SUPPORT PATIENT-CENTERED CARE

Reform Utilization Review Techniques
(Prior Authorization/Step Therapy)

Endorsed By:

The Maryland Medical Society (MedChi)
Nurse Practitioner Association of MD
Maryland Patient Care and Access Coalition
Maryland Academy of Advanced Practice Clinicians
Alkermes
Maryland State Dental Association
Maryland Society of Oral Maxillofacial Surgeon
Otsuka
Nomi Health
Maryland Nurses Association
American College of Nurse Midwives
Maryland Community Health Systems
Community Behavior Health Association of Maryland
Maryland Chapter of American College of Physicians
Maryland Occupational Therapy Association
Maryland Psychiatric Society
Baltimore County Medical Society
Montgomery County Medical Society
Baltimore City Medical Society
Anne Arundel Medical Society
Prince George's Medical Society
Washington Psychiatric Society
Quest
Maryland Podiatric Medical Association
US Oncology
Maryland Oncology and Hematology
Maryland Society of Eye Physicians and Surgeons
Maryland/DC Society of Clinical Oncologists
Maryland Chapter of the American Academy of Pediatrics
Maryland Dermatologic Society
American Physical Therapy Association, Maryland
American College of Obstetricians and Gynecologists, Maryland Section
Mid-Atlantic Association of Community Health Centers
Maryland Academy of Family Physicians
Maryland Hospital Association
Maryland Chiropractic Association
Maryland Clinical Social Work Coalition
Harford County Medical Society
Maryland Radiological Society
Maryland Neurological Society
Allegany County Medical Society

Why Utilization Review (UR) Reform is Needed:

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.

- 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.

- ***Reform Prior Authorization***

1. Allow a patient to stay on a prescription drug without another prior authorization if the insurer previously approved the drug and the patient continues to successfully be treated by the drug.
2. 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.
3. Require that the physician or the physician 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.
4. 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.
5. 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).
6. Exempt from prior authorization prescription drugs under the following circumstances: a) dosage change provided that the change is consistent with federal FDA labeled dosages; b) generic drugs; and c) a drug bundled under two prescriptions due to differing formulations can only have one prior authorization for both formulations.
7. 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.
8. 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.

- ***Reform Step Therapy:***

Maryland's law currently only allows a patient to override a step therapy protocol if the patient has already been on a drug for 180 days and the prescriber attests that the patient is doing well on the drug. This legislation recognizes there may be other clinical reasons why a patient cannot or should not take a certain drug. Therefore, the legislation will require a carrier to establish a process for requesting an exception to a step therapy protocol if, based on the professional judgement of a prescriber, the prescription drug required to be used by a step therapy protocol

- is contraindicated or will likely cause an adverse reaction, physician harm, or mental harm to the patient; or
- is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug regimen; or
- the patient is stable on a prescription drug selected by their health care provider; or
- the patient has already tried a prescription drug in the same pharmacologic class or has the same mechanism of action as the step therapy drug and was discontinued by the prescriber due to lack of efficacy or effectiveness, diminished effect, or an adverse event.

This legislation also exempts from step therapy protocols a prescription drug that is used to treat the insured or enrollee's mental disorder or condition under certain conditions.

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