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Health Insurance –Utilization Review – Revisions (HB 305)
Health and Government Operations Committee Hearing
February 16, 2023
SUPPORT WITH AMENDMENTS

Thank you for the opportunity to submit testimony **in support of HB 305 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.**

HB 305, 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). **HB 305 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 HB 305 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. HB 305, 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. HB 305 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, HB 305 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, HB 305 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 HB 305 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 HB 305, 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 HB 305 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.