June 29, 2023

Spencer Gear
Behavioral Health Administration

RE: PRP Authorization Form Errors & Clarifications

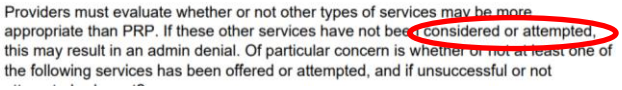
Dear Spencer:

Thank you for agreeing to seek urgent correction of the uninsured eligibility errors in the new PRP auth forms. In response to your request for feedback on errors or clarifications, we share the following:

1. PRP auth screen is narrower than MNC and published policy

The PRP authorization forms ask whether lower levels of care "have been tried."

This is narrower than existing MNC, which authorizes PRP if "less intensive levels of treatment have been *determined to be unsafe* or unsuccessful" (emphasis added) or if lower levels of care "have been *considered* or attempted, and/or are insufficient (emphasis added)."[1] In fact, Optum's Provider Alert on May 11 announcing changes to the PRP auth forms correctly states existing policy, using "considered or attempted" language as reflected in the screenshot below:[2]


Providers must evaluate whether or not other types of services may be more appropriate than PRP. If these other services have not been considered or attempted, this may result in an admin denial. Of particular concern is whether or not at least one of the following services has been offered or attempted, and if unsuccessful or not

Unfortunately, *the **auth form screenshot directly below this statement of policy does not conform to it***. The Optum PRP auth form asks only whether lower levels of care have been "tried," as reflected in the screenshot below:


Status of Less Intensive Levels of Treatment

1: Have peer supports and other informal supports such as family been tried?**
Yes No

2. Which of the following less intense services have been tried?

[1] Optum, "State of Maryland Medical Necessity Criteria," at p.16 (effective July 1, 2020).
[2] Optum, "Provider Alert: Changes to … PRP Clinical Request Forms" (May 11, 2023).

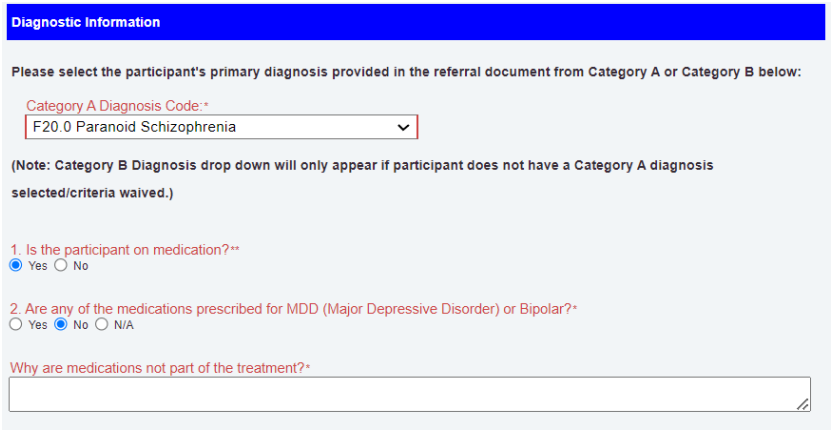
"Tried" is not the same as "considered." In our feedback to BHA on January 30 and June 7, we asked you to modify "tried" to conform to existing MNC and policy standards of "considered or attempted." BHA has not substantively responded to our two previous requests to correct this issue on the auth forms.

We are confused. Has policy changed?

Please tell us, in writing, whether BHA intends to update MNC to conform to the new auth screens, requiring patients to fail at unsafe lower levels of care before accessing PRP, or whether BHA intends to modify the auth screens to conform to existing policy.

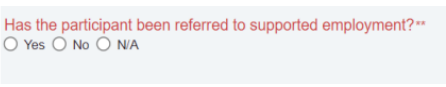
2. **Auth form requires providers to explain why they aren't using meds to treat bipolar conditions for patients diagnosed with schizophrenia.**

If a provider indicates that a patient has a schizophrenia diagnosis and is on medication, the form then asks if the medications are prescribed for MDD or bipolar diagnoses. The provider answers "no" because the patient has a schizophrenia diagnosis. The form logic treats a "no" response here as an indication that the patient is not on medication. The form logic for this portion needs to be modified to ensure that schizophrenia diagnoses with medications are not prompted as no medication responses.



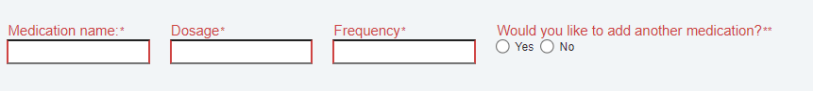
3. **Understanding logic of N/A option**

At several points throughout the new auth forms, providers are prompted to answer yes/no questions that contain a N/A option. It isn't clear to providers when a N/A answer is appropriate. It would be helpful if the screens could indicate when N/A is an appropriate response.



4. Clarifying language

Providers are confused by the "would you like to add another medication?" question. We assume that answering "yes" simply opens another data entry point to report an additional medication. To reduce confusion, please consider changing language to "would you like to report another medication?"



5. Suggestions for Improving Stakeholder Engagement Process

Although CBH provided comments on proposed changes to the auth forms on January 30 and June 7, 2023, we received no substantive response to our comments from BHA. As a result of this gap in closing the dialogue loop, some of changes made did not resolve our concerns (despite, we believe, BHA's effort to do so), and new changes were implemented with no prior notice or review by the provider community. Finally, it is important to note that Optum implemented the changes on June 16, in advance of the announced date.

We highlight these gaps in the dialogue process because they introduce inefficiencies and sometimes errors in the process of policy change. The absence of notice diminishes providers' ability to align their operations with policies, and increases the likelihood of disruptions in care. Particularly because Optum has no test environment for Incedo changes, we think a stronger dialogue with the provider community about planned changes is imperative.

We know that BHA values stakeholder engagement, and we hope you will hear our interest in closing dialogue loops and ensuring sufficient notice in your future policy-making endeavors.

Sincerely,

Shannon Hall
Executive Director

cc: Marshall Henson, Behavioral Health Administration