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Testimony Before the District of Columbia Council
Committee on Health
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Public Hearing:
B25-0124 - Prior Authorization Reform Amendment Act of 2023

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Good morning, Chairperson Henderson, and members of the Committee on Health. My name is Amber Rieke. I am the Project Lead for *A Path Forward* at Children's Law Center.[1] Children's Law Center believes every child should grow up with a strong foundation of family, health, and education and live in a world free from poverty, trauma, racism, and other forms of oppression. Our more than 100 staff – together with DC children and families, community partners, and pro bono attorneys – use the law to solve children's urgent problems today and improve the systems that will affect their lives tomorrow. Since our founding in 1996, we have reached more than 50,000 children and families directly and multiplied our impact by advocating for city-wide solutions that benefit hundreds of thousands more.

Thank you for the opportunity to testify today in support of B25-0124: Prior Authorization Reform Amendment Act of 2023. Last year, Children's Law Center co-authored a comprehensive report outlining a blueprint for transforming DC's behavioral health system for children and families based on evidence and consultation with stakeholders and community partners from across the city.[2] This report, *A Path Forward – Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, identifies 94 recommendations to better meet the behavioral health needs of DC children and families. Specifically, Path Forward includes recommendations to:

- Require MCOs to use standardized and simplified authorization, billing, and credentialing processes and protocols.
- Ensure proper clinical expertise in medical necessity determinations, which align with publicly available, evidence-based standards, independent from business considerations and consistent with generally accepted standards of care.

Our vision of the *Path Forward* project is the achievement of a working system that not only meets the service demand, but embodies the values of family-centered care, cultural humility, racial equity, and trauma-informed care.

We believe the *Prior Authorization Reform Amendment Act of 2023* will move us closer to realizing this vision by breaking down barriers to care for residents and easing burdens on our stressed healthcare provider network. We therefore support the proposed legislation and urge the Committee move this bill forward expeditiously. We also recommend two clarifications in the text to improve the equity impact of the bill:

- The proposed bill should explicitly include MCOs as utilization review entities to ensure provisions apply to Medicaid beneficiaries, as well as people with commercial insurance.
- The proposed bill should uphold parity between behavioral health and other health services.

Settling these questions in the text will make the bill more inclusive, so that any patient seeking healthcare in DC can enjoy the benefits created in the future law.

The Proposed Bill Will Reduce Barriers to Accessing Timely and Appropriate Healthcare for Patients

At Children's Law Center, the children we work with often have significant behavioral health needs. Unfortunately, many are not receiving the services our system should be able to provide them. Our clients consistently report being unable to find providers offering the services they need – or if they manage to find a provider, the wait for an appointment is prohibitively long. The *Path Forward* report summarizes many administrative and financing obstacles erected between residents and behavioral health care. These hurdles, like prior authorizations for certain treatments, increase the burden on patients and their healthcare provider to fight for medically indicated care, for the financial benefit the insurance company. In this case, determinations are often made by non-experts solely based on cost and issued in an opaque manner that discourage a patient or caregiver from advocating for themselves or their loved one.

The proposed bill sets more appropriate standards for a "utilization review entity" (*i.e.*, an insurance provider) to use the prior authorization hurdle, including clarity about policies and appeals, the qualifications for personnel authorized to make "adverse determinations" (i.e., denials of coverage for certain services) and oversee appeals, among other provisions.[3] Most centrally, the legislation requires that prior authorizations are required only based on a "determination of medical necessity," prohibiting insurance providers from requiring prior authorization for a treatment "solely based on cost."[4]

This bill would bring the District into alignment with most other states.[5] and improve access to health care by ensuring that prior authorizations are not mandated solely because of the cost of a treatment, and that determinations are: a) made by a qualified professional, b) with adequate communication, d) in a timely manner, and e) effective for a sufficient length of time.

a) The bill states that insurers "must ensure that all adverse determinations are made by a physician who: (1) Possesses a current and valid non-restricted license to practice medicine in the District of Columbia; (2) Is of the same specialty as a physician who typically manages the medical condition or disease or provides the health care service involved in the request; (3) Makes the adverse determination under the clinical direction of one of the utilization review entity's medical directors who is responsible for the provision of health care services provided to enrollees in the District of Columbia, and who is licensed in the District of Columbia."[6] Our Path Forward report recommends that the credential of any clinician denying care should be at least equal to the credential of the recommending clinician and based on relevant clinical experience.[7] (This is specifically recommended for MCO contracts in the public behavioral health system, which will be discussed later in this testimony.)

b) As one of several measures to improve communication about prior authorizations, the bill requires that "Prior to issuing an adverse determination, the enrollee's health care provider must have the opportunity to discuss the medical necessity of the health care service on the telephone with the physician who will be responsible for determining authorization of the health care service under review."[8]

c) In an effort not to bog down the course of treatment with administrative delays, the bill specifies that insurers must grant or deny the prior authorization, and notify the enrollee and provider, "within 3 business days of obtaining all information required; if the determination is not made within that time frame, such services shall be deemed approved."[9]

d) The bill also stipulates that "a prior authorization for shall be valid for at least one year from the date the health care provider receives the prior authorization."[10] This provision recognizes the long waits patients may have to find and schedule with specialty providers.

The Proposed Bill Will Ease Burdens on Healthcare Providers by Standardizing and Remodeling Authorization Protocols

Behavioral health providers report using an excessive amount of administrative time addressing prior authorizations and appealing denials in care, including by public insurers. In 2019 - the most recent data available when we wrote *A Path Forward* - the overall claims denial rate for District MCOs was 8.3%. Navigating complex, onerous,

inconsistent – even nonsensical – processes can result in increased costs, interrupted care, less time to serve patients, and providers opting not to accept public health insurance and thereby reduce accessibility to care.[11] To significantly minimize these challenges, providers prefer the process of submitting and reviewing authorizations to companies through an online portal or other electronic mechanism. This kind of process is not currently reflected in the bill.

As noted above, it is also important that individuals with the proper clinical, developmental, and treatment expertise are involved in the decision-making regarding medical necessity determinations, prior authorization decisions, denials, grievances, and appeals, especially regarding care for children. Additionally, medical necessity determinations must align with publicly available, evidence-based standards, independent from business considerations and consistent with generally accepted standards of care.[12]

We recommend that the timelines for issuing determinations based on "all information required" may be amended to include language related to the use of standardized, evidence-based tools as the framework for determinations. Specifically, to avoid companies creating delay tactics through paperwork or unnecessary information requests, the "information required" should be tied to pre-defined standards, based on the nature of the prior authorization request. Further, as a matter of health equity, the

provisions for the bill should apply to commercial insurers, as well as public insurers in DC.

The Proposed Bill Should Explicitly Include MCOs as Utilization Review Entities to Ensure Provisions Apply to Medicaid Beneficiaries

At Children's Law Center, nearly all of our clients are Medicaid beneficiaries. Further, the *Path Forward* project seeks to guarantee an adequate network of child-serving behavioral health providers to deliver appropriate services to Medicaid beneficiaries, including multilingual providers, through reasonable licensing and administrative processes, and adequate reimbursement rates.

Therefore, it is important for us to clarify whether the legislation's definition of "Utilization review entity" includes Medicaid Managed Care Organizations (MCOs) contracted by the DC Department of Health Care Finance. The bill states:

> "Utilization review entity" means an individual or entity that performs prior authorization for one or more of the following entities:
>
> (i) An employer with employees in the District;
> (ii) An insurer that writes health insurance policies;
> (iii) A preferred provider organization, or health maintenance organization; and
> (iv) Any other individual or entity that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to a person treated by a health care provider in the District under a policy, plan, or contract.

While it seems like this language encompasses all entities offering health benefits, Medicaid plans are often held apart from commercial plans in regulation. If this is the

legislative intent, the bill should be explicit. Further, we recommend clarifying how the law would apply to MCOs, and/or the Medicaid program broadly (which may include, for example, Fee-for-Service plans, or third-party contractors used to make determinations for services like long-term care.) We advocate that any patient seeking healthcare in DC should enjoy the benefits and rights created in the law, including those attaining that care through a Medicaid program.

The Proposed Bill Should Uphold Parity Between Behavioral Health and Other Health Services

Our final concern about the bill relates to whether the provisions will ease barriers to behavioral health care treatment, prescriptions, and services as with other medical care. We are glad the bill specifies that insurers may not require prior authorization "for the provision of medication-assisted treatment for the treatment of opioid-use disorder."[13] The bill does not call-out or otherwise distinguish other service types. We assume behavioral health care is included in the benefits of the proposed reforms for two reasons. First, providers encounter the same obstacles for behavioral health prescriptions, therapies, or treatment that the legislation seeks to remedy. Second, federal law requires some measures of parity in group health plans, including public plans.

The Federal *Mental Health Parity and Addiction Equity Act of 2008* does not require group health plans to *provide* mental/behavioral health or substance use disorder ("MH/SUD") benefits. However, if they do, any limitations applied MH/SUD benefits

cannot be more restrictive than those that apply to other medical/surgical benefits.[14] Though Medicaid coverage is not defined as a "group health plan" in the law, a 2016 rule specifies that MCOs cannot apply stricter "Nonquantitative Treatment Limitations" like prior authorization requirements to MH/SUD benefits than other medical/surgical benefits.[15] Therefore, we recommend that the legislation explicitly state that "Health Care Services" also encompass any mental/behavioral health care services.

Conclusion

Access to behavioral healthcare is essential to the well-being of District residents, especially our children. Reasonable administrative expectations are also essential for a sustainable provider network. It is important that the District continue to remove hurdles to accessing or providing care, especially when the hurdles they only serve to enrich insurance companies. We hope that the specific suggestions we have offered will ensure this bill includes Medicaid enrollees as those with commercial insurance, and behavioral health benefits in parity with other healthcare.

We thank Councilmember Pinto and her colleagues for introducing this legislation and to the Committee on Health for holding the hearing. Thank you for the opportunity to testify today. I welcome any questions from the Committee.

[1] *A Path Forward — Transforming the Public Behavioral Health System for Children, Youth, and their Families in the District of Columbia*, December 2021, *available at*: https://childrenslawcenter.org/wp-content/uploads/2021/12/BHSystemTransformation_Final_121321.pdf.
[2] *Id.*
[3] B25-0124: Prior Authorization Reform Amendment Act of 2023, legislative text, page 1. https://lims.dccouncil.gov/Legislation/B25-0124
[4] Id.
[5] Letter of Introduction for B25-0124, Councilmember Brooke Pinto, https://lims.dccouncil.gov/Legislation/B25-0124
[6] B25-0124: Prior Authorization Reform Amendment Act of 2023, legislative text, page 7. https://lims.dccouncil.gov/Legislation/B25-0124
[7] Path Forward, page 65
[8] *Id.*
[9] B25-0124: Prior Authorization Reform Amendment Act of 2023, legislative text, page 9. https://lims.dccouncil.gov/Legislation/B25-0124
[10] B25-0124: Prior Authorization Reform Amendment Act of 2023, legislative text, page 6. https://lims.dccouncil.gov/Legislation/B25-0124
[11] Path Forward, page 57
[12] Path Forward, page 65
[13] B25-0124: Prior Authorization Reform Amendment Act of 2023, legislative text, page 10-11. https://lims.dccouncil.gov/Legislation/B25-0124
[14] CMS: The Mental Health Parity and Addiction Equity Act (MHPAEA) https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet
[15] Federal Register, Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans, Centers for Medicare & Medicaid Services on 03/30/2016 https://www.federalregister.gov/documents/2016/03/30/2016-06876/medicaid-and-childrens-health-insurance-programs-mental-health-parity-and-addiction-equity-act-of