NCADD-MD - 2024 SB 93 FAV - UR Private Review Agen
Uploaded by: Ann Ciekot
Position: FAV

Senate Finance Committee
February 21, 2024

Senate Bill 93
Health Insurance – Utilization Review – Private Review Agents

Support

NCADD-Maryland supports Senate Bill 93, which will designate utilization review criteria and help Marylanders get evidence-based care regardless of their health plan.

Under current law, Maryland requires a single set of utilization review standards for substance use disorder care, ASAM Criteria. This Committee has played an important role in passing legislation over the years that ensures this uniform, evidence-based care regardless of which health plan a person has. However, Maryland gives carriers total discretion in selecting criteria for mental health care.

As proposed in Senate Bill 93, requiring private review agents to explain their application of the required criteria to the health care provider before issuing a denial will eliminate inappropriate denials and help Marylanders get more timely mental health treatment. Marylanders need stronger utilization review requirements to ensure they have access to the type and duration of mental health and substance use disorder treatment they need.

We urge a favorable report on Senate Bill 93.

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

MCF-SB093 Testimony-FAV.pdf
Uploaded by: Ashley Tauler
Position: FAV

SB093- Health Insurance – Utilization Review – Private Review Agents

Committee: Finance

Date: February 19, 2024

Position: Favorable

The Maryland Coalition of Families: Maryland Coalition of Families (MCF) is a statewide nonprofit organization that provides family peer support services at no cost to families who have a loved one with a mental health, substance use, or problem gambling disorder. Using their personal experience as parents, caregivers and other loved ones, our staff provide emotional support, resource connection and systems navigation as well as support groups and educational trainings and workshops.

Many of the families that our staff support are families with children. Last year we served 4,603 Families and nearly 70% were families with children. MCF supports this bill for several reasons.

- Requiring greater transparency from private insurers as to why a mental health or substance use claim is denied will help to ensure parity. Families who receive a denied claim with no explanation as to why, struggle to find treatment for their loved one. This sometimes worsens symptoms and behaviors prolonging access to appropriate treatment.

- Communication between a health care provider and the insurer may help in the understanding of the importance of the treatment that is being requested. This will help to ensure the quality and access to care for mental health and substance use disorder treatment.

Ashley Tauler

Policy and Advocacy Associate

Maryland Coalition of Families

8950 State Route 108, Suite 223

MC Federation of Famiies Testimony in Support of S

Uploaded by: Celia Serkin

Position: FAV

Montgomery County Federation of Families for Children's Mental Health, Inc.
Colesville Professional Center
13321 New Hampshire Avenue, Terrace B
Silver Spring, MD 20904
301-879-5200 (phone) ✦ 301-879-0012 (fax)
info@mcfof.org
www.mcfof.org (website)

SB 93 Health Insurance - Utilization Review - Private Review Agents
Senate Finance Committee
February 21, 2024
POSITION: SUPPORT

I am Celia Serkin, Executive Director of the Montgomery County Federation of Families for Children's Mental Health, Inc. (MC Federation of Families), a family peer support organization serving diverse families in Montgomery County who have children, youth, and/or young adults with mental health, substance use, or co-occurring challenges. Our Certified Family Peer Specialists are parents who have raised or are currently raising children with mental health, substance use, and/or co-occurring challenges. I am a Montgomery County resident and have two children, now adults, who have struggled since childhood with mental health challenges. My son has debilitating depression. My daughter has co-occurring challenges.

MC Federation of Families is pleased to support **SB 93 Health Insurance - Utilization Review - Private Review Agents.**

SB 93 requires that certain criteria and standards used by private review agents for health insurance utilization review relating to mental health and substance use disorder benefits meet certain requirements; requiring a private review agent to take certain actions before issuing an adverse decision; and specifying the procedure for private review agents to follow when making decisions related to mental health and substance use disorder benefits.

MC Federation of Families supports SB 93 because would it:

- Specify the utilization review criteria that private review agents (PRAs) must use for all mental health and substance use disorder care decisions:
    - Mental health care criteria must be developed by a non-profit professional mental health provider association, such as the American Association of Community Psychiatrists, the American Academy of Child and Adolescent Psychiatry, and the American Psychiatric Association.
    - Substance use disorder care must be based on the American Society of Addiction Medicine (ASAM) Criteria, as required by Maryland law since 2019.
- Require PRAs to explain to the patient's treating provider why the relevant criteria for the prescribed care are not met in the individual patient's case before denying care.

- Require PRAs to make all decisions consist with the required criteria for chronic care treatment and not limit treatment to services for acute care only.

Too many Marylanders cannot access the treatment that they need for mental health conditions and substance use disorders, and people are dying as a result. Many Maryland have encountered problems with their health insurance plan denying coverage for mental health or substance use disorder care based on either the care not being medically necessary or the care being not covered or excluded. Marylanders need stronger utilization review requirements to ensure they have access to the type and duration of mental health and substance use disorder treatment they need. They deserve protections to ensure their health plans are not inappropriately denying needed care and equitable access to care that is timely, clinically effective, and adequately reimbursed by insurers.

MC Federation of Families urges this committee to pass SB 93.

SB0093_MHAMD_FAV.pdf
Uploaded by: Dan Martin
Position: FAV

mhamd
MENTAL HEALTH ASSOCIATION OF MARYLAND

1301 York Road, #505
Lutherville, MD 21093
phone 443.901.1550
fax 443.901.0038
www.mhamd.org

Senate Bill 93 Health Insurance – Utilization Review – Private Review Agents
Finance Committee
February 21, 2024
Position: SUPPORT

Mental Health Association of Maryland (MHAMD) is a nonprofit education and advocacy organization that brings together consumers, families, clinicians, advocates and concerned citizens for unified action in all aspects of mental health and substance use disorders (collectively referred to as behavioral health). We appreciate the opportunity to provide this testimony in support of Senate Bill 93.

SB 93 modifies mental health utilization review criteria and processes to improve access to critical mental health care. The bill specifies that private review agents (PRAs) must use mental health care criteria developed by a non-profit professional mental health provider association, such as the American Association of Community Psychiatrists, the American Academy of Child and Adolescent Psychiatry, and the American Psychiatric Association. It also requires PRAs to explain to the patient's treating provider why the relevant criteria for the prescribed care are not met in the individual patient's case before denying care and requires PRAs to make all decisions consistent with the required criteria for chronic care treatment and not limit treatment to services for acute care only.

Too often, private health plans rely on medical necessity criteria that are not consistent with evidence-based care for mental health conditions. According to a recent national patient-experience survey conducted by NORC, nearly 70% of Marylanders reported that they had problems with their health insurance plan denying coverage for mental health or substance use disorder care based on either the care not being medically necessary or the care being not covered or excluded. SB 93 would bring Maryland in line with other states that have required private health plans to follow generally accepted standards of care for mental health utilization review, including Illinois, California, Georgia, Oregon and New Mexico.

Further, by requiring PRAs to explain their application of the required criteria to the health care provider before issuing a denial, SB 93 will eliminate inappropriate denials and help Marylanders get more timely treatment. Currently, less than one-half of one percent of adverse mental health and substance use disorder decisions are challenged. Appealing denials takes significant time and support particularly for individuals struggling with a mental health condition or substance use disorder.

Lastly, by requiring PRAs to make decisions consistent with criteria for chronic care treatment, SB 93 will ensure Marylanders have access to ongoing treatment to address the underlying causes of acute mental health crises, not just the crisis itself.

For these reasons, MHAMD supports SB 93 and urges a favorable report.

For more information, please contact Dan Martin at (410) 978-8865

Legal Action Center Testimony SB93_Utlization Revi
Uploaded by: Ellen Weber
Position: FAV

LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

Health Insurance – Utilization Review – Private Review Agents (SB 93)
Senate Finance Committee
February 21, 2024
FAVORABLE

Thank you for the opportunity to submit testimony in favor of SB 93, which would require private review agents to use uniform utilization review standards for mental health and substance use disorder treatment decisions and address two review practices that deny access to the appropriate level of care. This testimony is submitted by the Legal Action Center, a law and policy organization that has worked for 50 years to fight discrimination, build health equity and restore opportunities for individuals with substance use disorders, arrest and conviction records, and HIV and AIDs. In Maryland, we convene the Maryland Parity Coalition and work with our partners to ensure non-discriminatory access to mental health and substance use disorder services through enforcement of the federal Mental Health Parity and Addiction Equity Act (Parity Act) in both public and private insurance. Utilization review (UR) standards are at the core of whether Marylanders get access to the care they need and pay for through their insurance plan, and those standards must comply with the Parity Act in their design and application.

We support SB 93 to ensure that private review agents (PRA) (1) use the **right** medical necessity standards when making authorization and payment decisions for mental health (MH) and substance use disorder (SUD) treatment and (2) apply those criteria with **fidelity**. SB 93 has three critical components to strengthen the UR process for MH and SUD care, all of which mirror or complement the standards in SB 791.

1. **Mandatory Use of Evidence-Based Medical Necessity Standards Developed by Mental Health Professional Societies.**

SB 93, like SB 791, would require private review agents to use the medical necessity and level of care standards that have been developed by the non-profit medical and clinical specialty society for mental health practitioners for all UR decisions. Since 2019, Maryland has required the use of such evidence-based standards for SUD care – the American Society of Addiction Medicine (ASAM) Criteria. Ins. § 15-802(d)(5). The **same statutory protection does not exist for mental health care**, even though well-recognized professional society standards are available. Instead, private review agents have complete discretion to select proprietary standards (e.g. InterQual or MCG) that often limit access to MH care. For example, a nationwide class action lawsuit successfully challenged United Behavioral Health's (UBH) Level of Care Guidelines for MH and SUD care, finding that the standards UBH developed were "significantly and pervasively more restrictive than generally accepted standards of care" and were developed to put its financial interests above it plan members' right to benefits. Wit v. United Behavioral Health, 2020 WL 6479273 *49 (N.D. CA), *aff'd in part, rev'd in part, remanded*, 79 F.4th 1068 (9th Cir. 2023). Nationally recognized MH professional society standards include those developed by the American Association of Community Psychiatrists (LOCUS and CALOCUS), the American Academy of Child & Adolescent Psychiatry (CASII and ESCII),the American Psychiatric Association, and World Professional Association for Transgender Health (WPATH).

810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.5712 nationalpolicy@lac.org www.lac.org

Consumers and providers will benefit tremendously from the mandatory use of a non-profit professional medical society's standards. Regardless of a consumer's insurance plan, access to care will be based on standardized professional care guidelines that address the patient's full medical condition and psychosocial needs. A patient and their practitioner will have greater control over their health care because the UR/medical necessity criteria are developed by a body that has no financial stake in the authorization of patient care. And patients will not have to choose between accepting a lower level of care that their insurer will authorize or paying out-of-pocket for the prescribed care that aligns with the professional society criteria. Receiving the right level of care at the initiation of treatment facilitates recovery and reduces the likelihood that the individual will cycle needlessly through more costly episodes of care.

Equally important, providers will spend less time challenging authorization and continuing care denials that have been based on proprietary standards that are inconsistent with professional society standards. We know that some MH providers do not participate in carrier networks because the administrative effort associated with addressing denials of patient care is far too burdensome. The proposed UR standard, if implemented with fidelity, will, over time, improve patient care and practitioner participation in networks. This standard aligns with the American Medical Association's Prior Authorization and Utilization Management Reform Principles.

2. Require Level of Care Determinations Based on a Patient's Underlying Chronic Condition Not Acute Symptoms

SB 93 would also address a very common practice that PRAs use to deny access to more intensive and expensive levels of care: **authorizing treatment based only on the patient's acute symptoms rather than the underlying chronic condition.** Like many medical conditions, an individual with a MH or SUD may present both acute symptoms (e.g. an overdose, psychotic episode, suicidal ideation) and an underlying condition (e.g. major depression, an alcohol or opioid use disorder), both of which must be treated through a range of services of varying degrees of intensity and/or medications. Health plans commonly deny authorization for medically necessary subacute care, which is delivered in a residential or partial hospitalization/day treatment level of care, by using UR standards that require on-going acute symptoms that will not be present if a patient's acute condition has been stabilized. Frequently, the health plan will deny care and determine that the patient can be treated at a lower level of care, even if the patient has failed repeatedly at that less intensive level of care and setting. Health plans across the country have been sued for denying children and adults authorization for subacute services based on restrictive UR standards that require acute symptoms and for refusing to authorize care based on the patient's underlying chronic condition as with other medical care. *See e.g., B.H. v. Anthem Health Plans of Virginia,* Inc., 2023 WL 5270658 (E.D. Va, 2023).

While the required use of the professional society's UR standards will begin to address this problem, the PRAs must also be required to implement those standards with fidelity. Even with the required use of the ASAM criteria for SUD care, PRAs continue to authorize care based only on the patient's acute drug use symptoms rather than their complete medical and psychosocial needs – such as covering treatment for their withdrawal management from the substance but denying ongoing care at the proper intensity of services to address the underlying SUD. Essentially, a PRA should not selectively apply the criteria in a way that prevents the patient from getting the care they need to recover. To prevent this misapplication or selective application of the "right" criteria, SB 93 would explicitly require the PRA to make all decisions consistent with the required criteria for chronic care treatment and not limit treatment to services for acute care.

810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.5712 nationalpolicy@lac.org www.lac.org

3. Justify Adverse Care Decision Before Issuing a Denial Based on Required Criteria

SB 93 would adopt a second safeguard against the misapplication of the required UR criteria for MH and SUD services: it would require the PRA to explain to the treating provider the specific criteria a patient does not meet ***before issuing the denial*** to allow for immediate corrective action. PRAs will commonly issue an explanation of benefits (EOB) that denies a requested level of care without identifying the specific reason(s) and UR criterion that are the basis for such denial, even though current state law requires that information. Ins. § 15-10A-02(f). For MH and SUD care, a PRA may signal simultaneously that it would authorize a lower level of care, which can lead to patients accepting the lower level of care to get "some" services and not incur unaffordable out-of-pocket costs for the prescribed care. While a practitioner may challenge the PRA's decision in a peer-to-peer conversation, the patient often cannot afford the care pending that review and leave treatment prematurely.

It is essential to prevent incorrect denials of MH and SUD care in addition to requiring PRAs to provide more detailed information in their denial notices, as proposed by SB 791. Marylanders with MH and SUD rarely challenge adverse decisions: only **one-half of one percent (0.59%)** of MH and SUD adverse decisions are challenged in a grievance process even though **one-third (37%) of challenged decisions are overturned by the carrier.** Office of Attorney General, Health Education and Advocacy Unit, Annual Report on the Health Insurance Carrier Appeals and Grievances Process for FY 2023. Marylanders challenge adverse decisions for other health services at a far higher rate: 47% for pharmacy, 24% for dental, 12% for laboratory/radiology, 6% for physician, 4% other, 2% durable medical equipment; and 1% inpatient hospital adverse decisions. With 37% of MH and SUD decisions being overturned, it is clear that many Marylanders who do not challenge their adverse decision are being denied insurance coverage to which they are entitled.

SB 93 would mitigate the burden on both patients who do not understand their appeal rights or do not have the support or capacity to challenge an adverse decision as well as practitioners who must spend significant time engaging in post-denial discussions. Addressing this administrative barrier to care will ease workforce challenges, improve access to care and lower costs associated with incorrect authorization denials.

Thank you for considering our views. We urge the Committee to issue a favorable report on SB 93.

Ellen M. Weber, J.D.
Sr. Vice President for Health Initiatives
Legal Action Center
eweber@lac.org

810 First St, NE, Suite 200, Washington, DC 20002 T 202.544.5478 F 202.544.5712 nationalpolicy@lac.org www.lac.org

SB 93.pdf
Uploaded by: Joseph Hobelmann
Position: FAV

Maryland-DC Society of Addiction Medicine
A Chapter of American Society of Addiction Medicine

MDDCSAM is the Maryland state chapter of the American Society of Addiction Medicine whose members are physicians and other health providers who treat people with substance use disorders.

SB 93 Health Insurance- Utilization Review- Private Review Agents

FAVORABLE

MDDCSAM supports SB 93, with particular attention to the following point:

Uniform Utilization Review Criteria for Mental Health Treatment Will Improve Level of Care Decisions: In our experience, requiring the ASAM criteria to be used by all carriers as the utilization review (UR) standards for SUD care has, over time, resulted in improvements in our authorization/continuing care discussions with carriers/private review agents. Based on this experience, requiring uniform UR standards for mental health care should also improve provider-carrier discussions and result in better access to care.

Requirement to Approve Care for SUDs as a Chronic Condition Not Just Acute Episodes: Private review agents often do not apply the ASAM criteria correctly, particularly for the more intensive and expensive levels of care, such as residential treatment. They fail to assess all 5 dimensions required for an appropriate level of care determination and force patients to step down to a lower level of care prematurely. For example, many carriers will deny residential care unless the patient is suicidal or requires 24-hour medical treatment. That limitation misapplies the ASAM criteria and is more restrictive than the standards applied for other medical care, as it focuses only on a patient's acute condition, not their chronic condition. For that reason, we support the provision in SB 93 that requires carriers to treat SUDs as a chronic condition and not limit treatment based on the acute episode.

Identifying Level of Care Criteria Not Met by Patient Before Denying Care: We also support the SB 93 provision that would require private review agents to identify the criterion that have not been met in a patient's case before they issue a denial for initial or continued care. This will help avoid incorrect denials of care, particularly when they fail to assess all 5 ASAM dimensions and will allow us to submit additional information to support our requested level of care, as needed, **before the patient is forced to step down or pay out-of-pocket for the denied level of care**. We currently have patients leave treatment sooner than medically advised because the carrier will not authorize on-going care at the recommended level and the patient cannot afford to pay out-of-pocket for on-going care, as we seek to resolve the dispute in peer-to-peer discussions.

Thank you for your consideration.

J Greg Hobelmann, MD, MPH
Board certified in psychiatry and addiction medicine
Public Policy Committee, MDDCSAM

2024 ACNM SB 93 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

AFFILIATE OF AMERICAN COLLEGE of NURSE-MIDWIVES With women, for a lifetime®

Committee:	**Senate Finance Committee**
Bill Number:	**SB 93 – Health Insurance – Utilization Review – Private Review Agents**
Hearing Date:	**February 21, 2024**
Position:	**Support**

The Maryland Affiliate of the American College of Nurse Midwives (ACNM) strongly supports *Senate Bill 93 – Health Insurance – Utilization Review – Private Review Agents*. The bill requires that certain criteria and standards used by private review agents for health insurance utilization review relating to mental health and substance use disorder benefits meet generally accepted standards of care and requires a private review agent to give the patient's treating provider an opportunity to speak before issuing an adverse decision.

A certified nurse midwife plays a crucial role in providing healthcare services to women during pregnancy, childbirth, and postpartum periods. However, their ability to effectively carry out their duties can be hindered if insurance carriers make adverse decisions regarding coverage for their services. It is important for a certified nurse midwife to have the opportunity to speak with an insurance carrier's private review agent before such decisions are rendered. This would allow the midwife to provide additional information, clarify any misunderstandings, and advocate for the best interests of their patients. By engaging in direct communication with the review agent, the certified nurse midwife can ensure that their expertise and knowledge are taken into account during the decision-making process. This opportunity would ultimately lead to better outcomes for both the midwife and their patients.

We ask for a favorable report. If we can provide any additional information, please contact Robyn Elliott at relliott@policypartners.net.

2024 LCPCM SB 93 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

LICENSED CLINICAL PROFESSIONAL COUNSELORS OF MARYLAND

Committee:	**Senate Finance Committee**
Bill Number:	**Senate Bill 93 – Health Insurance – Utilization Review – Private Review Agents**
Hearing Date:	**February 21, 2024**
Position:	**Support**

The Licensed Clininical Professional Counselors of Maryland (LCPCM) strongly supports *Senate Bill 93 – Health Insurance – Utilization Review – Private Review Agents*. The bill requires that certain criteria and standards used by private review agents for health insurance utilization review relating to mental health and substance use disorder benefits meet generally accepted standards of care and requires a private review agent to give the patient's treating provider an opportunity to speak before issuing an adverse decision.

A licensed clinical professional counselor (LCPC) should have the opportunity to speak with a private review agent before an adverse decision is rendered. This would allow LCPCs to provide additional information or clarification regarding their practice and the services they provide. By engaging in a conversation with the private review agent, the counselor can address any misunderstandings or misconceptions that may have arisen during the evaluation process. Secondly, speaking directly with a private review agent can offer the counselor an opportunity to advocate for themselves and present their case in a more personal and nuanced manner if the alternative is to have an adverse decision made with no specific understanding. This can be crucial in ensuring a fair and unbiased decision is made. Providing licensed clinical professional counselors with the chance to speak with a private review agent before an adverse decision is reached can enhance transparency, fairness, and effective communication in the evaluation process.

We ask for a favorable report. If we can provide any further information, please contact Robyn Elliott at relliott@policypartners.net.

2024 MCHS SB 93 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Community Health System

Committee: **Senate Finance Committee**

Bill: **Senate Bill 93 - Health Insurance – Utilization Review – Private Review Agents**

Hearing Date: **February 21, 2024**

Position: **Support**

The Maryland Community Health System (MCHS) supports Senate Bill 93 - Health Insurance – Utilization Review – Private Review Agents. The bill requires that certain criteria and standards used by private review agents for health insurance utilization review relating to mental health and substance use disorder benefits meet generally accepted standards of care and requires a private review agent to give the patient's treating provider an opportunity to speak before issuing an adverse decision.

MCHS is a network of seven federally qualified health centers with 55 sites serving communities across Maryland. A healthcare provider should have the opportunity to speak with a private review agent before an adverse decision is rendered for several reasons. This allows the health provider to provide additional information or clarification regarding the case in question. This can help the private review agent better understand the circumstances and potentially reconsider their decision. Speaking directly with the review agent allows the health provider to address any concerns or discrepancies in the review process, ensuring a fair and unbiased assessment. Allowing a healthcare provider to speak with a private review agent before an adverse decision is rendered is crucial in ensuring fairness, transparency, and quality in the decision-making process.

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

2024 MOTA SB 93 Senate Side.pdf
Uploaded by: Michael Paddy
Position: FAV

Maryland Occupational Therapy Association

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

Committee: **Senate Finance Committee**

Bill Number: **Senate Bill 93**

Title: **Health Insurance – Utilization Review – Private Review Agents**

Hearing Date: **February 21, 2024**

Position: **Support**

The Maryland Occupational Therapy Association (MOTA) supports Senate Bill 93 – *Health Insurance – Utilization Review – Private Review Agents*. The bill requires that certain criteria and standards used by private review agents for health insurance utilization review relating to mental health and substance use disorder benefits meet generally accepted standards of care and requires a private review agent to give the patient's treating provider an opportunity to speak before issuing an adverse decision.

Occupational therapists play a critical role in promoting the health and well-being of individuals. They are trained professionals who assess and provide therapy to help individuals regain functional independence in their daily lives. Given the importance of their work, it is essential that occupational therapists have the opportunity to speak with a private review agent before an adverse decision is rendered. This would allow them to explain their treatment approach, provide additional information, and address any concerns that the private review agent may have. By having this opportunity, occupational therapists can ensure that their expertise and knowledge are properly considered, leading to fair and informed decisions regarding patient care. Providing occupational therapists with the chance to speak with a private review agent before an adverse decision is made will contribute to improved patient outcomes and a more comprehensive understanding of the therapeutic process.

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

SB93 FAV.pdf
Uploaded by: Morgan Mills
Position: FAV

NAMI Maryland
National Alliance on Mental Illness

February 21, 2024

Chairwoman Beidle, Vice Chair Klausmeier, and distinguished members of the Finance Committee,

The National Alliance on Mental Illness, Maryland and our 11 local affiliates across the state represent a statewide network of more than 58,000 families, individuals, community-based organizations, and service providers. NAMI Maryland is a non-profit that is dedicated to providing education, support, and advocacy for persons with mental illnesses, their families and the wider community.

The complexity of navigating the healthcare and insurance system is already a major obstacle for individuals seeking mental health care. The process can be incredibly overwhelming. Additional barriers exist for people with mental illness.

SB93 specifies utilization review criteria to be used for mental health and substance use disorder benefits. This legislation requires carriers to utilize review criteria and standards that have been developed by non-profit health care professional associations and/or specialty societies—this includes the WHO's International Statistical Classification of Diseases and Related Health Problems or the American Psychiatric Association's DSM. This increases transparency in the utilization review process by allowing providers a better understanding of how to meet those standards.

This bill also requires that private review agents take into account the need of atypical patient populations, and that standards are sufficiently flexible to allow deviation from norms when justified. Every individual is unique in their needs—and this bill helps account for that.

Finally, this legislation requires that private review agents discuss the medical necessity of the treatment request with the requesting provider before issuing an adverse decision. This will help decrease the volume of denials. The appeal process is difficult to navigate; by requiring a discussion between review agent and provider PRIOR to the issuance of a denial, we are helping facilitate better access to care for Marylanders who need it most.

For these reasons, we urge a favorable report.

Kathryn S. Farinholt
Executive Director
National Alliance on Mental Illness, Maryland

Contact: Morgan Mills
Compass Government Relations
Mmills@compassadvocacy.com

SB 93 - Support - MPS WPS.pdf
Uploaded by: Thomas Tompsett
Position: FAV

February 20, 2024

The Honorable Pamela Beidle
Senate Finance Committee
Miller Senate Office Building – 3 East
Annapolis, MD 21401

RE: Support – Senate Bill 93: Health Insurance – Utilization Review – Private Review Agents

Dear Chair Beidle 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/WPS represent over 1000 psychiatrists and physicians currently in psychiatric training.

MPS/WPS support Senate Bill 93: Health Insurance – Utilization Review – Private Review Agents (SB 93)

To begin, we would like to provide an overview of prior authorization, which this body has deliberated for the last few sessions. 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 healthcare savings mechanism, this process 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 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, leading 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 healthcare costs and devastating***

effects for individuals and their families. This includes recurrence or worsening of psychiatric symptoms, withdrawal symptoms, medical complications related to metabolism or blood pressure, relapse, and risk of harm to themselves or others.

SB 93 seeks to fix a part of the nebulous and cumbersome prior authorization process. The goal of Senate Bill 93 is to require private review agents (PRAs) to use specific utilization review standards for authorization, medical necessity, and level of care decisions for mental health and substance use disorder. State law already requires PRAs to use the American Society of Addiction Medicine (ASAM) Criteria for all utilization review decisions for substance use disorder treatment. However, current law does not provide specific utilization review standards for mental health care decisions. As a result, PRAs often use stringent criteria to deny the recommended level of care, particularly more complex and more expensive services. SB 93 remedies that issue by codifying the appropriate standards to be used when considering a prior authorization for a patient with mental health or substance use disorder care.

In addition, SB 93 would require utilization review agents to use medical necessity and placement criteria that the non-profit society of MH professionals have developed. If no such standards are in place, PRAs must adopt criteria that comply with "generally accepted standards of care," as defined in the bill. The bill would also require PRAs to speak with the prescribing provider before issuing a denial to identify the standard that has not been satisfied in an effort to avoid incorrect denials.

Patients, especially those with mental health and substance use disorders, need timely access to medication. Please support SB 93, 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 93.

If you have any questions regarding 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

SB93 Sponsor Testimony.docx.pdf
Uploaded by: Malcolm Augustine
Position: FWA

MALCOLM AUGUSTINE
Legislative District 47
Prince George's County

PRESIDENT PRO TEMPORE

Executive Nominations Committee

Education, Energy and the Environment Committee

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 214
Annapolis, Maryland 21401
410-841-3745 · 301-858-3745
800-492-7122 *Ext.* 3745
Fax 410-841-3387 · 301-858-3387
Malcolm.Augustine@senate.state.md.us

February 21, 2024

Senate Bill 93 - Health Insurance - Utilization Review - Private Review Agents

Dear Colleagues,

I am pleased to present **Senate Bill 93 - Health Insurance - Utilization Review - Private Review Agents**, which requires private review agents to adopt best practices in the criteria and standards they use for health insurance utilization reviews relating to mental health and substance use disorder (MH/SUD) benefits, provide clear rationale linked to established criteria before issuing an adverse decision, and specifies the procedure private review agents must follow when making decisions about MH/SUD benefits.

In 2020, HB455 and SB334 established a new requirement for insurance carriers to submit reports to the Maryland Insurance Administration (MIA) demonstrating that they were in compliance with state and federal parity law. Following a 2 ½ year review of parity compliance reports with clear guidance and examples, followed by detailed insufficiency letters and penalties for late and incomplete reports, the **MIA has still not received the information** it needs to verify that carriers are in compliance. In a report of their findings, the MIA stated that **reports were "uniformly and significantly inadequate**," comparative analyses were either **missing or had "extensive [deficiencies] at each step**," and conclusions regarding compliance were described as "problematic and hollow" because **none of the carriers submitted complete comparative analyses** that could support their conclusions.[1]

Yet there continues to be evidence from providers and patients of inconsistent practices, lack of transparency, and a lack of clear rationale justifying adverse decisions. The Mental Health Association of Maryland outlines common examples of non-quantitative treatment limitations (NQTLs) that patients and providers should investigate if they seem more burdensome for behavioral health care than for medical/surgical care:

- **Frequent and time-consuming authorization requirements** like repeated resubmission of treatment plans, lengthy phone calls to request the full outpatient treatment or inpatient stay recommended by a physician (beyond simply acute crisis stabilization), or burdensome treatment contracts that impact a patient's willingness or ability to engage in treatment.

[1] Maryland Insurance Administration. 2023 Interim Report on Nonquantitative Treatment Limitations and Data. 1 Dec 2023. Accessed 22 Jan 2024. https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/2023-Interim-Report-on-Nonquantitative-Treatment-Limitations-and-Data-MSAR-12745.pdf

MALCOLM AUGUSTINE
Legislative District 47
Prince George's County

PRESIDENT PRO TEMPORE

Executive Nominations Committee

Education, Energy and the Environment Committee

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 214
Annapolis, Maryland 21401
410-841-3745 · 301-858-3745
800-492-7122 *Ext.* 3745
Fax 410-841-3387 · 301-858-3387
Malcolm.Augustine@senate.state.md.us

- **"Fail-first" policies** that require a documented history of failure with lower level treatments, regardless of a provider's clinical judgment, patient's demonstrated need, or local capacity and available resources.
- Requiring evidence that the patient is **"likely to demonstrate improvement"** and making determinations that **contradict a provider's clinical judgment** and assessment of the patient**.**
- Inconsistent reimbursement rates, unclear criteria for closing panels and not accepting more in-network providers, and overly restrictive requirements for providers to join these networks.[2]

In the absence of clear criteria and evidentiary standards for insurance utilization review, and the MIA's inability to verify the conclusions due to incomplete comparative analyses of NQTLs, **the burden of detecting parity violations remains on overworked providers and Marylanders in crisis.**

<u>What SB93 would do:</u>

- Requires private review agents to adopt **best practices in the criteria and standards they use for health insurance utilization reviews** relating to mental health and substance use disorder (MH/SUD) benefits.
- Specifies the **procedure private review agents must follow when making decisions** about MH/SUD benefits.
- Require private review agents to **provide clear rationale linked to established criteria** before issuing an adverse decision.

<u>How SB93 improves statutory language:</u>

Strengthens and clarifies standards for the utilization review process:

- Adds language around **timely access, communication, transparency, and clear criteria** for utilization review.
- Specifies that MH/SUD criteria will be **evaluated at least annually** (which is consistent with federal requirements).
- Provides specific standards for criteria used in utilization review of MH/SUD benefits. Existing standards for utilization review criteria make no distinction between behavioral health care and somatic care. Currently, criteria must be:
  - Objective
  - Clinically Valid
  - Compatible with established principles of care
  - Flexible enough to allow for deviation and case-by-case decisions

  In theory, this should result in no difference in the way MH/SUD benefits are evaluated (and applied) when compared to medical/surgical benefits. But this is not what we are seeing in practice. New language for MH/SUD criteria **aligns with existing criteria for**

[2] Mental Health Association of Maryland. Navigating Parity Toolkit. Oct 2019. Accessed 22 Jan 2024. https://www.mhamd.org/wp-content/uploads/2019/10/Parity-Toolkit-2018-final.pdf

MALCOLM AUGUSTINE
Legislative District 47
Prince George's County

PRESIDENT PRO TEMPORE

Executive Nominations Committee

Education, Energy and the Environment Committee

THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

James Senate Office Building
11 Bladen Street, Room 214
Annapolis, Maryland 21401
410-841-3745 · 301-858-3745
800-492-7122 *Ext.* 3745
Fax 410-841-3387 · 301-858-3387
Malcolm.Augustine@senate.state.md.us

somatic care (sometimes word-for-word), but **provides elaboration where elaboration is needed**.

Requires greater transparency surrounding adverse decisions:

- requires private review agents to first **give the individual provider a voice in the process** (the opportunity to speak to the medical necessity of that treatment), and for MH/SUD benefits **demonstrate how they came to their decision** (how criteria and standards were applied).
- Specifies that the same criteria used for utilization review must be clearly **applied to any decision related to service intensity, level of care placement, continued stay, transfer, and discharge**.

Decisions should be consistent with the **required criteria for chronic care treatment,** and private review agents **may not limit treatment to acute care only.**

The amendment submitted to Senate Bill 93 emphasizes that private review agents must certify that the criteria and standards for utilization review are generally recognized by health care providers practicing in the relevant clinical specialties. It provides detailed criteria for physical health conditions and mental health disorders, including reliance on peer-reviewed scientific studies, development by nonprofit health care provider professional societies or organizations working directly with health care providers, recommendations by federal agencies, and compliance with various quality and updating standards. The amendment also includes considerations for atypical patient populations and diagnoses and mandates compliance with other criteria and standards required for coverage under the specified title, including treatment of substance use disorders.

Furthermore, Senate Bill 93 strengthens statutory language by delineating clear standards for utilization review criteria, emphasizing timely access, communication, and transparency. It establishes annual evaluation of MH/SUD criteria and ensures consistency in decision-making regarding service intensity, level of care, and treatment duration.

In essence, Senate Bill 93 seeks to rectify the disparities between behavioral health care and somatic care in utilization review processes. By promoting transparency, accountability, and adherence to established criteria, SB93 aims to safeguard the rights of Marylanders in need of MH/SUD treatment and improve access to quality care.

Thank you for your attention to this critical matter. I urge the committee to give a **favorable** report for **Senate Bill 93 - Health Insurance - Utilization Review - Private Review Agents as amended.**

Sincerely,

Malcolm Augustine

Senator Malcolm Augustine

SB 93_Prior Auth 2_Oppose.pdf
Uploaded by: Allison Taylor
Position: UNF

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

February 21, 2024

The Honorable Pamela Beidle
Senate Finance Committee
3 East, Miller Senate Office Building
11 Bladen Street
Annapolis, Maryland 21401

RE: SB 93 – Oppose

Dear Chair Beidle and Members of the Committee:

Kaiser Permanente respectfully opposes SB 93, "Health Insurance – Utilization Review – Private Review Agents."

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for over 825,000 members. In Maryland, we deliver care to approximately 475,000 members.

The carriers and provider community worked hard with all stakeholders to come to consensus on SB 791, which also addressed utilization management. That bill's sponsor convened a number of meetings throughout the summer and fall, and all stakeholders had a fair opportunity to participate in the process. We'd also like to thank MedChi for their hard work in building consensus. SB 791 is a fair compromise that we hope provides a better experience for patients and physicians while still providing health plans with appropriate tools to manage costs. To that end, we ask the committee to pass SB 791 instead of this bill.

Thank you for the opportunity to comment. Please feel free to contact me at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor

Allison Taylor
Director of Government Relations
Kaiser Permanente

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

DOCS-#234419-v1-SB93_OPPOSE_2024.pdf
Uploaded by: Matthew Celentano
Position: UNF

The League of Life and Health Insurers of Maryland

15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

February 21, 2024

The Honorable Pam Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, MD 21401

Senate Bill 93 - Health Insurance – Utilization Review – Private Review

Dear Chair Beidle,

The League of Life and Health Insurers of Maryland, Inc. respectfully **opposes** *Senate Bill 142 - Health Insurance – Utilization Review – Private Review* and urges the committee to give the bill an unfavorable report.

The League and our members are committed to finding ways that prior authorization can be improved, while balancing efficiency and evidence with safety, necessity, and cost controls. While we understand the intentions of this legislation, we believe the most appropriate vehicle for these changes is *SB 791 - Health Insurance - Utilization Review – Revisions* sponsored by Senator Klausmeier. SB 791 is the result of a collaborative and comprehensive approach that began at the end of the 2023 legislative session and has continued throughout the interim.

For these reasons, the League urges the committee to give Senate Bill 93 an unfavorable report.

Very truly yours,

Matthew Celentano
Executive Director

cc: Members, Senate Finance Committee

SB93 Written Statement 2.21.2024.pdf
Uploaded by: Laura Vykol-Gray
Position: INFO

WES MOORE
Governor

ARUNA MILLER
Lieutenant Governor

Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

HELENE GRADY
Secretary

MARC L. NICOLE
Deputy Secretary

SENATE BILL 93 Health Insurance – Utilization Review – Private Review Agents

STATEMENT OF INFORMATION

DATE: February 21, 2024

COMMITTEE: Finance

SUMMARY OF BILL: Senate Bill 93 seeks to expand the use of outside private review agents to conduct utilization management review services for mental health and substance use disorders.

EXPLANATION: The Secretary of Budget and Management (DBM) has broad authority for administration of the State Employee and Retiree Health and Welfare Benefits Program (the Program) and responsibility for ensuring the Program complies with all federal and State laws governing employee benefit plans, under State Personnel & Pensions Article, Section 2-502, 2-503. DBM's Office of Personnel Services and Benefits, Employee Benefits Division, administers medical and prescription drug benefits coverage for State employees, retirees, and their dependents.

The State's health care carriers currently utilize private review agents to review claims or services in a more limited capacity. An example of this limited capacity is when services are deemed "not medically necessary". Senate Bill 93 would require an expansion of the reviews currently conducted by private review agents, which would significantly increase administrative costs and create additional layers of utilization management to the State's plan. This expanded requirement on health care carriers would likely require them to add staff and create a process to manage the volume of claims associated with mental health and substance use disorders.

The Program would expect an increase in administrative fees charged to the Program between 0.2% and 0.4% in the first year of implementation of Senate Bill 93, which equates to $25 million to $50 million in additional cost to the State. Additionally, it is expected the increases will trend forward annually. It would be challenging for the State to take on these additional costs. Premium increases shared between the State and employees/retirees would likely be necessary.

For additional information, contact Laura Vykol-Gray at
(410) 260-6371 or laura.vykol@maryland.gov