to burnout.
- 74% of respondents agreed or strongly agreed that prior authorization requirements negatively impact patients' clinical outcomes.
- 76% of facilities and private practice owners have added nonclinical staff to accommodate administrative burden.
- 65% of respondents say more than 30 minutes of staff time is spent preparing an appeal for one claim.

If you have any questions, please contact us at 800-306-5596 or aptamd@aptamd.org.

Sincerely,

Michelle Jamin *JD Sheppard*

Michelle Jamin
Director for Government Relations
APTA Maryland

JD Sheppard
President
APTA Maryland

Health Insurance - Utilization Review - Revisions (HB305/SB308) at a Glance

APTA Maryland
A Chapter of the American Physical Therapy Association

HOW IT AFFECTS THE PHYSICAL THERAPY PROFESSION

Prior Authorization is one type of utilization review

Before a patient can receive physical therapy services, permission from their insurance company is required.

can delay access to medically necessary care by more than 25%

credentials should align when making critical decisions about patient care.

Evidence-based, peer reviewed criteria

is required for pre-auth decisions and developed by an organization that works directly with health care providers or a professional medical specialty society.

Promote delivery of quality healthcare

and access to healthcare services by accounting for the needs of atypical patient population/diagnoses.

allows for deviations from norms on a case-to-case basis.

Rather than deny care and then allow for a peer-to-peer meeting after the fact.

Enhance communication

by alerting the requesting provider before delivering an adverse decision to discuss the basis for the denial .

Standardize electronic systems

rather than each carrier having their own system, using the same data points and a single point of entry.

Save **25%** of administrative time with a standardization of prior authorization forms and processes

MDS AADA Support SB 308 Prior Auth.pdf
Uploaded by: Daniel Shattuck
Position: FAV

MDS Maryland Dermatologic Society

February 16, 2023

The Honorable Melony Ghee Griffith
Chair, Senate Finance Committee
11 Bladen Street
James Senate Office Building, Room 220
Annapolis, Maryland 21401

Dear Chairperson Griffith,

On behalf of the Maryland Dermatologic Society, and nearly 16,500 U.S physician members of the American Academy of Dermatology Association ("Academy"), we write in support of SB 308. This legislation would be a critical step to ensure patients have access to their prescription medicines by placing guardrails on the use of prior authorization. Prior authorization is a cost containment tool used by health insurance plans requiring physicians and other health care providers to obtain advance approval from a health plan before delivering a specific procedure, service, device, supply or medication. SB 308 would ensure that the prior authorization process is clinically based and does not unduly burden physicians or patients in accessing optimal drug therapy.

While we understand the need to manage the unpredictable and growing costs of health care, prior authorization is often a hurdle to accessing medication and other procedures, such as Mohs micrographic surgery, phototherapy, and patch testing. As explained below, we urge you and members of the Senate Finance Committee to support SB 308.

Prior authorization has greatly impacted the ability of our patients to access their medications. According to a 2020 survey of Academy members, approximately one quarter of dermatology patients per day require prior authorization, and only half are successful. Of the 50% who do not access the medication prescribed by their dermatologist, 36% reported receiving a less effective

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medication and 27% either delayed or abandoned their treatment. Dermatology patients who seek biologics often wait more than two weeks to more than one month to obtain their medications as a result of prior authorization. Delays in accessing prescription medications can cause irreparable harm to patients in need of timely access to specific treatments. The choice of therapy should be between a physician and his/her patient where consideration of all factors—efficacy and safety of all treatment options, co-morbidities, and support system—are fully vetted and discussed. Prior authorization places a third party, with no knowledge of the complexity or full history of a patient's condition, in an inappropriate decision-making role.

Further, prior authorization poses significant administrative burdens on dermatology practices. The financial cost to practices averages $40,000 to either hire or redistribute staff to manage the prior authorization process, which can take up to an average 3.5 hours of work per day. According to dermatology practice administrators, the time spent on prior authorization equates to an average five to eight additional patients per day that could be scheduled.

We appreciate the opportunity to provide written comments on this important public health issue and urge your support for SB 308. As physicians, our number one priority is the health and welfare of our patients. The passage of this legislation will improve access to prescription medications that are in the best interest of the patient. For further information, please contact Lisa Albany, director of state policy for the American Academy of Dermatology Association at LAlbany@aad.org or (202) 842-3555.

Sincerely,

Mark D. Kaufmann, MD, FAAD
President
American Academy of Dermatology Association

Chikoti Mibenge Wheat, MD, FAAD
President
Maryland Dermatologic Society

SB 308 The Maryland State Dental Association Suppo
Uploaded by: Daniel T Doherty, Jr.
Position: FAV

The Maryland State Dental Association Supports SB 308 – Health Insurance – Utilization Review – Revisions

Submitted by Daniel T. Doherty, Jr. on behalf of the Maryland State Dental Association

A. Utilization review is a system used by insurance companies to determine if the proposed health care services treatment is medically necessary. Prior authorization is the process which requires dentists to obtain approval from the carrier in advance of treatment.

1. **In 2021 insurers deemed 81,143 procedures were not medically necessary, of which dental denials constituted 15,133 (18.6%).** This number of dental prior approval denials in 2021 were significantly lower than in 2018, primarily because Covid caused a significant reduction in the number of patients who received dental care. In 2018 the number of total denials was 78,314, of which 24,677 (31.5%) were dental denials. *These denials, based on the carrier's determination that the services were not dentally necessary, rather than the judgement of the treating provider, were reversed under Maryland's Health Care Appeals and Grievance Law 70.5%.*

2. **In 2022 the Maryland Insurance Commissioner (MIA)** modified or reverse the insurers' decision (including when a carrier reverse its decision during the course of investigation) 72.4% of the time on filed complaints. *This means that in 7 out of 10 cases the* ***insurer WAS WRONG.***

3. **In 2021 the American Medical Association conducted a survey on the impact that prior authorizations have on patients and physicians finding that:**
    a. 93% of the time access to necessary care was delayed;
    b. 82% of the time patients abandoned their recommended course of treatment because of prior authorization denials;
    c. Often the basis used by the carrier to determine medical necessity is questionable – often the criteria was not evidenced based,

B. SB 805 will provide patients with the much-needed reform to the system of Prior Authorization.

1. It will require evidence-based, peer reviewed criteria as the standard of care developed by an organization that works directly with health care providers or a professional medical specialty society.

2. SB 308 will also require that the health care provider, dentist or physician that serves on the

health care service review panel that made an adverse decision be knowledgeable and experienced in the diagnosis and the treatment under review rather than only board certified or eligible in the same specialty.

3. It mandates that a physician or dentist who made or participated in the adverse decision notify the insured's physician, dentist or health care practitioner prior to making the adverse decision and be available to discuss the basis for the denial and the medical necessity of the health care service rather than deny care and then allow for a peer-to-peer meeting after the fact.

4. It will require that the physician or dentist that served on the panel making the adverse decision possess a current and valid Maryland license to practice medicine or dentistry.

5. It provides for a study to determine how to standardize electronic systems across all carriers (rather than each carrier having their own system) with the same data points and using a single point of entry, such as CRISP.

6. It requires a study of the feasibility of implementing a "gold card" standard in Maryland, which would exempt health care practitioners who meet certain criteria from prior authorization standards.

The Maryland State Dental Association requests that SB 308 receive a favorable report.

Submitted by:
Daniel T. Doherty, Jr.
February 15, 2023

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SB0308_FAV_MedChi, MDACEP, MDAFP, MSEPS, MDACOG, M
Uploaded by: Danna Kauffman
Position: FAV

TO: The Honorable Melony Griffith, Chair
Members, Senate Finance Committee
The Honorable Katherine Klausmeier

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine Krone
410-244-7000

DATE: February 15, 2023

RE: **SUPPORT** – Senate Bill 308 – *Health Insurance – Utilization Review – Revisions*

On behalf of the Maryland State Medical Society, the Maryland Chapter of the American College of Emergency Physicians, the Maryland Academy of Family Physicians, the Maryland Society of Eye Physicians and Surgeons, the Maryland Section of the American College of Obstetricians and Gynecologists, the Mid-Atlantic Association of Community Health Centers, and the Maryland Clinical Social Work Coalition, we submit this letter of **support** for Senate Bill 308.

Senate Bill 308 makes changes to the utilization review policies used by health insurance carriers to determine when a requested health care service is medically necessary. Too often, these policies are negatively affecting patients by either denying or delaying necessary care. In 2021, the American Medical Association conducted a survey on the impact that prior authorizations have on patients and found that 93% (more than 9 out of 10) of physicians reported delays in access to necessary care and 82% (more than 8 out of 10) of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.

The 2021 Report on the Health Care Appeals and Grievances Law (released December 1, 2022) reported that health insurance carriers rendered 81,143 adverse decisions (e.g., denials of health care services) in 2021 compared to 78,134 in 2018, representing an increase over the 4-year period. Even more troubling is the high rate of reversals by the Maryland Insurance Administration (MIA) when complaints are filed. In 2022, MIA modified or reversed the carrier's decision (or the carrier reversed its own decision during the course of investigation) 72.4% of the time, up from 70.5% in 2021. This means that in more than 7 out of 10 cases, the MIA ruled that the carrier was wrong, and that the patient should have received the health care service.

Utilization review policies, such as prior authorization, are also resulting in negative outcomes for providers. Two out of five physicians (40%) have staff dedicated to working on prior authorization requests. Physicians have also reported that their staff spends almost two business days each week completing prior

authorization requests. The time and money spent on completing prior authorization requests would be better used on clinical care.

Therefore, Senate Bill 308 seeks to address issues with prior authorization and utilization review management techniques to ensure that patients receive the care needed and providers are not overly burdened. First, Senate Bill 308 reduces the volume of prior authorization requests by:

- Allowing a patient to stay on a prescription drug without another prior authorization if the insurer previously approved the drug and the patient continues to be successfully treated by the drug.
- Exempting prescription drugs from requiring a prior authorization for dosage changes provided that the change is consistent with federal FDA labeled dosages.
- Removing the need to obtain a prior authorization for generic drugs.
- Eliminating the need for the patient to obtain more than one prior authorization for the same medication during the same treatment when the treatment is divided into two or more prescriptions because of differing formulations of the drug.

Senate Bill 308 makes changes to ensure greater transparency and accountability in how insurers determine whether a health care service is medically necessary by:

- Requiring that the criteria used in determining whether care is medically necessary is evidence-based and peer reviewed and that it is developed by organizations that work directly with health care providers or by a professional medical specialty society.
- Requiring that the physician making or involved in making the denial is knowledgeable of and experienced in the diagnosis and the treatment under review.
- Mandating that, prior to making a denial, the insurance carrier (i.e., physician responsible for determining denials) notifies the insured's physician or health care practitioner of the potential denial and makes him or herself available to discuss the basis for the denial and the medical necessity of the health care service.
- Requiring that the physician (or dentist) who is responsible for determining denials possess a current and valid Maryland license to practice medicine (or dentistry).
- Requiring that, if requesting additional information, the insurer provide the criteria and standards to support the need for the additional information.
- Altering response timeframes to account for the fact that patients need health care services 24/7.

Lastly, Senate Bill 308 seeks to improve the utilization review process by studying two major areas by:

- Standardizing electronic systems across all carriers (rather than each carrier having their own system) with the same data points and using a single point of entry, such as CRISP, to minimize the length of time required to submit and respond to prior authorization requests.
- The feasibility of implementing a "gold card" standard in Maryland, which would exempt health care practitioners who meet certain standards from prior authorization requirements.

With these changes, we believe that patients will be able to access needed health care services in a timely manner and will improve the accountability and understanding of current processes used. We urge a favorable vote.

written testimony.pdf
Uploaded by: Erinn Maury
Position: FAV

TO: The Honorable Melony Griffith, Chair

Members, Senate Finance Committee

The Honorable Katherine Klausmeier

FROM: Erinn Maury, MD
Rheumatologist, Owner of Mid-Atlantic Rheumatology in Millersville, MD phone: 410-787-9400

DATE: February 15, 2023f

RE: SUPPORT – Senate Bill 308 – Health Insurance – Utilization Review – Revision

On behalf of my patients and myself, I am writing in support of SB308 to improve the prior authorization process which will improve timely appropriate care to patients, allow my staff to provide other services such as chronic care management. Chronic care management can reduce costs to the health care system as a whole by keeping patients out of the ER, urgent care, and prevent the need for hospitalizations.

This example is of a patient who has insurance that is under the control of the Maryland Insurance Administration, who was mismanaged and ended up with serious complications because of the problems with the current prior authorization process not following clinical guidelines and evidence-based medicine.

My patient is a woman in her late 50s, working full time with a commercial insurance plan. She has had rheumatoid arthritis for about 7 years which has been somewhat difficult to control at times. She had recurrent denials for Orencia for management of rheumatoid arthritis even though I had clinical evidence indicating she would benefit from being on this drug rather than going back on yet another tumor necrosis factor inhibitor (TNF inhibitor) of which she had failed at least 2 in the past.

I provided journal articles showing the science behind why she would benefit from being on Orencia. Peer-reviewed scientific articles indicate that those who have 2 positive antibodies for rheumatoid arthritis are more likely to respond positively to Orencia than respond to TNF inhibitors. Because of delaying care, she had to be on prednisone much longer by months than would have been necessary. Instead, they forced my hand, and I ended up having to put her on a third TNF inhibitor, Remicade.

As anticipated, she did not respond all that well to Remicade. She then developed a rash which we were uncertain of its origin since it did not seem to be exactly correlated with when she had her Remicade and she had had rashes in the past. The rash became severe and she had to discontinue Remicade after the third dose. She had to go on even higher doses of steroids than she already was because the Remicade was not working for her. He had to go to the dermatologist where she was seen a few times and was finally biopsied. It turned out to be a drug eruption, likely secondary to Remicade. She had to stay on higher doses of steroids as it took quite a long time for this rash to completely resolve. She was covered head to toe, and it was extremely itchy for several months.

After that, I once again tried getting Orencia approved, however, her insurance company then requested that she try yet another tumor necrosis factor inhibitor after failing 3, 1 of which caused a serious rash

requiring high-dose steroids. You may be aware that high-dose steroids for a long period of time increases the risk of osteoporosis, diabetes, obesity, heart disease, adrenal insufficiency, and other problems. The side effects of prednisone at a high dose for a long period of time are generally not reversible. Although some people will no longer be diabetic once they stop steroids, other people remain diabetic.

She was on more steroids continuously for a year than she had to be. Over those 12 months, I tried 3 times to get Orencia approved. It wasn't until the 3rd try, writing a scathing appeal letter in support of putting the patient on Orencia and using the state Attorney General's office to assist in the appeal, the pharmacy benefit manager/insurance company finally relented and approved Orencia. Within a month of starting on Orencia, the patient's rheumatoid arthritis significantly improved, and I was able to reduce her dose of steroids.

Unfortunately, the patient developed osteoporosis during that time despite preventive medication and I started her appropriately on more powerful medication for management of osteoporosis. And even more unfortunately the patient now has thoracic spine fractures for which she needed to undergo 2 spine surgeries in the last month. I highly doubt that this patient would have incurred spinal fractures had I been allowed to manage her appropriately given my knowledge of rheumatology, staying up to date on the guidelines and using evidence-based medicine for her management. This patient is only in her late 50s. She works hard. She and her husband do not have a lot of money. He had to go out on disability due to his own medical problems. And now she is looking at having to go out on disability due to her own medical issues.

If the insurer had only followed clinical guidelines for management of rheumatoid arthritis as put out by the American College of rheumatology, or even pain attention to the peer-reviewed scientific evidence I provided showing that this patient would likely benefit from being on a different drug, I know that she would have avoided the terrible time with a whole-body drug rash, months and months of high-dose steroids at ate away her bones, and now the spinal fractures and spine surgeries that she has had to undergo.

This bill requires that ensures and pharmacy benefit managers follow clinical guidelines that are peer-reviewed and use evidence-based science and are formed by specialty societies such as the American College of rheumatology. In practice, rheumatologists use these guidelines, follow these guidelines, read new guidelines when they come out and our patients benefit from us following these guidelines. I only want the insurance carriers and pharmacy benefit managers to follow the same high standards that we follow in the practice of medicine.

Additional reasons to support SB308:

Generic drugs should be exempt from utilization review.

Here are real life examples I have seen multiple times in my practice of misapplication of the utilization review process:

1. Requests for prior authorization for a generic drug that costs $4.00 out of pocket at Wal-Mart.

2. Requests for prior authorization for a generic drug that costs less than $10.00 out of pocket at Wal-Mart
3. Request for prior authorization for a prednisone taper because the insurance company said that prednisone is considered a “drug for transplanted organs”. This is true, but prednisone is prescribed exceedingly more commonly to kids and adults for poison ivy, asthma, and allergic reactions, bronchitis, emphysema flare up etc. It also costs less than $5.00 out of pocket. If someone with severe asthma can’t get their prescription of prednisone filled right away because it’s being held up by a prior authorization, they risk ending up in the ER or hospitalized; this is much more expensive to the health care system (and the patient) than a $5.00 prescription.
4. Request for prior authorization for a generic antibiotic. Generic antibiotics are cheap. Generic antibiotic dispensing should never be delayed by utilization review since infections can progress and lead to hospitalization, ER visits, or death and cost the health care system more money.
5. In rheumatology, we have prior authorization requests for our basic generic drugs which are generally less than $100 out of pocket. We’ve been using these drugs to treat autoimmune diseases for at least 30 years. I have heard that the insurers have said that they request to prior authorization because they want to make sure we’re using the drug properly. This is a ludicrous reason. I have passed my boards for rheumatology twice and twice for internal medicine in the last 16 years. I also have 4 years of medical school, 3 years of internal medicine residency, 2 years of rheumatology fellowship, and 16 years of experience managing rheumatology patients. If I am not using these drugs properly by now, there is no way I would have passed my boards, and way I would still be in practice.

SB308 requires that there is making decisions on behalf of the insurance company, pharmacy benefit manager or in a peer-to-peer review be of the same specialty either board eligible or board-certified and have knowledge and experience in treating the conditions being reviewed. This should be the standard of care.

I have had to do peer-to-peer reviews as a second appeal after 2 denials for drug. I am a rheumatologist. Once, the "peer" they gave me was a pediatrician. While she was a physician, she was not my peer since she was not a rheumatologist. I made a statement as such to the physician on the other end of the phone. She, initially, was somewhat offended. However, after I explained that I was not her peer either. As an adult rheumatologist, I would never presume to make decisions regarding pediatric care. I have only had 6 weeks of training in pediatrics which was in medical school which was many years ago. I am not board-certified in pediatrics. In fact, I would think it malpractice or I to practice pediatrics unless in an extreme emergency where there were no other options. With my "peer" being a pediatrician, I would hope she would feel it to be inappropriate for her to make decisions on adult rheumatology patients. Our patients require the use of powerful immunosuppressive drugs and some chemotherapy drugs which require intensive monitoring. Pediatricians do not have training in these drugs except possibly during a pharmacology class in medical school.

SB308 also addresses timelines and improves transparency for the prior authorization process. I recently had a 24-year-old woman wait 2 months for a prior authorization to be addressed by the

insurer. Two months after we sent in the prior authorization, I get a phone call from a physician asking if I done the TB test which needs to be done prior to starting on the drugs that we use in rheumatology. I pointed out to the physician with whom I was speaking that on page 6 of the initial prior authorization we have sent in 2 months prior he would find the negative TB test which he was requesting. I do not understand how it took them 2 months to review the prior authorization for a basic rheumatology drug and they could not even read the 6 pages that we sent them from the initial prior authorization. This poor woman ended up quitting her job in the meantime because she could not keep up at work because of the severity of her psoriatic arthritis. She has since had to drop out of the workforce due to the delay in care and worsening of her arthritis. She hopes to get back into the work force at some point. This is an intelligent, hardworking, college educate, young woman who was aspiring to get a master's degree. That is now all on hold.

I appreciate your time and consideration in reviewing the merits of this bill. My goal is to protect patient's wellbeing, improve access to appropriate health care by following evidence-based medicine, common sense, and providing better services to my patients such as chronic care management. The revisions in this bill will help physicians and patients and will reduce overall costs to the health care system.

Sincerely

Erinn Maury, MD
Rheumatologist

SB0308.LOS.pdf
Uploaded by: Heather Forsyth
Position: FAV

ANTHONY G. BROWN
Attorney General

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February 14, 2023

TO: Melony Griffith, Chair
Senate Finance Committee
FROM: Office of the Attorney General, Health Education and Advocacy Unit
RE: SB0308 – Health Insurance – Utilization Review – Revisions: **Support**

The Office of the Attorney General's Health Education and Advocacy Unit (HEAU) supports the goal of curtailing the unjustifiably negative effects of utilization review by carriers that increasingly deny claims for drugs and medical services prescribed by providers. Utilization review is the process whereby carriers effectively make medical judgments about a provider's treatment recommendation and substitute their judgment about that treatment, using criteria that are often not publicly shared in advance with consumers or providers. The HEAU also supports eliminating unnecessary preauthorization requirements and streamlining the preauthorization process when appropriately utilized. The changes this bill proposes should help eliminate dangerous delays in care, reduce inappropriate denials of medically necessary care, and reduce administrative costs.

The HEAU assists consumers in mediating and filing a grievance or appeal of carrier adverse decisions (denials based on medical necessity, appropriates or efficiency) or coverage decisions (denials other non-coverage decisions). In fiscal year 2022, the HEAU closed nearly 600 appeals and grievances cases, mediating 436 of those cases. Of the 436 cases, 26% were adverse decision cases, 56% were coverage decision cases, and 18% were eligibility cases. The HEAU mediation process resulted in 65% of the medical necessity cases and 56% of the coverage decision cases being overturned or modified.

In one case, a 42-year-old woman diagnosed with psoriatic arthritis had been stable on Remicade infusions every 6 weeks with a dosage of 7 mg/kg since 2017. In July 2021, the carrier abruptly denied the Remicade claim, declaring "you will be held to FDA dosing guidelines not to exceed [6 mg/kg every 8 weeks]." In her internal appeal

letter, the rheumatologist said "I have been made aware that the new policy at [the carrier] is to automatically deny any medication for a patient that is a higher dose or more frequent schedule than what the FDA product insert guide lists; even if it is a proven dose and schedule that has had significant benefit for a particular patient. This policy will jeopardize my patient's treatments and cause disease relapse, unnecessary pain, loss of income from not being able to work and irreversible damage to her joints." With the HEAU's intervention, the denial was overturned, and the prior dosage and frequency resumed. Several other patients filed complaints about the same carrier, which was denying medication claims notwithstanding each patient's established need for medically necessary treatments tailored to their disease progression and symptoms. The HEAU also obtained reversals of those denials.

In another case, a patient and her surgeon wanted to use a transoral approach to thyroidectomy, in which the thyroid is removed via the mouth to avoid the scarring of the neck that otherwise results from a traditional approach. The patient suffered from multinodal thyroid disease and enlarged goiter. The carrier denied the pre-authorization request. The day before the surgery, the HEAU received the complaint. The HEAU immediately filed an expedited appeal. The transoral thyroidectomy was then authorized in time for the surgery to proceed on schedule.

Additional data and case examples can be found in the HEAU's FY 2022 Annual Report to the General Assembly on the health insurance carrier appeals and grievances process. That report highlights the fact that HEAU's success rate for consumers is not unusual; carriers routinely deny claims that are usually overturned on appeal. In its Annual Report, the HEAU is also required to report on MIA's appeals and grievances data, which reflects that 72% of carrier grievance decisions in FY 2022 were reversed or overturned once the MIA investigated the denial. The same report reveals that while carriers overturned or modified 54% of their original adverse decisions during the internal grievance process in FY 2022, only 11% of consumers actually challenged the denial.

This bill attempts to address some of the concerns reflected in the data, which the HEAU fully supports. But, the HEAU does have some technical concerns about the bill and other recommendations, including, but not limited to:

1. The HEAU has some concerns about the language on page 7 lines 3-4, which appears to limit the notice requirements to adverse decisions, excluding coverage decisions in 10D. The proposed language is unnecessary because the provisions of 10A and 10B are required without the addition. If the proponents prefer the added language, we recommend including coverage decisions (10D), to avoid ambiguity the absence could create.

2. The HEAU supports elimination of prior authorizations for dosage changes of previously authorized prescription drugs within FDA limits but believes opioids should be carved out because the ongoing opioid epidemic continues to pose a threat to Marylanders. The FDA often approves drugs in wide ranges proposed by manufactures to cover rarer cases that are not mainstream, and assuming the administration of such doses will be confined to the worst cases. However, in the case of opioids, prior authorization requirements have acted as a check against overreaching. In a December 2019 National Drug Threat Assessment, the DEA noted Controlled Prescription Drugs were responsible for the most drug-involved overdose deaths and second most commonly abused substance in the United States. In the case of opioids, the goals of eliminating delays in care, reducing inappropriate denials of medically necessary care, and reducing administrative costs, are outweighed by the goals of preventing abuse, accidental over-dosing, and death.

3. The HEAU recommends requiring 60 days' notice of the introduction of a new prior authorization requirement because such a change amounts to a material plan modification. (Page 8, line 12)

4. Under current 15-10A-06 (page 15, lines 21-30), carriers report the number of adverse decisions to the Commissioner quarterly, but do not report the number of clean claims processed by the carrier. In our annual reports, the HEAU has long advocated for inclusion of the number of enrollees and clean claims in carrier quarterly reports because an analysis of the number of adverse decisions cannot be performed effectively without comparing that number to total enrollee and number of claims processed.

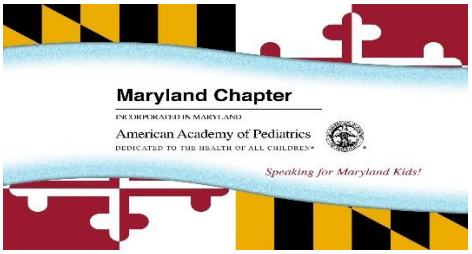
5. The HEAU supports requiring the offer of peer-to-peer (private review agent and provider) discussion when issuing an adverse decision but suggests removing the phrase "*medical necessity"* on page 20 in line 3 because adverse decisions are denials based on medical necessity, appropriateness or efficiency, and use of the term medical necessity alone could be misconstrued to be limiting.

We support this well-intentioned bill and look forward to working with all stakeholders to strengthen consumer protections regarding utilization review without inadvertently reducing or hindering consumer rights under existing law.

SB0308HB305 - HI - Utilization Review - Bernstein

Uploaded by: Jeffrey Bernstein

Position: FAV



Senate Bill 308/House Bill 305: Health Insurance – Utilization Review – Revisions
POSITION: SUPPORT

Maryland Chapter of the American Academy of Pediatrics is in strong support of **Senate Bill 308/House Bill 305: Health Insurance – Utilization Review – Revisions**. These bills will better ensure that patients, especially pediatric patients, can access medications and health care services in a timely manner and not be subject to unnecessary and often harmful delays.

The process for submitting prior authorization requests must be improved. While in some instances, the electronic prior authorization format is functional, it too often is non-productive and results in patient care delays. Being rigidly formatted, it is difficult to determine the trigger or criteria that will be needed for approval of a prior authorization. Multiple submissions of documentation are often requested with no clear path to success. In addition, because the electronic prior authorization systems don't link to electronic medical records, any additional information must be separately uploaded to the system, taking an enormous amount of staff time. Access to empowered, knowledgeable, practicing pediatric physicians is missing when prior authorization rules mandate medications that are incompatible with certain ages or developmental capabilities. For example, a commonly mandated inhaled asthma controller medication is incompatible with the spacer administration devices required for effective use in young children. Consequently, staff are required to use a system that will ultimately deny the medication, which then requires us to submit additional documentation or schedule a peer-to-peer meeting to explain why the medication is medically necessary. Difficult to efficiently arrange, the peer-to-peer meeting is sometimes not even with a pediatrician.

In addition, fluidity to reflect real-time changes in diseases, treatments, and recommendations must improve. For example, recently, there was an unexpected shift in the season of the prevalence of RSV -- Respiratory Syncytial Virus. A sharp rise in cases began occurring in May and June before the usual fall/winter season. The American Academy of Pediatrics reviewed the situation and issued a recommendation that certain at-risk pediatric patients be prescribed Synagis as a preventative treatment against this life-threatening disease. There was one particular patient of mine, a young child with complex congenital heart disease -- a child whose condition matched the Academy's recommendation and the recommendation of his cardiology specialists. Despite the clearly stated updated recommendations for dosing during

this atypical season and our determination that the patient should receive it, there was an approximate six (6) week gap of exposed vulnerability between the time of the initial request for the medication and the actual administration, due primarily to denials and requirements for additional documentation.

As pediatricians, we are aligned with the goals of ensuring that our recommendations are optimally indicated, safe, appropriate, and cost-effective. We are well-aware of drug interactions and safety issues of medications, as well as the need to efficiency utilize health care services and resources. We are, by nature, protective of our patients and families, not subjecting them to unwarranted discomfort, risks, and expense. Data on my practice and prescribing patterns are continually collected and evaluated by the same payers executing multiple duplicative layers of reviews, restrictions, and appeals. A physician with a documented record of appropriate and cost-efficient care should have their prescribed treatments promptly received based on initial attestation of medical necessity and propriety. Be it a "gold card" or similar, there should be approval mechanisms which don't require the repeated demonstration and evaluation of necessity. We believe that the changes contained in Senate Bill 308/House Bill 305 will bring much needed relief to our physicians while Maryland studies how to better improve these systems. Thank you.

Submitted by:

Dr. Jeffrey P. Bernstein, M.D.
Pediatrician

CRISP LOS HB305-SB308_2023-02-14.pdf
Uploaded by: Kelley Gallagher
Position: FAV

CRISP

February 14, 2023

The Honorable Joselyn A. Pena-Melnyk
Chair, House Government & Operations Committee
House Office Building, Room 241
11 Bladen St.
Annapolis, MD 21401

The Honorable Melony G. Griffith
Chair, Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen St.
Annapolis, MD 21401

Dear Madam Chair Pena-Melnyk and Madam Chair Griffith:

On behalf of Chesapeake Regional Information System for our Patients (CRISP), the designated health information exchange (HIE) and health data utility (HDU) for Maryland, I am writing to express our strong support for HB305 / SB308 pertaining to *Health Insurance – Utilization Review and Prior Authorization Reform.* We at CRISP believe this legislation is essential to addressing shortfalls in the current prior authorization process for many reasons, the most critical being to improve the timely delivery of care and health outcomes for Maryland's patients.

According to the Centers for Medicare and Medicaid Services (CMS), the administrative burden, delays in care, and other issues associated with inefficient prior authorization processes and framework are widespread. In response, CMS released the updated Advancing Interoperability and Improving Prior Authorization Processes Proposed Rule (CMS-0057-P) in December 2022 which seeks to address these issues and further promote efficient health data exchange between payers, providers, and patients. We acknowledge the compatibility between this Rule and the provisions outlined in HB 305 and are confident that should this legislation pass, Maryland will be well-positioned to not only achieve our desired outcomes, but do so in a way that aligns with federal healthcare and interoperability priorities.

CRISP particularly supports the provisions outlined in §15-10B-16 (2) (1) of the draft legislation which call for (i) revising electronic processes to achieve greater standardization among payors and reduce the burden of prior authorization, (ii) replacing proprietary health plan portals with a standardized solution that can enable single sign-on for payors and third-party administrators, and (iii) establishing a pilot program to implement and support these activities. The pilot study language further aligns with MHCC 2011 report to the General Assembly (*Recommendations for Implementing Electronic Prior Authorizations)* which proposed a single sign-on solution and leveraging the State's HIE as a single point of entry.

CRISP has long supported local, state, and regional healthcare priorities with technology solutions adopted though cooperation and collaboration, and we would be very pleased to partner with the Maryland Health Care Commission (MHCC), providers, payors, and other stakeholders to advance prior authorization reform in Maryland. Thank you once again for your consideration and the opportunity to express our strong support for HB305 / SB308.

Sincerely,

Craig Behm
President & CEO
CRISP

CancerCare_SB 0308_02.14.2023.pdf
Uploaded by: Kim Czubaruk
Position: FAV

SB 0308: "Health Insurance – Utilization Review – Revisions."
Submitted by Kim Czubaruk, Senior Director, Strategy and Policy, Cancer*Care*
February 14, 2023

Senator Klausmeier and members of the Finance Committee, I am Kim Czubaruk, Senior Director of Strategy and Policy for Cancer*Care*, a leading national organization providing free, professional support services and information to help people manage the emotional, practical, and financial challenges of cancer. In 2022, our staff answered more than 38,000 calls to our helpline and served clients with 90 different types of cancer in all 50 states. Our comments are informed by the stories we hear from our clients as they navigate the confusing, expensive, and frustrating process of accessing and paying for vital – and sometimes life-saving – cancer care and treatment. I am writing in support of SB 0308: "Health Insurance – Utilization Review – Revisions."

SB 0308 revises and establishes requirements for utilization management (UM) of health care services, specifically, preauthorization or prior authorization (PA). PA requires that certain services, treatments, or prescriptions be submitted to and approved by the payer as medically necessary before a patient can receive that care. Payers have designed and implemented PA in a manner that imposes significant barriers to patients' accessing necessary, appropriate, and timely care. The requirements and guardrails in SB 0308 will help prevent PA from being used as a means to delay and/or deny care to reduce payers' costs at the expense of patients receiving the care and treatment they need when they need it.

A survey by the American Society for Clinical Oncology (ASCO) illustrates the serious consequences of prior authorization (PA) on cancer care and treatment, with nearly all respondents (n=300) reporting that PA caused harm to patients. This included:

- 96% reporting delays in treatment,
- 94% reporting delays in diagnostic imaging,
- 93% reporting patients being forced onto a second-choice therapy,
- 88% reporting patients experienced increased out-of-pocket costs,
- 87% reporting therapy was denied, and
- 80% reporting disease progression.

In addition, while almost all PBMs and health plans claim to use peer-reviewed evidence-based studies when designing their PA programs, 30% of physicians report that PA criteria are rarely or never evidence-based, and 43% report that the criteria are only sometimes supported by evidence. While patients and providers are focused on determining the best course of care to treat a serious disease, PA's obstacles pose too much for many patients, leading to 37% of prescriptions subject to PA being abandoned by patients at the pharmacy

counter and never filled. PA's impact on patient abandonment is further revealed by a 2021 AMA survey in which 82% of physician respondents (n=1,004) reported that PA can at least sometimes lead to treatment abandonment. This same AMA survey showed PA's negative impact on providers, with 88% of physicians describing the burden associated with PA as high or extremely high, 40% of physicians having staff who work exclusively on PA, and physicians and staff spending almost two business days each week completing PA requirements.

The revisions and requirements in SB 0308 will go a long way to ensure that cancer patients and others with a health condition receive the timely and appropriate medical care prescribed by their providers to treat their disease. SB 0308 will prevent payers' from continuing to use PA as a tool to delay and/or deny care that results in patient harm that is often irreparable and imposes consequential burdens on health care providers.

Thank you for the opportunity to submit this testimony and for your thoughtful consideration.

SB 308 Support.pdf
Uploaded by: Lindsey Viscarra
Position: FAV

INTERNATIONAL FOUNDATION FOR
AUTOIMMUNE & AUTOINFLAMMATORY ARTHRITIS
(AIARTHRITIS)

February 14, 2023

Maryland Senate Finance Committee
Legislative Services Building
90 State Circle
Annapolis, MD 21401

RE: Senate Bill 308

Dear Members of the Finance Committee,

On behalf of the International Foundation for Autoimmune & Autoinflammatory Arthritis (AiArthritis), I encourage you to support SB308 when it is before you in committee.

We are leaders in advancing education, advocacy, and research for those impacted by autoimmune and autoinflammatory arthritis (AiArthritis) diseases through peer-led guidance, collaboration, and resources that are driven by patient-identified issues and patient-infused solutions. As we are led by patients we well understand the importance of ensuring that healthcare providers can provide continuity of care to their patients, particularly when it comes to our medications.

HB305/SB308 will eprovide better continuity of care by requiring that health plans allow patients to remain on medications without further prior authorization, provided that the health plan covers the drug and the patient is stable on these medication. It will also allow that prescription drugs with dosage changes and generic switches remain authorized, thus allowing a seamless change with no delay. For many medications, even a few days without can have serious consequences for their disease. This bill will also ensure that coverage decisions are made by physicians not just licensed in the appropriate specialty, but knowledgeable in and experienced with the specific treatment. This is crucial to ensure that the best decisions are made.

Patients with Autoimmune & Autoinflammatory Arthritis diseases are frequently prescribed medications that require a pre-authorization. Many plans require that every time a patient is sent the medication (typically every 4-8 weeks), a new pre-authorization is required. Not only does this pose a risk to the patient, but it also requires countless hours of paperwork on the part of the physician's office, the infusion center, and often the patient as well.

For these reasons, we urge you to continue to protect patients by voting YES on SB308.

Sincerely,

Lindsey Viscarra
Public Policy Manager
International Foundation for Autoimmune & Autoinflammatory Arthritis

SB 308 LOS 2023 Leg NAPNAP-2.pdf
Uploaded by: MD Chesapake NAPNAP
Position: FAV

National Association of Pediatric Nurse Practitioners℠
MD: CHESAPEAKE

Support: SB 308 Health Insurance - Utilization Review - Revisions

2/12/2023

Maryland Senate
Finance Committee
3 East
Miller Senate Building
Annapolis, Maryland 21401

Dear Honorable Chair, Vice-Chair and Members of the Committee:

On behalf of the pediatric nurse practitioners (PNPs) and fellow pediatric-focused advanced practice registered nurses (APRNs) of the National Association of Pediatric Nurse Practitioners (NAPNAP) Chesapeake Chapter, I am writing to express our support of **HB 305 Health Insurance- Utilization Review- Revisions.**

Prior authorization and step therapy policies (known as utilization review) used by the insurance carriers are increasingly hurting patients and overburdening health care providers. Denials by insurance carriers continue to rise. In 2018, there were 78,314 denials based on medical necessity; in 2021 that number increased to 81,143. More importantly, when patients filed complaints with the Maryland Insurance Administration (MIA), the MIA ruled that in more than 7 out of 10 cases the insurance carrier was wrong, and that the patient should have received the health care service.

In 2021, the American Medical Association (AMA) conducted a survey on the impact that prior authorization/step therapy processes have on providers and patients and found that:

- 93% of providers reported delays in access to necessary care.
- 82% of physicians reported that patients abandoned their recommended course of treatment because of prior authorization denials.
- 73% of providers reported that criteria used by carriers for determining medical necessity is questionable - 30% of providers reported that it is rarely or never evidence-based and 43% only sometimes evidence-based.
- 24% of providers report that PA has led to a patient's hospitalization.
- 18% of providers report that PA has 18% led to a life-threatening event or required intervention to prevent permanent impairment or damage.
- 8% of providers report that PA has led to a patient's disability/ permanent bodily damage, congenital anomaly/birth defect or death.

The survey also reported that 88% of providers describe the burden of prior authorizations as high or very high with 40% of providers reporting that they have staff who exclusively work on prior authorizations.

National Association of Pediatric Nurse Practitioners℠
MD: CHESAPEAKE

NAPNAP along with other advanced provider and physician specialty societies and patient advocacy groups, are supporting legislation to put care back in the hands of physicians and protect patients from delays and denials in care.

For these reasons the Maryland Chesapeake Chapter of NAPNAP extends their support to **SB 308 Health Insurance- Utilization Review- Revisions and requests a favorable report.**

The pediatric advanced practice nurses of your state are grateful to you for your attention to these crucial issues. The members of Chesapeake Chapter of the National Association of Pediatric Nurse Practitioners are committed to improving the health and advocating for Maryland's pediatric patients. If we can be of any further assistance, or if you have any questions, please do not hesitate to contact Lindsay J. Ward, the Chesapeake Chapter President at 410-507-3642 or lindsayjward@hotmail.com.

Sincerely,

Lindsay J. Ward CRNP, RN, IBCLC, MSN, BSN
Certified Registered Nurse Practitioner- Pediatric Primary Care
International Board-Certified Lactation Consultant
National Association of Pediatric Nurse Practitioners (NAPNAP)
Chesapeake Chapter President

Evgenia Ogordova

Evgenia Ogordova-DNP
National Association of Pediatric Nurse Practitioners (NAPNAP)
Chesapeake Chapter Legislative Chair

2023 ACNM SB 308 Senate Side FAV.pdf
Uploaded by: Michael Paddy
Position: FAV

Support

Senate Bill 308 – Health Insurance - Utilization Review - Revisions

Senate Finance Committee

February 15, 2023

The Maryland Affiliate of the American College of Nurse-Midwives supports Senate Bill 308 – *Health Insurance - Utilization Review - Revisions*. The bill alters the requirements for providers and carriers related to health insurance utilization review including provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, preauthorization for prescription drugs, and private review agents. Additionally, the bill alters the timelines related to internal grievance procedures and adverse decision procedures, and increases the penalties for violating certain provisions of law regarding private review agents.

ACNM supports this legislation because preauthorization has become an overly complicated burden for providers and most importantly delays care for our patients. Carriers have each created their own preauthorization process which means there is little conformity between carriers which complicates the preauthorization process and ultimately leads to more denials. As the Maryland Insurance Administration (MIA) has stated in there 2021 Report on the Health Care Appeals and Grievances Law, carriers rendered 81,143 adverse decisions (e.g., denials of health care services based on the carrier's decision that the health care service was not medically necessary rather than the judgment of the treating practitioner). In the same report the MIA modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation), 72.4% of the time on filed complaints, up from 70.5% in 2021. ACNM believes that this bill will address a number of the burdens the utilization review system has placed on providers and patients and ultimately improve the health outcomes for patients.

We ask for a favorable report on this legislation. If we can provide any additional information, please contact Michael Paddy at mpaddy@policypartners.net.

2023 LCPCM SB 308 Senate Side FAV.pdf
Uploaded by: Michael Paddy
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 308**

Title: **Health Insurance – Utilization Review – Revisions**

Hearing Date: **February 15, 2023**

Position: **Support**

The Licensed Clinical Professional Counselors of Maryland (LCPCM) supports Senate *Bill 308 - Health Insurance – Utilization Review – Revisions.* The bill alters the requirements for providers and carriers related to health insurance utilization review including provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill alters the timelines related to internal grievance procedures and adverse decision procedures, and increases the penalties for violating certain provisions of law regarding private review agents.

LCPCM supports this legislation because the current law allows to many inconsistencies between carriers which makes the preauthorization process uncessicarily burdensome for our members and delays the care our patients require. Specifically the bill would require that the provider or the provider that serves on the health care service review panel that made an adverse decision be knowledgeable of and experienced in the diagnosis and the treatment under review rather than only board certified or eligible in the same specialty. We believe this is one of many changes the bill proposes that will decrease the rate of denials and allow our patients to receive timely care.

We ask for a favorable report on this legislation. If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net

2023 MCHS SB 308 Senate Side FAV.pdf

Uploaded by: Michael Paddy

Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill: **SB 308 - Health Insurance - Utilization Review - Revisions**

Hearing Date: **February 15, 2023**

Position: **Support**

The Maryland Community Health System (MCHS) supports Senate Bill 308 - *Health Insurance - Utilization Review - Revisions*. The bill would alter the requirements for providers and carriers related to health insurance utilization review which would include the provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill would alter the timelines related to internal grievance procedures and adverse decision procedures, and increases the penalties for violating certain provisions of law regarding private review agents.

As a network of federally qualified health centers, we provide somatic, behavioral, and oral health service to underserved communities. Our practitioners spend a significant amount of time navigating the unneeded complexities of the preauthorization process. Our clinicians could spend more time on direct patient care if the preauthorization process was standardized across carriers. This legislation provides a reasonable framework to bring uniformity to the preauthorization system.

We ask for a favorable report. If we can provide any further information, please contact Michael Paddy at mpaddy@policypartners.net

2023 MNA SB 308 Senate Side FAV.pdf
Uploaded by: Michael Paddy
Position: FAV

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 308 – Health Insurance – Utilization Review – Revisions**

Hearing Date: **February 15, 2023**

Position: **Support**

The Maryland Nurses Association (MNA) supports Senate *Bill 308 – Health Insurance – Utilization Review – Revisions*. The bill would alter the requirements for providers and carriers related to health insurance utilization review which would include the provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill would alter the timelines related to internal grievance procedures and adverse decision procedures, and increases the penalties for violating certain provisions of law regarding private review agents.

MNA supports this legislation because the current law, in practice, has created more hurdles and roadblocks for providers trying to deliver care to their patients, and most importantly timely care to their patients. This legislation requires that a provider which made or participated in the adverse decision notify the insured's provider prior to making the adverse decision and be available to discuss the basis for the denial and the medical necessity of the health care service rather than deny care and then allow for a peer-to-peer meeting after the fact. The 2021 report on the Health Care Appeals and Grievances Law related by the Maryland Insurance Administration (MIA) stated that the MIA modified or reversed the carrier's decision (or the carrier reversed it during the course of investigation) 72.4% of the time on filed complaints, up from 70.5% in 2021. As the data suggests, this is a tremendous roadblock today in delivering timely care and House Bill 305 would significantly address one of the most care delaying hurdles.

We ask for a favorable report. If we can provide any additional information, please contact Michael Paddy at mpadd@policypartners.net.

2023 MOTA SB 308 Senate Side FAV.pdf

Uploaded by: Michael Paddy
Position: FAV

Maryland Occupational Therapy Association

PO Box 36401, Towson, Maryland 21286 ♦ www.mota-members.com

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 308 - Health Insurance - Utilization Review - Revisions**

Hearing Date: **February 15, 2023**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports Senate *Bill 308 - Health Insurance - Utilization Review - Revisions.* The bill would alter the requirements for providers and carriers related to health insurance utilization review which would include the provisions regarding benchmarks for standardizing and automating the preauthorization process, and the online preauthorization system for payors, and preauthorization for prescription drugs, and private review agents. Additionally, the bill would alter the timelines related to internal grievance procedures and adverse decision procedures, and increases the penalties for violating certain provisions of law regarding private review agents.

Occupational therapy services are effective in assisting individuals to manage chronic diseases more effectively, thereby improving their quality of life and ability to engage in meaningful occupations, while decreasing frequency of medical interventions. The current preauthorization requirements in law only hinder occupational therapists in delivering care, and this bill will alleviate a number of burdens such as different preauthorization systems between carriers and require evidence-based, peer reviewed criteria as the standard of care developed by an organization that works directly with health care providers or a professional medical specialty society rather than what a carrier is currently permitted to do.

We as for a favorable report. If we can provide any additional information, please feel free to contact Michael Paddy at mpaddy@policypartners.net.

NCADD-MD - 2023 SB 308 FAV - Utilization Review Re

Uploaded by: Nancy Rosen-Cohen

Position: FAV

Senate Finance Committee
February 15, 2023

Senate Bill 308
Health Insurance – Utilization Review – Revisions
Support

NCADD-Maryland supports Senate Bill 308. Reforming the utilization review process as proposed in this bill will protect patients in a number of ways.

First, people should be allowed to remain on a prescription medication without endless prior authorizations when the treatment or management of the condition is successful. Prior authorizations should also not be needed for certain dosage changes, nor when the prescription has to be divided because of the different formulations of the drug.

Second, we hear from substance use treatment providers that determinations are made by carriers' private review agents who are not trained in the specialty of addiction medicine. It is frustrating when a provider who has a great deal of experience in one area of health care cannot rely on the level of expertise or experience of the person making important decisions for their patients.

Finally, NCADD-Maryland **supports the strengthening amendments being offered by the Legal Action Center** that will help make the process using private review agents more uniform.

With these changes, we urge a favorable report on Senate Bill 308.

The Maryland Affiliate of the National Council on Alcoholism and Drug Dependence (NCADD-Maryland) is a statewide organization that works to influence public and private policies on addiction, treatment, and recovery, reduce the stigma associated with the disease, and improve the understanding of addictions and the recovery process. We advocate for and with individuals and families who are affected by alcoholism and drug addiction.

National Council on Alcoholism & Drug Dependence – Maryland Chapter
28 E. Ostend Street, Suite 303, Baltimore, MD 21230 · 410-625-6482 · fax 410-625-6484
www.ncaddmaryland.org

SB 308- LWVMD- FAV- Health Insurance- Utilization

Uploaded by: Nora Miller Smith

Position: FAV

LEAGUE OF WOMEN VOTERS® OF MARYLAND

TESTIMONY TO THE SENATE FINANCE COMMITTEE

SB 0308: Health Insurance- Utilization Review- Revisions

POSITION: Support

BY: Nancy Soreng, President

DATE: February 15, 2023

The League of Women Voters Maryland supports **Senate Bill 0308: Health Insurance- Utilization Review- Revisions.**

Passage of the bill would reform the cumbersome process by which an insurance company's "prior authorization" staff reviews information provided by a health care provider about a patient's proposed treatment. Only if a planned procedure, service, or medication meets **the payer's definition** of "medical necessity" will payment be approved. **This cost-control system has created many barriers to care, and reform will be welcomed by both medical providers and patients.**

Our current healthcare payment system can be seen as a structure with two opposing forces: those who deliver hands-on care, and those who, from far away, evaluate the care and make payment decisions. This automatically sets up the two sides as adversaries. **The patient is in the middle, and is ultimately the one who suffers.**

The League of Women Voters believes that health care is a human right, and that every U.S. resident should have access to affordable, quality health care. It has also lobbied in strong support of patient rights, and endorses the reduction of administrative costs as one way to ensure that health care can be equally accessible and affordable for all.

An AMA survey[1] of practicing physicians notes that "Payers' prior-authorization requirements delay treatment, have a negative impact on clinical outcomes and lead patients to abandon treatment." And "The very manual, time-consuming processes used in these programs burden providers (physician practices, pharmacies, and hospitals) and divert resources away from direct patient care."[2]

[1] https://www.ama-assn.org/practice-management/prior-authorization/how-insurance-companies-red-tape-can-delay-patient-care

[2] https://www.ama-assn.org/system/files/principles-with-signatory-page-for-slsc.pdf

But it doesn't have to stay this way. Multiple states,[3] including Georgia, Illinois, Kentucky, and Michigan have recently passed laws reforming the prior authorization process in their states.

Reforms such as those included in Senate Bill 308 will improve transparency in the prior auth process, minimize repetitive requirements, and **protect patients from harmful treatment interruptions.** An insurance company's Physician Advisor making a care decision will be required to have expertise in that particular medical condition, be licensed in Maryland, and **follow patient-centered care protocols** by using evidence-based, nationally accepted criteria, making timely decisions, and obeying clearly defined rules and standards for appeals. After all, these serious decisions to delay or deny authorization and payment for care can negatively impact patients' health and well-being.

Reforming Maryland's prior auth process will lessen the administrative burdens of practitioners forced to spend so much time away from patient care. This will improve our health care system, and the health of all Marylanders who rely on it.

The League of Women Voters Maryland and its 1,500+ members **urge the committee to give a favorable report to Senate Bill 0308.**

[3] https://www.ama-assn.org/practice-management/prior-authorization/how-michigan-s-prior-authorization-reform-law-was-passed

MPA Testimony 2023 - Support - Senate Bill 308 - H

Uploaded by: Pat Savage

Position: FAV

MARYLAND PSYCHOLOGICAL ASSOCIATION

10480 Little Patuxent Parkway, Ste 910, Columbia, MD 21044. Office 410-992-4258. Fax: 410-992-7732. www.marylandpsychology.org

February 10, 2023

Senator Melony, Griffith, Chair
Senator Katherine Klausmeier, Vice Chair
Finance Committee, 3 East
Miller Senate Office Building
Annapolis, MD 21401

RE: Senate Bill 308 - Health Insurance – Utilization Review – Revisions -SUPPORT

Dear Chair, Vice-Chair, and Members of the Committee:

The Maryland Psychological Association, (MPA), which represents over 1,000 doctoral level psychologists throughout the state, asks the Senate Finance Committee to **FAVORABLY REPORT** on Senate Bill 308.

The Maryland Psychological Association supports the intent of Senate Bill 308 to protect Maryland's citizens who are required to undergo the time-consuming, costly, and anxiety-provoking Utilization Review (UR) process for treatments and medications recommended by their treating providers.

The Utilization Review process used by insurers has been the equivalent of the fox guarding the hen house – that is, each insurer has had the authority to write their own guidelines and requirements for the review process they use to determine whether they will pay for a treatment already recommended by their practitioner. We support the intent of this bill to provide more robust standards for the UR process. We also appreciate and strongly support the revised time guidelines which provide more timely notification to the consumer and their treating practitioner. Furthermore, we support the new language which provides for some guardrails to the UR process for prescription medications.

Utilization review is used by insurers to restrict access to care. We sincerely appreciate your efforts to hold insurers accountable for these processes and make them more transparent and standardized. We urge a **FAVORABLE** report on SB 308.

Thank you for considering our comments on Senate Bill 308. If we can be of any further assistance as the Senate Finance Committee considers this bill, please do not hesitate to contact MPA's Legislative Chair, Dr. Pat Savage at mpalegislativecommittee@gmail.com.

Respectfully submitted,

Rebecca Resnik, Psy.D.
Rebecca Resnick, Psy.D.
President

R. Patrick Savage, Jr., Ph.D.
R. Patrick Savage, Jr., Ph.D.
Chair, MPA Legislative Committee

cc: Richard Bloch, Esq., Counsel for Maryland Psychological Association
Barbara Brocato & Dan Shattuck, MPA Government Affairs

MDCSCO_ASCO_UM Reform SB308.pdf
Uploaded by: Paul Celano
Position: FAV

MDCSCO
MARYLAND/DISTRICT OF COLUMBIA
SOCIETY OF CLINICAL ONCOLOGY

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY

February 15, 2023

Senator Melony Griffith, Chair
Senate Committee on Finance
Room 3, East Wing
Miller Senate Office Building
Annapolis, MD 21401

Dear Chair Griffith, Vice Chair Klausmeier, and Members of the Senate Finance Committee,

The Maryland/District of Columbia Society of Clinical Oncology (MDCSCO) and the Association for Clinical Oncology (ASCO) are pleased to support SB 308, which establishes guardrails around prior authorization in the state.

MDCSCO is committed to improving the quality and delivery of care in medical oncology in the State of Maryland and the District of Columbia. ASCO is a national organization representing physicians who care for people with cancer. With nearly 45,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable cancer care.

Prior authorization requires patients or their providers to secure pre-approval as a condition of payment or insurance coverage of services. In a recent ASCO survey, 80% of respondents said that a patient has experienced significant impacts on their health, such as disease progress, because of prior authorization processes. The most common harms to patients include delays in treatment (95%) and diagnostic imaging (94%), patients being forced onto second-choice therapy (93%) or denied therapy (87%) and increased out-of-pocket costs (88%). These survey results confirm that prior authorization results in unnecessary delays or denials of cancer care.

MDCSCO and ASCO are committed to supporting policies that reduce cost while preserving quality of cancer care; however, it is critical that such policies be developed and implemented in a way that does not undermine patient access. Payer utilization management approaches like prior authorization are of particular concern because they represent greater likelihood of raising barriers to appropriate care for individuals with cancer.

MDCSCO and ASCO are pleased that SB 308:

- **Promotes continuity of care** by allowing a patient to stay on a prescription drug without another prior authorization if the insurer previously approved the drug;
- **Enhances clinical validity** by requiring clinical review criteria to be evidence-based and developed by an organization that works directly with health care providers or a professional medical specialty society
- **Accommodates the needs of specialized patient populations** by requiring that the physician that serves on the health care service review panel be knowledgeable of and experienced in the diagnosis and treatment under review;

- **Improves the review process** by requiring a physician who makes an adverse decision to notify the patient's physician before making an adverse decision and be available to discuss the basis for denial rather than deny care prior to a peer-to-peer conversation;
- **Alleviates administrative burden on physicians** by exempting certain drugs from prior authorization, including generic drugs, drugs that have changed dosage consistent with federal FDA labeled dosages, and drugs bundled under two prescriptions due to differing formulations; and
- By requiring studies on the feasibility of standardizing electronic systems across all carriers and implementing a "gold card" prior authorization exemption standard.

MDCSCO and ASCO are encouraged by the steps SB 308 takes toward improving prior authorization in Maryland, and we welcome the opportunity to be a resource for you. For a more detailed understanding of our policy recommendations on this issue, we invite you to read the ASCO Position Statement: Prior Authorization. Please contact Sarah Lanford at ASCO at Sarah.Lanford@asco.org if you have any questions or if we can be of assistance.

Sincerely,

Paul Celano, MD, FACP
President
Maryland/DC Society of Clinical Oncology

Lori J. Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology

SB 308_MPCAC_Ltr of Support_FIN.pdf
Uploaded by: Ramana Rameswaran
Position: FAV

MPCAC

MARYLAND PATIENT CARE AND ACCESS COALITION

February 14, 2023

VIA ELECTRONIC SUBMISSION
Melony G. Griffith, *Chair*
Senate Finance Committee
Miller Senate Office Building, 3 East Wing
11 Bladen Street
Annapolis, MD 21401-1991

Re: S.B. 308 - Health Insurance – Utilization Review – Revisions

Dear Chairwoman Griffith:

We are writing to you on behalf of the Maryland Patient Care and Access Coalition ("MPCAC") to express our support for S.B. 308. Over the past few months, MPCAC has been working with other organizations on the topic of reforming the method for utilization reviews used by health insurance carriers to determine medical necessity, when a patient's medical provider orders certain healthcare services. One of the most important aspects of the legislation—reform of prior authorization, addresses a health insurance carrier's cost-control process that requires physicians and other health care professionals to obtain advance approval from the carrier before a specific service is delivered to a patient to qualify for payment coverage.[1] Too often, these prior authorization reviews cause significant delays and, at times, outright denials, of critical health care services for Maryland patients.

MPCAC strongly believes that S.B. 308 would allow Marylanders to obtain the treatment they need without unnecessary delay by reducing burdens of unnecessary prior authorization requirements, requiring more timely communication between providers and carriers, and having utilization reviews conducted by practitioners with the appropriate medical specialization to conduct the reviews. **MPCAC proudly supports S.B. 308 and stands ready to serve as an ongoing resource to the Senate Finance Committee in its efforts to reform and evaluate utilization review laws.**

[1] "What is prior authorization", American Medical Association, https://www.ama-assn.org/practice-management/prior-authorization/what-prior-authorization, updated July 12, 2022 and accessed February 13, 2023.

The Maryland Patient Care and Access Coalition

For nearly 20 years, the Maryland Patient Care and Access Coalition ("MPCAC") has been the voice of independent physician specialty practices in the State that deliver integrated, high-quality, cost-efficient care to patients in the medical office and freestanding ambulatory surgical facility ("FASF") settings. With hundreds of physicians in the fields of gastroenterology, orthopaedic surgery, urology, pathology, radiation oncology, and anesthesiology, MPCAC's member medical practices cared for Marylanders in nearly two million patient visits during the past year. In addition, the physicians in MPCAC's member practices perform approximately 200,000 procedures in FASFs and endoscopy centers annually.

S.B. 308 - Changes to Prior Authorization

Maryland patients have long needed responsible legislation like S.B. 308 to protect their access to timely medical care. Current law unnecessarily burdens patients with prior authorization obstacles in the following ways: (i) Marylanders with chronic conditions can be subject to reauthorization requirements once a year for the same treatment, despite the provider knowing the treatment works and no change in the patient's medical condition; (ii) for dosage changes which are fully consistent with the FDA's dosage labels; and (iii) for obtaining *generic* drugs, Marylanders can be subject to prior authorization requirements. By enacting S.B. 308, these unnecessary and burdensome barriers to care would be removed.

One of MPCAC's Board members described the treatment of moderate to severe Crohn's Disease and Ulcerative Colitis, which often requires the use of biologic medication, which can be very expensive without coverage. The treatment of these diseases requires patients to continue to stick to their treatments to avoid what can be dangerous flare-ups which may require hospitalization and even surgery. Under current law, patients suffering from these diseases will face requests for medical records and be forced to jump through unnecessary administrative hurdles even when the patient has been using biologics for years. Even when prior authorization is eventually obtained, the burdens on patient and medical practice result in delays to treatment, risking flare-ups, increasing patient anxiety, and ultimately adding to the cost of the care.

Similarly, the AMA found in a 2021 survey that: (a) 91% of respondents reported prior authorization can lead to negative clinical outcomes with 34% reporting serious adverse events in patients' care because of prior authorizations; and (b) 82% of respondents reported prior authorizations can cause patients to abandon their course of treatment.[2]

And these prior authorization roadblocks exist even for medical practices with very high rates of approvals, which demonstrates that the practices are providing medically necessary care based on the guidelines set by the carriers. S.B. 308 includes an important study on the feasibility of implementing a "gold card" standard in Maryland, which exempts healthcare providers who meet certain approval thresholds from prior authorization. We urge the General Assembly to pass S.B. 308, so that we can move forward with this study and, ultimately, the adoption of a "gold card" program in Maryland, which would allow patients to obtain treatment in a timelier manner.

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[2] *See id.*

In situations where a prior authorization review is required, MPCAC also supports many of the changes in S.B. 308, which narrow the time that carriers are given for review and decision making on prior authorization requests and related appeals. These improvements in the prior authorization process will reduce delays in treatment and improve Maryland patients; quality of life.

S.B. 308 – Communication and Expertise of Reviewers

MPCAC also supports S.B. 308's requirements for health insurance carriers to use providers who are not only board certified in a specialty (as required under current law), but also knowledgeable of and experienced in the particular diagnosis and course of treatment under review. Additionally, mandating a peer-to-peer discussion between a carrier and the treating physician *prior* to making an adverse decision as to medical necessity, can hopefully limit the circumstances in which patients need to wait for the outcome of an appeal.

It is our understanding that in 2022, the Maryland Insurance Administration modified or reversed the carrier's decision (or the carrier reversed its decision during the course of an investigation), 72.4% of the time on filed complaints. In other words, nearly three out of every four times, a carrier's initial decision that created a barrier to patients receiving timely and appropriate care was overturned. MPCAC believes that the changes set forth in S.B. 308 will help reverse this disturbing statistic.

Overall, we believe S.B. 308 is a necessary step towards helping Maryland's health care providers deliver—and patients receive—the health care services needed without the delays and burdens allowed under existing law. MPCAC looks forward to continuing to serve as a trusted partner to members of the Maryland General Assembly as we work together to confront the challenges and opportunities facing our health care system and to promote and protect the high quality, cost-efficient and convenient care furnished in the independent medical practice setting.

Sincerely,

Nicholas P. Grosso, M.D.
Chairman of the Board & President, MPCAC

Benjamin Lowentritt, M.D.
Board Member, MPCAC

cc: All Senate Finance Committee Members
Joe Bryce, Manis Canning

MARYLAND PSYCHIATRIC SOCIETY TESTIMONY .pdf
Uploaded by: ROBERT HERMAN
Position: FAV

MY NAME IS ROBERT HERMAN. I AM A PSYCHIATRIST AND I REPRESENT APPROXIMATELY 775 PSYCHIATRISTS WHO ARE MEMBERS OF THE MARYLAND PSYCHIATRIC SOCIETY.

WE ARE ALL PROUD TO BE PHYSICIANS WITH EXPERTISE IN DIAGNOSING AND TREATING MENTAL HEALTH DISORDERS, WHICH ARE A MAJOR CAUSE OF DISABILITY AND SUFFERING WORLDWIDE. OUR FIELD IS IN A PERIOD OF RAPID CHANGE, AND NEW TREATMENTS ARE BECOMING AVAILABLE TO OUR PATIENTS AT A RAPID PACE. THIS GIVES HOPE TO THE PATIENTS WE TREAT AND THEIR FAMILIES FOR HEALTHIER HAPPIER AND BETTER LIVES.

THERE ARE UNIQUE BARRIERS THAT OUR PATIENTS FACE WHEN TRYING TO OBTAIN TREATMENT. SHAME, STIGMA, AND SILENCE STILL EXIST AROUND PSYCHIATRIC ILLNESS. IT IS DIFFICULT FOR A PATIENT SUFFERING FROM SEVERE DEPRESSION, FOR EXAMPLE, PSYCHOSIS, TO FILE A COMPLAINT WITH THEIR INSURANCE COMPANY OR THE MARYLAND INSURANCE ADMINISTRATION WHEN THEIR TREATMENT IS DENIED. MOST OF US ARE IN SOLO PRACTICE, AND REIMBURSEMENT FOR US IS LOW COMPARED TO OTHER SPECIALISTS, AND SO MANY OF US CANNOT AFFORD TO HIRE ADMINISTRATIVE STAFF TO DO BATTLE WITH INSURANCE COMPANIES OR PHARMACY BENEFIT MANAGERS, AND ARE E FORCED TO SPEND MANY HOURS COMPETING FORMS OR ARGUING ON THE PHONE IN ORDER FOR US TO GET THE TREATMENT OUR PATIENTS NEED.

PRIOR AUTHORIZATION IS COMMON WHEN PATIENTS SWITCH PSYCHIATRISTS OR HEALTH PLANS, AFTER A CERTAIN PERIOD OF TIME ON A MEDICATION, WHEN DOSAGES ARE CHANGED, OR WHEN THE MEDICATION IS BEING USED FOR A PURPOSE OTHER THAT THE INSURANCE COMPANY DICTATES. THIS SUBSTITUTES A COMPANY'S JUDGEMENT FOR THEIR PHYSICIAN'S JUDGEMENT. THESE JUDGEMENTS ARE USUALLY MADE NOT BY A PERSON BUT BY A COMPUTER ALGORITHM WHICH USES A CERTAIN RIGID AND OFTEN OUTDATED OR SIMPLY INCORRECT CRITERIA IN ORDER TO DENY MEDICATION. WHEN A MEDICAL REVIEWER IS INVOLVED THE PHYSICIAN REVIEWER IS OFTEN NOT A PRACTICING PSYCHIATRIST. FOR EXAMPLE I HAVE HAD MEDICATIONS FOR A PATIENT WITH BIPOLAR DISORDER DENIED BY AN ORTHOPEDIC SURGEON, AND A MEDICATIONS FOR OPIOID ADDICTION DENIED BY A PEDIATRICIAN.

IF THE PREMISE OF PRIOR AUTHORIZATION IS TO IMPROVE THE QUALITY OF CARE FOR PATIENTS WITH PSYCHIATRIC ILLNESS, THEN THE ALGORITHMS THAT ARE USED TO GUIDE THESE DECISIONS SHOULD BE CREATED AND CONTINUALLY UPDATED BY RECOGNIZED EXPERTS IN THE FIELD. THEY SHOULD ALSO RECOGNIZE THAT THERE ARE UNIQUE CIRCUMSTANCES THAT SHOULD PERMIT EXCEPTIONS TO THESE GUIDELINES. THIS BILL IS AN ATTEMPT TO DO THIS

IF THE PURPOSE OF PRIOR AUTHORIZATION IS TO SAVE COSTS TO THE INSURANCE PLAN, THEN THERE IS ABSOLUTELY NO REASON THAT PRIOR AUTHORIZATION SHOULD BE REQUIRED FOR GENERIC DRUGS , WHICH DUE TO HEALTHY COMPETITION AMONG MANUFACTURERS ARE A FRACTION OF THE COST OF BRANDED DRUGS. THIS BILL WOULD PROHIBIT PRIOR AUTHORIZATION FOR GENERIC DRUGS, WHICH WOULD REDUCE THE BURDEN ON PSYCHIATRISTS AND THEIR PATIENTS GETTING NECESSARY CARE.

I WILL CLOSE WITH THE WORDS OF A PATIENT OF MINE WITH BIPOLAR DISORDER THAT WE FOUGHT FOR NEARLY TWO MONTHS TO GET HER INSURANCE COMPANY TO APPROVE OF A MEDICATION SHE NEEDED, AND THEN TO HAVE IT DENIED AGAIN WHEN SHE CHANGED INSURANCE PLANS. SHE WROTE

"HUMAN BEINGS WHO ARE SUFFERING, MOST OF WHOM WILL CONTINUE TO SUFFER BECAUSE ACCESSING PROPER AND TIMELY HEALTH CARE IS AN ALMOST IMPOSSIBLE FEAT. FOR MANY INDIVIDUALS STRUGGLING WITH MENTAL HEALTH, SUICIDE ENDS UP FEELING LIKE THE ONLY OPTION GETTING PROPER HELP IS AN URGENT MATTER. I CAN'T HELP BUT THINK "WHY DOES IT FEEL LIKE SO MANY PEOPLE JUST DON'T CARE? DO WE NOT VALUE THE LIVES AND WELL BEING OF FELLOW HUMAN BEINGS WHO ARE SICK? IF PEOPLE WANT ME TO GET OFF OF TEMPORARY DISABILITY SO I CAN BE A PRODUCTIVE MEMBER OF SOCIETY AND BEGIN WORKING AGAIN THEN WHY IS IT SO HARD TO GET THE HELP I NEED SO THAT I AM ABLE TO DO SO? I BEG YOU TO HAVE A LITTLE MORE EMPATHY FOR INDIVIDUALS LIKE ME WHO ARE STRUGGLING TO FIGHT FOR OUR LIVES AND HELP US. IT SIMPLY SHOULDN'T BE THIS HARD TO GET HELP. "

SB 308 NMSS Testimony in Support Wood .pdf
Uploaded by: Shannon Wood
Position: FAV

SB 308: Testimony of Shannon Wood (In Support)
Director of Advocacy and Policy
National Multiple Sclerosis Society
Senate Finance Committee 2/15/23

On behalf of the National Multiple Sclerosis Society (the Society), thank you for the opportunity to provide testimony in support of SB 308, to addresses Maryland's prior authorization process.

Multiple sclerosis (MS) is an unpredictable disease of the central nervous system. Currently there is no cure. Symptoms vary from person to person and may include disabling fatigue, mobility challenges, cognitive changes, and vision issues. An estimated 1 million people live with MS in the United States. Early diagnosis and treatment are critical to minimize disability.

The treatment of MS has vastly improved over the years. When someone is diagnosed with MS, their clinician will typically prescribe a medication referred to as a disease-modifying therapy (DMT). Evidence shows that early and ongoing treatment with a DMT is the best way to manage the MS disease course, prevent accumulation of disability, and protect the brain from damage due to MS.

Depending on your perspective, utilization review requirements such as prior authorization can be viewed as valuable safeguards on healthcare quality and cost, or as additional paperwork burdens for providers. Prior authorization processes can result in delays or disruptions in treatment as patients wait for their health plan to determine whether they will cover care as prescribed. If coverage is denied, additional delays may occur if the provider and patient have to go through an appeals process. The appeals process, including the steps required to file a dispute, may take several additional days or weeks to process.

For people with MS, prolonging ineffective treatment (and delaying access to the right treatment) may result in increased disease activity, loss of function and possible irreversible progression of disability. For example, a person with MS may have to delay receiving an MRI, or accessing a prescribed medication, for weeks or even months until their insurer's prior authorization forms are submitted, reviewed, and approved. People living with MS may increase their risk of lapses in treatment or worsening disease course as a result of these delays.

Because prior authorization reviews can sometimes result in delays or disruptions in treatment, the Society supports efforts to streamline and strengthen prior authorization reviews. The Society urges reasonable solutions to make the process more transparent, timely, and user-friendly, such as those included in SB 308.

Specifically, as our position relates to SB 308, we support the timeline for turning around of both urgent and non-urgent requests, the requirement that a physician serving on the health care service review panel be knowledgeable of and experienced in the diagnosis and treatment under review and also possess a current and valid Maryland license to practice medicine, the requirement that the prescriber be contacted prior to making an adverse decision, as well as the study on standardization of electronic systems across all carriers. All of these proposals will not only lessen the burden placed upon providers, but also ensure greater access to necessary treatment and diagnostic tools for people affected by MS, which in turn will lead to improved health outcomes.

We thank the Senate Finance Committee for the opportunity to offer this testimony. If you have any questions regarding the Society's position, please do not hesitate to contact Shannon Wood, Director of Advocacy and Policy at shannon.wood@nmss.org.

SB 308 - Health Insurance Utilization Review - Let
Uploaded by: Steven Chen
Position: FAV

Maryland
Hospital Association

February 15, 2023

To: The Honorable Melony G. Griffith, Chair, Senate Finance Committee

Re: Letter of Support – Senate Bill 308- Health Insurance – Utilization Review – Revisions

Dear Chair Griffith:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment in support of Senate Bill 308. Health insurance carriers often require "prior authorization," which is a process where the carriers review in advance whether a patient-requested item or service is medically necessary. While the practice can be useful, improper use of prior authorization delays access to vital health care services, leading to negative health outcomes. MHA supports proposals to reduce unnecessary delays and expedite patient access to critical health care items and services.

Maryland hospitals operate under a unique Global Budget Revenue model. Under the model, the Health Services Cost Review Commission sets each hospital's total annual revenue at the beginning of a fiscal year regardless of the number of patients served or the amount of services provided. Maryland hospitals therefore have no incentives to provide unnecessary care since additional patients or procedures would not increase a hospital's total revenue. Thus, prior authorization under GBR is largely formalistic as hospitals are already motivated to provide only necessary services.

This is consistent with the findings by the Maryland Insurance Administration (MIA). In its 2021 Report on the Healthcare Appeals & Grievances Law, MIA found that out of the 81,143 adverse decisions issued by health insurance carriers in 2021, only 1.3% were for inpatient hospital services.[1] The finding suggests that the vast majority of inpatient hospital service prior authorization requests were approved by carriers, which is consistent with the aim of the GBR to incentivize hospitals to provide only medically necessary care.

Given the low number of denials for inpatient hospital services, MHA believes that reforms to expedite—or in certain instances eliminate—prior authorization would reduce unnecessary delays to critical health care services. SB 308's proposal to shorten the amount of time carriers have available to review a prior authorization request, for example, should reduce the delay that patients must endures as they wait for health insurance carriers to approve a request. Similarly, the bill's proposal to require a study to examine adjustments to prior authorization requirements if a provider already has a high approval rate should also alleviate patient wait time. Since a

[1] "2021 Report on the Healthcare Appeals & Grievances Law." 2022. https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2021-Report-on-the-HealthCare-Appeals-and-Grievances-Law-MSAR-6.pdf.

significant majority of inpatient hospital services will be approved, a lengthy carrier review period only prolongs unnecessary patient anxiety and delay access to necessary care.

For these reasons, we request a ***favorable*** report on SB 308.

For more information, please contact:
Steven Chen, Director, Policy
Schen@mhaonline.org

SB 308 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

February 14, 2023

The Honorable Melony Griffith
Senate Finance Committee
3 East – Miller Senate Office Building
Annapolis, MD 21401

RE: Support – Senate Bill 308: Health Insurance - Utilization Review - Revisions

Dear Chairman Griffith and Honorable Members of the Committee:

The Maryland Psychiatric Society (MPS) and the Washington Psychiatric Society (WPS) are state medical organizations whose physician members specialize in diagnosing, treating, and preventing mental illnesses, including substance use disorders. Formed more than sixty-five years ago to support the needs of psychiatrists and their patients, both organizations work to ensure available, accessible, and comprehensive quality mental health resources for all Maryland citizens; and strive through public education to dispel the stigma and discrimination of those suffering from a mental illness. As the district branches of the American Psychiatric Association covering the state of Maryland, MPS and WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS strongly support Senate Bill 308: Health Insurance - Utilization Review - Revisions (SB 308) as this is a priority piece of legislation for both these physician groups.

When a physician or other clinician prescribes medication or treatment for a patient, the patient's insurance company or pharmaceutical benefits manager (PBM) requires an explanation as to why it is necessary before approving coverage. This utilization management tool of the insurance carriers and PBMs is called "prior authorization." While prior authorization is promoted as a health care savings mechanism, this process simply creates extensive paperwork requirements, multiple phone calls, and significant wait times for both prescribers and their patients. In the end, prior authorization often leads to patients experiencing arbitrary limits on medications and untimely and/or incomplete treatment of their underlying conditions. A staggering ninety percent (90%) of physicians report that prior authorization significantly negatively impacts patient outcomes.

Remarkably, no clear evidence exists that prior authorization improves patient care quality or saves money. Instead, it often results in unnecessary delays in receiving life-sustaining medications or other treatments and leads to physicians spending more time on paperwork and less time treating their patients. For individuals with psychiatric disorders, including those with serious mental illness or substance use disorders, gaps in treatment due to pre-authorization denials can lead to relapse, with increased health care costs and devastating effects for individuals and their families

As a start to fixing prior authorization, policymakers and other stakeholders should consider how the volume of prior authorization impacts patients, physicians, and the health care system. While this utilization management tool may reduce the amount health insurers are paying for care in the short term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. Instead, prior authorization, if used at all, must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians, and other providers. SB 308 takes just that approach.

SB 308 seeks to accomplish the following:

- **Eliminate prior authorization for generic medications that are not controlled substances.** These medications are cheap and not addictive; therefore, prior authorization provides no benefit to costs or patient safety.

- **Eliminate prior authorization for dosage strength changes of the same medication**. Patients may often require a dosage adjustment, and prescribers should not be constricted by administrative barriers to use their professional judgment.

- **Eliminate prior authorization for generic and brand drugs after patients have been on the medication for six months without interruption.** Once a patient has demonstrated a stable adherence to their treatment plan, his or her prescriber should not be subjected to additional prior authorizations.

- **Prohibit plans from denying medication on the grounds of therapeutic duplication if the patient has already been subject to review for the same dosage and it was previously approved.** When a patient requires a certain dosage of medication that is not manufactured in that specific dosage, prescribers may write two corresponding prescriptions to create a unique dose for the patient. Patients are often denied coverage of this medication based on "therapeutic duplication" without recognizing the patient's dosing needs.

- **Require denials and denial reviews to be conducted by physicians in the same profession or similar specialty as the health care provider whose recommended treatment is under review.** Insurers and PBMs have been empowered to practice medicine without a license to make coverage denials. Even when a physician is conducting utilization reviews, a psychiatrist may receive a denial from a cardiologist, who lacks the clinical expertise. This change would ensure that denial and denial reviews are overseen by an expert who is familiar with the treatment plan and type of patient under review.

Patients, especially those with mental health and substance use disorders, need timely access to medication. Please support SB 308, which makes common-sense changes to prior authorization. For all the reasons above, MPS and WPS ask the committee for a favorable report on SB 308.

If you have any questions with regard to this testimony, please feel free to contact Thomas Tompsett Jr. at tommy.tompsett@mdlobbyist.com.

Respectfully submitted,
The Maryland Psychiatric Society and the Washington Psychiatric Society
Legislative Action Committee

2023 Legislation - SB 308 Health Insurance-Utiliza

Uploaded by: David Sharp

Position: FWA

MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

2023 SESSION POSITION PAPER

BILL NO: **SB 308**

COMMITTEE: **Senate Finance Committee**

POSITION: **SUPPORT WITH AMENDMENTS**

TITLE: Health Insurance – Utilization Review – Revisions

BILL ANALYSIS

SB 308 - Health Insurance – Utilization Review – Revisions alters and establishes requirements related to health insurance utilization review, benchmarks for standardizing and automating the preauthorization process, an online preauthorization system for payors, preauthorization for prescription drugs, and private review agents. The bill requires the Maryland Health Care Commission (the "Commission") in consultation with providers, payors, and the State Designated Health Information Exchange (HIE) to develop recommendations to achieve greater standardization and uniformity across payors to ease the burden of preauthorization and other utilization management techniques for patients, providers, and payors. This includes, replacing use of proprietary web-based portals with the adoption of uniform implementation specifications and standardization with a single sign-on option for payor and third-party administrator websites, and a pilot program through the State Designated HIE. The bill also requires the Commission and the Maryland Insurance Administration, in consultation with providers and payors, to study the development of standards for the implementation of payor programs to modify preauthorization requirements for prescription drugs, medical care, and other services based on provider-specific criteria.

POSITION AND RATIONALE

The Commission supports SB 308 with amendments that extend the time to complete various areas of study in Sections 2 and 3 and delay implementation of Section 1 requirements until the studies have been completed. The additional time is needed to complete the work adequately and assess the potential impact of pending federal legislation related to preauthorization. On December 13, 2022,[1, 2] the Centers for Medicare & Medicaid Services (CMS) released a Proposed Rule that aims to streamline processes related to preauthorization, among other things. The Proposed Rule would require implementation by 2026 and includes requirements intended to reduce overall provider and payor hardship and improve patient access to health information.

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[1] The CMS Proposed Rule is available at: www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[2] The CMS Proposed Rule comment period is 90-days, or through March 13, 2023.

Electronic preauthorization emerged to streamline communications between providers and payors regarding patient coverage, eligibility, and medical necessity of a medical service or pharmaceutical.[3] In 2012, Maryland became one of the first states to enact legislation that required payors to implement preauthorization requirements in a phased approach, which included establishing web-based portals.[4, 5] Chapters 534 and 535 (SB 540, HB 470) of the 2012 Laws of Maryland required the Commission to work with payors and providers to attain benchmarks for standardizing and automating the preauthorization process and establish regulations through which a payor or provider may be waived from attaining one or more benchmarks.[6] SB 308 requires payors to adopt new processes and technology, with the intent to ease the administrative workload of preauthorizations that continue to burden providers and their supporting staff.

The Commission supports the aims of SB 308 in reshaping medical oversight and review by payors and notes that more time is needed by payors to consider the impact of the bill on existing preauthorization processes and technology systems. The Commission recommends the Committee require the Commission, in collaboration with payors, to identify barriers to implementing the legislation and propose solutions as part of the study requirements in the bill.

For the reasons noted, the Commission suggests delaying implementation of the legislation until completion of all areas of required study. Should the Committee decide to advance SB 308, the Commission recommends that the bill be amended as follows.

AMENDMENTS:

AMENDMENT NUMBER ONE:

- Page 24, line 23 strike December 1, 2023, and replace with, NOVEMBER 1, 2024

AMENDMENT NUMBER TWO:

- Page 25, line 7 strike December 1, 2023, and replace with, NOVEMBER 1, 2024

[3] *Altarum Institute*, "Impacts of Prior Authorization on Health Care Costs and Quality," November 2019. Available at: www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.
[4] Md. Code Ann., Health-Gen. § 19-108.2.
[5] An web-based portal is a standalone system; also referred to as an "online preauthorization system."
[6] Enactment of the law was informed by a Maryland Health Care Commission report based on recommendations from a multistakeholder workgroup, *Recommendations for Implementing Electronic Prior Authorizations, December 2011.*

AMENDMENT NUMBER THREE:

- Page 25, line 20 strike after the word "effect" January 1, 2024, and replace with, JULY 1, 2025, AFTER THE STUDIES CONDUCTED BY THE MARYLAND HEALTH CARE COMMISSION HAVE BEEN COMPLETED AND CONSIDERED BY THE GENERAL ASSEMBLY

Note: The Maryland Health Care Commission is an independent State agency, and the position of the Commission may differ from the position of the Maryland Department of Health.

Legal Action Center Testimony+Attachments SB 308_H
Uploaded by: Ellen Weber
Position: FWA

LEGAL ACTION CENTER

Health Insurance –Utilization Review – Revisions (SB 308)
Finance Committee Hearing
February 15, 2023
SUPPORT WITH AMENDMENTS

Thank you for the opportunity to submit testimony **in support of SB 308 with amendments** to improve the development and application of utilization review requirements that private review agents use in making medical necessity determinations for state regulated private health plans and the utilization review criteria applied in Medicaid. This testimony is submitted on behalf of the Legal Action Center, a law and policy organization that fights discrimination, builds health equity and restores opportunities for individuals with substance use disorders, arrest and conviction records, and HIV or AIDs. In Maryland, the Legal Action Center convenes the Maryland Parity Coalition and works with its partners to ensure non-discriminatory access to mental health (MH) and substance use disorder (SUD) services through enforcement of the Mental Health Parity and Addiction Equity Act (Parity Act).

State and federal parity laws prohibit state-regulated insurers, the Medicaid program and entities that conduct utilization review on their behalf from imposing more restrictive utilization review criteria and authorization requirements for MH and SUD benefits than medical/surgical benefits. **These discriminatory practices were common prior to the Parity Act's adoption in 2008, and they continue to this day.** As a federal District Court in California found in *Wit v. United Behavioral Health*, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019), *aff'd in part and rev'd in part,* 2023 WL 411441(9th Cir. Jan. 26, 2023), United Behavioral Health (UBH) created its own proprietary level of care guidelines and applied those criteria to deny coverage of more intensive levels of care – intensive outpatient, partial hospitalization and residential care – for tens of thousands of individuals with MH and SUDs. UBH denied treatment requests that practitioners based on nationally accepted care guidelines developed by the non-profit professional associations of SUD and MH providers. For individuals with some state-regulated health plans, UBH ignored state-mandated utilization review criteria which supported the requested level of care. **The Court concluded that UBH violated its fiduciary obligation by putting its financial interests above the health needs of its members through its application of restrictive proprietary utilization review criteria.**

SB 308, with strengthening amendments, will ensure that Maryland's carriers cannot engage in similar life-threatening care decisions for individuals with mental health and substance use disorders.

I. Maryland's Utilization Review Standards for Substance Use Disorder and Mental Health Services

In 2019, the Maryland General Assembly adopted legislation (HB 599/SB 631) to standardize the criteria that private health plans are required to use for all SUD medical necessity and utilization review determinations. All health plans **must use** the American Society of Addiction Medicine (ASAM) criteria when making any SUD care determination, rather than their own proprietary criteria or that of other for-profit companies. Ins. § 15-802(d)(5). **SB 308 would not alter state law requirements regarding the use of the ASAM criteria, and we have proposed an amendment to make clear that the ASAM criteria requirement is not superseded by the proposed SB 308 requirements.** (Attachment A, Amendment 3). Additionally, state law bars private health plans from imposing prior authorization on any medication used to treat opioid use disorder that contains methadone, buprenorphine or naltrexone. Ins. § 15-851. SB 308, which would establish prior authorization requirements for medications to treat mental health and other conditions, similarly would not supersede requirements for MOUD.

State law does not adopt standardized utilization review criteria for mental health benefits. SB 308 would add important utilization review guardrails by requiring private review agents (PRA) to use criteria that are (1) peer-reviewed and evidence-based and (2) developed by specific entities with expertise in the relevant health care condition. Additionally, SB 308 would require that, prior to issuing an adverse determination, PRAs mut give the practitioner an opportunity to speak to the medical necessity of the requested treatment. **We support these standards and offer several amendments to strengthen them and reinforce that experts in the treatment of MH conditions (and all other health conditions) should be the source of medical necessity/utilization review criteria and the PRA should be required to demonstrate which criterion has not been satisfied prior to denying a MH or other medical service.** We urge the Committee to adopt the proposed amendments. (Attachment A).

A. Utilization Review Criteria Should be Developed by the Non-Profit Clinical Specialty Society for the Relevant Condition and the Utilization Review Criteria Must be Consistent with Generally Accepted Standards of Care.

The source of the utilization review criteria is inextricably linked to the validity of the criteria. Practitioners with expertise in the treatment of the relevant medical condition, including MH and SUDs, are best positioned to identify the appropriate criteria for utilization review. **While the clinical standards for treating a specific condition should not differ across plans or utilization reviewers**, **the American Medical Association has identified considerable variation in authorization criteria, extensive use of proprietary forms, and a lack of standardization across utilization review entities.** Prior Authorization and Utilization Management Reform Principles (Principle 18). The variability imposes tremendous administrative burden on practitioners and means that patients receive wildly different – and often inappropriate – care depending on their health plan and the PRA's utilization standards.

To achieve uniformity, all health plans must be required to use standards that are developed by the expert non-profit professional clinical societies that have no financial stake in the criteria or their application in any patient's case. As drafted, SB 308 would permit the health plan/private review agent to use proprietary utilization review criteria rather than those established by the clinical experts:

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- We propose that the utilization criteria must be "consistent with generally accepted standards of care" in addition to being peer-reviewed and evidence-based. The AMA's model utilization review act, Ensuring Transparency in Prior Authorization Act, includes this criterion as one element in its definition of "medically necessary health services."[1] We have also offered a definition of the term "generally accepted standards of care," key aspects of which have been adopted by California,[2] Illinois[3] and Oregon[4] for MH and SUD utilization review decisions.

- We propose that the private review agent **must use** the utilization review standards that have been developed by the non-profit professional clinical specialty society for the relevant clinical specialty,[5] except to the extent clinical criteria for a specific health condition have not been developed by that specialty society. In those circumstances, an external organization's utilization review criteria may be used as long as the organization meets the standard proposed in SB 308 and also demonstrates that its criteria are consistent with generally accepted standards of care. **This will ensure that, regardless of the health plan or private review agency, consistent criteria will used and the health plan's financial interests will not influence the development of the utilization review criteria.**

- We have proposed that the utilization review criteria must be age appropriate and account for different care standards for youth and adolescents, a critically important requirement for MH care.

B. To Reduce Incorrect Utilization Review Determinations, Private Review Agents Must Demonstrate to the Commissioner that they Apply Utilization Review Criteria Consistent with the Proposed Standardization Requirements and Demonstrate to the Provider that a Pending Denial is Supported by the Criteria.

To ensure prompt access to appropriate MH care across all health plans, the PRA should have the responsibility of demonstrating to the Commissioner that it implements internal controls to ensure that the required criteria are, in fact, applied for all utilization review determinations. INS. § 15-10B-05(a)(1). (Attachment A, Amendment 2). This protects members against carriers and PRAs that purport to adhere to state mandates on utilization review criteria, but do not.[6]

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[1] "Medically necessary health care services" means health care services that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (i) ***in accordance with generally accepted standards of medical practice***; (ii) clinically appropriate in terms of type, frequency, extent, site and duration, and (iii) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider." AMA, "Ensuring Transparency in Prior Authorization Act" at 3 (emphasis added).

[2] CAL. HEALTH & SAFETY §§ 1374.721(a) and 1374.721(f)(1); CAL. INS. § 10144.5(3)(a)(i) (requiring generally accepted standards of mental health and substance use disorder care).

[3] 215 ILL. COMP. STAT. ANN. § 5/370c(h).

[4] OR. REV. STAT. §§ 743A.168(5)(a)(A) and 743A.168(1)(e)(A).

[5] For mental health conditions, the non-profit specialty societies are the American Academy of Child and Adolescent Psychiatry and the American Association of Community Psychiatry, which developed the LOCUS and CALOCUS instruments for service need assessment.

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A second level of consumer protection should apply at the member level prior to the PRA issuing a denial. In addition to the standard proposed in SB 308, which would give the provider the right to speak with the PRA prior to the denial (§15-10B-06), **we propose that the PRA be required to explain how the standardized criteria, when applied to the patient's condition, justify the denial.**

Preempting an unjustifiable denial is particularly important for individuals with MH conditions because few individuals appeal an adverse decision. Of the 620 adverse decisions issued by private health plans for MH and SUD services in 2022, only 75 internal grievances (.78%) were filed with the carrier.[7] Mental health and substance use matters ranked among the lowest conditions for which grievances were filed. Additionally, carriers overturned or modified their initial denials of MH and SUDs infrequently and at a far lower rate compared to the rate for all conditions: 35% for MH and SUD compared to the overall rate of 54%.[8] These numbers reflect the difficulty individuals with MH and SUDs have in challenging a care denial in the midst of a crisis. Marylanders will have far better access to MH and SUD care by requiring the PRA to explain why a patient does not meet accepted standards of care in advance of issuing the denial.

We urge the Committee to issue a favorable report on SB 308 with the proposed amendments.

Thank you for considering our views.

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[6] In *Wit*, the Court held that UBH applied criteria were impermissibly inconsistent state standards that required the use of the ASAM criteria or other state-mandated utilization review criteria for SUD care. 2019 WL 1033730 * 42-45. UBH did not appeal this portion of the Court's judgment. 2023 WL 411441 * 9.

[7] Office of the Attorney General, Annual Report on the Health Insurance Carrier Appeals and Grievances Process, FY 2022, at 26.

[8] *Id*. at 5.

Attachment A

ATTACHMENT A

AMENDMENT 1

15–10B–02.

The purpose of this subtitle is to:

(1) promote the delivery of quality health care in a cost effective manner THAT ENSURSE TIMELY ACCESS TO HEALTH CARE SERVICES;
(2) fosters greater coordination, COMMUNICATION, AND TRANSPARENCY between payors and providers conducting utilization review activities;
(3) protect patients, business, and providers by ensuring that private review agents are qualified to perform utilization review activities and to make informed decisions on the appropriateness of medical care and **ADHERE TO THE UTILIZATION REVIEW CRITERIA TO BE USED UNDER 15-10B-05**.

AMENDMENT 2

15-10B-05

(a) In conjunction with the application, the private review agent shall submit information that the Commissioner requires including:
  (1) a utilization review plan that includes:
    (i) the specific criteria and standards to be used in conducting utilization review of proposed or delivered health care services IN ACCORDANCE WITH ITEM (11) OF THIS SUBSECTION:
    (ii) those circumstances, if any, under which utilization review may be delegated to a hospital utilization review program; ~~and~~
    (iii) **THE PROCESS FOR CONFIRMING THAT A PRIVATE REVIEW AGENT APPLIES THE SPECIFIC CRITERIA AND STANDARDS TO BE USED UNDER 15-10B-05 IN MAKING ALL UTILIZATION REVIEW DECISIONS**; AND
    (iv) If applicable, any provisions by which patients, physicians, or hospital may seek reconsideration.

AMENDMENT 3

15-10B-05(a)

(11) certification by the private review agent that the criteria and standards to be used in conducting utilization review **[**are**]**:
[(i) objective;
(ii) clinically valid;
(iii) compatible with established principles of health care; and
(iv) flexible enough to allow deviations from norms when justified on a case by case basis**]**

(I) ARE EVIDENCE–BASED, PEER–REVIEWED, **CONSISTENT WITH GENERALLY ACCEPTED STANDARDS OF CARE** AND DEVELOPED BY**:**

1. **A NON-PROFIT** PROFESSIONAL CLINICAL [MEDICAL] SPECIALTY SOCIETY **FOR THE RELEVANT CLINICAL SPECIALTY,** OR

2. **FOR UTILZATION REVIEW CRITERIA FOR HEALTH CARE THAT IS NOT WITHIN THE SCOPE OF THE RELEVANT NON-PROFIT CLINICAL SPECIALTY SOCIETY CRITERIA**, AN ORGANIZATION THAT WORKS DIRECTLY WITH HEALTH CARE PROVIDERS IN THE SAME SPECIALTY FOR THE DESIGNATED CRITERIA WHO ARE EMPLOYED OR ENGAGED WITHIN THE ORGANIZATION OR OUTSIDE THE ORGANIZATION TO DEVELOP THE CLINICAL CRITERIA, PROVIDED THAT THE ORGANIZATION DOES NOT RECEIVE DIRECT PAYMENTS BASED ON THE OUTCOME OR PRIOR AUTHORIZATION DECISIONS **AND DEMONSTRATES THAT ITS CLINICAL CRITERIA ARE CONSISTENT WITH GENERALLY ACCEPTED STANDARDS OF CARE; AND**

(II) SHALL:

1. TAKE INTO ACCOUNT THE NEEDS OF ATYPICAL PAITENT POPULATIONS AND DIAGNOSES;

2. ENSURE QUALITY OF CARE AND ACCESS TO NEEDED HEALTH CARE SERVICES;

3. BE SUFFICIENTLY FLEIXIBLE TO ALLOW DEVIATIONS FROM NORMS WHEN JUSTIFIED ON A CASES-BY-CASE BASIS;

4. **BE AGE APPROPRIATE, INCLUDING TAKING INTO ACCOUNT THE UNIQUE NEEDS OF CHILDREN AND ADOLESCENTS; AND**

5. BE EVALUATED AT LEAST ANNUALLY AND UPDATED AS NECESSARY.

(III). NOTHING IN THIS SECTION SHALL SUPERSEDE SECTION 15-802 WITH REGARD TO THE USE OF THE ASAM CRITERIA FOR ALL MEDICAL NECESSITY AND UTILIZATION MANAGEMENT DETERMINATIONS FOR SUBSTANCE USE DISORDER BENEFS.

(IV) FOR THE PURPOSES OF THIS SUBSECTION, "GENERALLY ACCEPTED STANDARDS OF CARE" MEANS STANDARDS OF CARE AND CLINICAL PRACTICE THAT ARE GENERALLY RECOGNIZED BY HEALTH CARE PROVIDERS PRACTICING IN THE RELEVENT CLINCAL SPECIALTIES. VALID, EVIDENCE-BASED SOURCES REFLECTING GENERALLY ACCEPTED STANDARDS OF MEDICAL PRACTICE INCLUDE PEER-REVIEWED SCIENTIFIC STUDIES AND MEDICAL LITERATURE, RECOMMENDATIONS OF NONPROFIT HEALTH CARE PROVIDER PROFESSIONAL ASSOCIATIONS AND SPECIALTY SOCIETIES, INCLUDING BUT NOT LIMITED TO PATIENT PLACEMENT CRITERIA AND CLINICAL PRACTICE GUIDELINES, RECOMMENDATIONS OF FEDERAL GOVERNMENT AGENCIES, AND DRUG LABELING APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION.

AMENDMENT 4

15-10B-06

(B) BEFORE ISSUING AN ADVERSE DECISION, A PRIVATE REVIEW AGENT SHALL:

(1) GIVE THE PATIENT'S TREATING PHYSICIAN, DENTIST, OR OTHER HEALTH CARE PRACTITIONER THE OPPORTUNITY TO SPEAK ABOUT THE MEDICAL NECESSITY OF THE TRETMENT REQUEST WITH THE PHYSICIAN, DENTIST, OR PANEL RESPONSIBLE FOR THE ADVERSE DECISION; **AND**

(2) EXPLAIN HOW THE SPECIFIC CRITERIA AND STANDARDS TO BE USED UNDER 15-10B-05 ARE APPLIED IN THE INDIVIDUAL CASE AND RESULT IN THE ADVERSE DECISION.

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MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

2023 SESSION POSITION PAPER

BILL NO: **SB 308**

COMMITTEE: **Senate Finance Committee**

POSITION: **SUPPORT WITH AMENDMENTS**

TITLE: Health Insurance – Utilization Review – Revisions

BILL ANALYSIS

SB 308 - Health Insurance – Utilization Review – Revisions alters and establishes requirements related to health insurance utilization review, benchmarks for standardizing and automating the preauthorization process, an online preauthorization system for payors, preauthorization for prescription drugs, and private review agents. The bill requires the Maryland Health Care Commission (the "Commission") in consultation with providers, payors, and the State Designated Health Information Exchange (HIE) to develop recommendations to achieve greater standardization and uniformity across payors to ease the burden of preauthorization and other utilization management techniques for patients, providers, and payors. This includes, replacing use of proprietary web-based portals with the adoption of uniform implementation specifications and standardization with a single sign-on option for payor and third-party administrator websites, and a pilot program through the State Designated HIE. The bill also requires the Commission and the Maryland Insurance Administration, in consultation with providers and payors, to study the development of standards for the implementation of payor programs to modify preauthorization requirements for prescription drugs, medical care, and other services based on provider-specific criteria.

POSITION AND RATIONALE

The Commission supports SB 308 with amendments that extend the time to complete various areas of study in Sections 2 and 3 and delay implementation of Section 1 requirements until the studies have been completed. The additional time is needed to complete the work adequately and assess the potential impact of pending federal legislation related to preauthorization. On December 13, 2022,[1, 2] the Centers for Medicare & Medicaid Services (CMS) released a Proposed Rule that aims to streamline processes related to preauthorization, among other things. The Proposed Rule would require implementation by 2026 and includes requirements intended to reduce overall provider and payor hardship and improve patient access to health information.

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[1] The CMS Proposed Rule is available at: www.federalregister.gov/documents/2022/12/13/2022-26479/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

[2] The CMS Proposed Rule comment period is 90-days, or through March 13, 2023.

Electronic preauthorization emerged to streamline communications between providers and payors regarding patient coverage, eligibility, and medical necessity of a medical service or pharmaceutical.[3] In 2012, Maryland became one of the first states to enact legislation that required payors to implement preauthorization requirements in a phased approach, which included establishing web-based portals.[4, 5] Chapters 534 and 535 (SB 540, HB 470) of the 2012 Laws of Maryland required the Commission to work with payors and providers to attain benchmarks for standardizing and automating the preauthorization process and establish regulations through which a payor or provider may be waived from attaining one or more benchmarks.[6] SB 308 requires payors to adopt new processes and technology, with the intent to ease the administrative workload of preauthorizations that continue to burden providers and their supporting staff.

The Commission supports the aims of SB 308 in reshaping medical oversight and review by payors and notes that more time is needed by payors to consider the impact of the bill on existing preauthorization processes and technology systems. The Commission recommends the Committee require the Commission, in collaboration with payors, to identify barriers to implementing the legislation and propose solutions as part of the study requirements in the bill.

For the reasons noted, the Commission suggests delaying implementation of the legislation until completion of all areas of required study. Should the Committee decide to advance SB 308, the Commission recommends that the bill be amended as follows.

AMENDMENTS:

AMENDMENT NUMBER ONE:

- Page 24, line 23 strike December 1, 2023, and replace with, NOVEMBER 1, 2024

AMENDMENT NUMBER TWO:

- Page 25, line 7 strike December 1, 2023, and replace with, NOVEMBER 1, 2024

[3] *Altarum Institute*, "Impacts of Prior Authorization on Health Care Costs and Quality," November 2019. Available at: www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf.
[4] Md. Code Ann., Health-Gen. § 19-108.2.
[5] An web-based portal is a standalone system; also referred to as an "online preauthorization system."
[6] Enactment of the law was informed by a Maryland Health Care Commission report based on recommendations from a multistakeholder workgroup, *Recommendations for Implementing Electronic Prior Authorizations, December 2011.*

AMENDMENT NUMBER THREE:

- Page 25, line 20 strike after the word "effect" January 1, 2024, and replace with, JULY 1, 2025, AFTER THE STUDIES CONDUCTED BY THE MARYLAND HEALTH CARE COMMISSION HAVE BEEN COMPLETED AND CONSIDERED BY THE GENERAL ASSEMBLY

Note: The Maryland Health Care Commission is an independent State agency, and the position of the Commission may differ from the position of the Maryland Department of Health.