June 9, 2023

Marshall Henson
Behavioral Health Administration

RE: PRP Authorization Form Changes

Dear Marshall:

I am writing to request that BHA delay proposed changes to PRP authorization forms that are scheduled to take effect on June 17, 2023. We seek delay in order to allow BHA time to consider feedback from CBH and other stakeholders to the proposed changes.

An early draft of the proposed changes was shared with CBH, and we provided feedback to BHA on January 30, 2023. Our concerns raised in this letter focus solely on changes that we saw for the first time when the auth form update was announced on May 24, 2023,[1] as well as restating our previously stated concerns about the efficacy of the proposed changes and their impact in reducing access to care.

Our foremost concern is that BHA's goals will not be achieved by the changes to the auth forms. We understand and share BHA's concern about substandard practice among some PRP providers. Unfortunately, the proposed changes penalize all PRP, not just substandard providers. Without targeting the problem, BHA's changes will limit access among high quality providers while being ineffective at changing behavior among substandard providers.

When access to specialty community-based services is squeezed in the midst of a crisis, the need for care doesn't evaporate: it shifts to Maryland hospitals.

The Link between PRP and Hospital Utilization

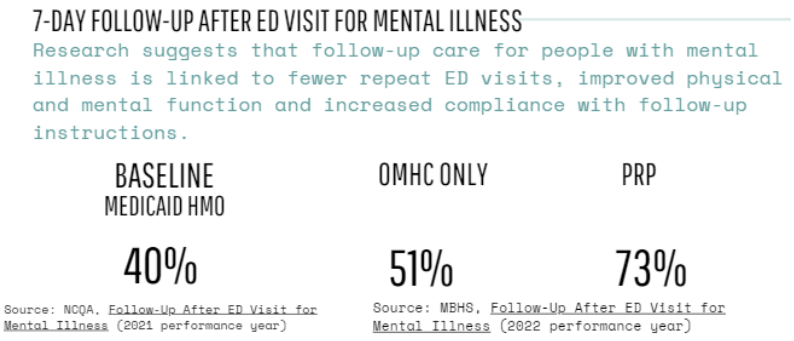
Data suggests that BHA's policies restricting access to PRP may be having an unintended consequence of increasing ED utilization and institutional lengths-of-stay. The average monthly rate of new admissions to PRP programs shrank by 24% between January 2020 and December 2022, according to data from CBH's MBHS provider network. As access to high-

[1] Optum, "Provider Alert: Changes to Adult Initial and Concurrent PRP Clinical Request Forms" (May 11, updated May 24, 2023).

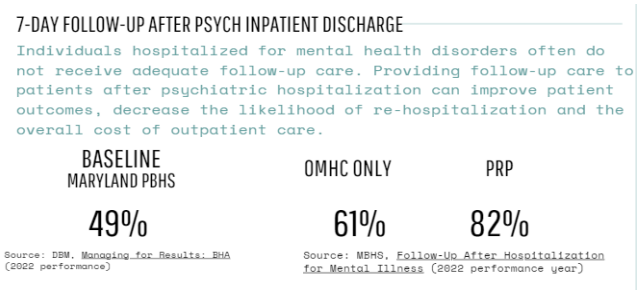
performing PRP providers shrank over the last two years, ED utilization has grown and length-of-stay in institutional settings grew by 32% for adults.[2]

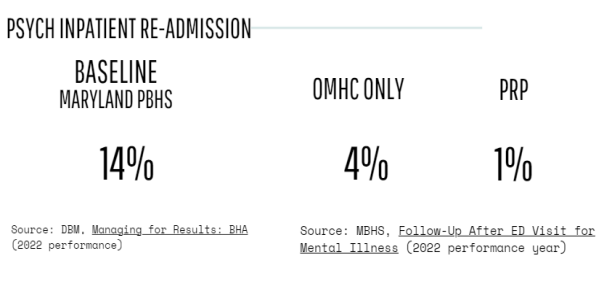
There is a direct link between access to high-performing PRPs and reduced hospital utilization. The MBHS provider network's data demonstrates the critical role that effective PRP providers play in reducing hospital utilization and speeding access to care following hospital discharges.

Within the MBHS network, 73% of clients linked to PRP received a follow-up mental health visit within 7 days of an ED visit for mental illness, compared to 40% for Medicaid HMOs.



Maryland measures its PBHS performance on 7-day follow-up after psychiatric inpatient discharge and psychiatric inpatient re-admission. Within the MBHS network, clients enrolled in PRP demonstrate 7-day follow up at nearly double the rate of the PBHS as a whole, while readmissions are one-tenth of the PBHS performance.





The MBHS network data indicates that PRP is an essential tool to help high-risk individuals with serious mental health conditions access appropriate care. When BHA's policies restrict access to PRP as a whole, rather than targeting problem providers, Maryland increases strain on its hospitals.

[2] Compare SAMHSA, "Maryland 2019 Mental Health National Outcome Measures (NOMS)" at page 17 (Appropriateness Domain: Length of Stay in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers) with "Maryland 2021 Mental Health National Outcome Measures (NOMS)" at page 13 (Appropriateness Domain: Length of Stay in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers).

Changes Requested To Address PRP Concerns

For these reasons, we renew our standing requests that BHA develop strategies to address substandard PRP performance, rather than approaches that penalize all PRP providers. We have previously recommended that BHA develop a policy manual that clearly describes standards in one place, develop a compliance strategy that targets increased audit and authorization policies for the providers whose performance warrants additional oversight, and take other policy steps that promote quality performance and effective compliance. None of these recommendations has been acted on to date.

Thus, we are concerned that enactment of the auth form changes will reduce access to PRP services across all providers based on administrative burdens, reducing access to care for the children and adults who may benefit from the service, rather than focusing attention on substandard care.

Feedback on PRP Auth Form Changes

The auth changes published on May 11 contained material changes from the draft shared in January. We request two modifications and two deletions to the newly-released changes in the PRP auth form.

We ask BHA to delete the requirement of including an NPI for the referring clinician or agency. At a time when clinical coordination has already proven more challenging, increasing the data required from referral sources simply raises the likelihood that clients will be denied care due to the absence of data fields, not the absence of need. Optum can already cross-reference the referring clinician's name with ePrep for compliance purposes. We recommend deleting the NPI requirement from the auth form.

We also ask BHA to make changes to ensure that the auth form language conforms the expressed policy. Language in the proposed authorization form is more limited than the policy states. The accompanying policy states that certain services should be "attempted **or considered**" (emphasis added) before PRP, but the auth form requires that the services "have been tried." This limitation is at odds with the PRP medical necessity criteria and stated policy. We ask that the auth form mimic the policy language by asking whether services were "attempted or considered."

In addition, we ask that providers have the option of uploading a medication list rather than manually inputting a list of medications.

Of particular concern is the new requirement that requires a separate clinical justification for a client to receive PRP in conjunction with Supported Employment (SE) services. These two services are complimentary but have very different goals. In Optum's medical necessity criteria, diagnoses

and functional impairments that qualify an individual for PRP fully overlap with the diagnoses and impairments that qualify for SE. As a result, providers have no idea what additional clinical justification is needed to secure PRP. In fact, PRP is a required component to an evidence-based Supported Employment program, so providers are in the dark about what justification is required under this policy change. It would be helpful to have clinical justifications clearly spelled out by updating the medical necessity criteria, not the authorization forms. Having clearly articulated standards will also improve BHA's ability to audit noncompliant programs. In the absence of an update to MNC to delineate the clinical justification between the services, we urge the Department to drop this update from the PRP auth form changes.

Finally, we note that Optum's authorization denials do not concretely identify the primary reason that an authorization request was denied. The absence of clear feedback prevents BHA from effective oversight, and decreases providers' ability to be educated and improve their practice. We have strong concerns that clients have and will be denied access to PRP simply because the client has chosen not to take medication. For these reasons, we urge BHA to consider process changes to the PRP authorization denials checklists in order to promote transparency and accountability of all parties.

Sincerely,

Shannon Hall
Executive Director

cc: Spencer Gear, Behavioral Health Administration