

HB0015: Pediatric Autoimmune Neuropsychiatric Coverage

For the purpose of requiring the Maryland Medical Assistance Program to provide services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome under certain circumstances; requiring insurers, nonprofit health service plans, and health maintenance organizations that provide certain health insurance benefits under certain insurance policies or contracts to provide coverage for certain diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome; providing that the required coverage may be subject to certain deductibles, copayments, and coinsurance. There is extensive research documenting the emergence of tics and obsessive-compulsive symptoms in some children who have been exposed to streptococcal infections. These are known as PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infection). For children suffering from PANDAS, the first-line treatment of PANDAS is with antibiotics. However, for subset of these children who develop severe symptoms, intravenous immunoglobulin (IVIG) has shown to be an effective treatment. We therefore support insurance coverage in order to ensure that children in need will have access to this treatment.

HB0077/SB0399: Decriminalization Attempted Suicide

Providing that attempted suicide is not a crime in the State; prohibiting that the act of attempting to commit suicide may not form the basis of a certain criminal charge; and providing that the common law offense of attempted suicide is abrogated and repealed. MPS supports House Bill 77 (HB 77). The criminalization of an individual for attempting suicide is not an appropriate response to this tragic behavior. Psychiatrists routinely see patients who have contemplated and/or even attempted suicide. MPS as a group believes that preserving the crime of attempted suicide has not and will not prevent suicide or suicide attempts. In addition, MPS believes that convicting a person of the crime of attempted suicide could further destabilize that person's life and mental health as such a conviction will not only further stigmatize the person's actions but also make it harder for him/her to find gainful employment, safe and affordable housing, or even to seek meaningful mental health services.

HB0148/SB0165: Safe Schools Maryland Act of 2019

Establishing the Safe Schools Maryland Program in the Maryland Center for School Safety; requiring the School Safety Subcabinet to develop program guidance on or before September 1, 2019; requiring a local school system that elects to participate in the program to follow the program guidance; requiring the Center to perform certain tasks related to the program; providing that certain documents and information submitted to the Center are not subject to the Maryland Public Information Act. Governor Hogan supported establishment of the Safe Schools tip line, where one can report an anonymous tip re mental health crises, bullying, school and community violence, drug activity, abuse and harassment. Maryland Center for School Safety will focus on emergency management, bullying, substance abuse and mental health and generally take a preventive "all-hazard" approach. Under this bill, local school systems can elect to participate in the program to coordinate with Maryland Safe Schools. The Center will train schools, law enforcement etc. Information regarding concerns may flow either direction between schools and Maryland Center for School Safety. There are provisions allowing release of the information only under specific circumstances.

HB0599/ SB0631: Required Compliance Reports

Requiring certain carriers on or before July 1 each year to submit a report to the Maryland

Insurance Commissioner to demonstrate the carrier's compliance with the federal Mental Health Parity and Addiction Equity Act; requiring a carrier on or before July 1 each year to submit a report to the Commissioner on data for certain benefits by certain classification; requiring the reports to include certain information and be submitted in a certain manner. MPS supports enforcement of the Mental Health Parity and Addiction Equity Act to increase access to mental health and addiction treatment services. In order to do this, there must be ongoing monitoring and comparison of how both medical and behavioral health services are managed and restricted in order to ensure that people with mental illness do not have worse access to care. HB 599 is an avenue to codifying such monitoring and comparison. HB 599 requires carriers to submit annual parity compliance reports for each of their plans, reports that are modeled after the U.S. Department of Labor's Self-compliance Tool and make these reports available for public review. We all know that the sunlight from public scrutiny improves corporate behaviors and transparency. In addition, HB 599 will enable Maryland Insurance Administration and all stakeholders to better hold plans accountable to how they treat vulnerable people with mental health and substance use disorders. Finally, HB 599 rightfully requires carriers to use national standards for addiction treatment and that they educate their members about their parity rights.

HB0605/SB0524: Telemedicine Psychiatric Nurse Practitioners

Requiring the Maryland Department of Health, under certain circumstances, to include psychiatric nurse practitioners who are providing Assertive Community Treatment or mobile treatment services to certain Maryland Medical Assistance Program recipients in the types of providers eligible to receive reimbursement for health care services that are delivered through telemedicine and provided to Program recipients. The Maryland Psychiatric Society supports efforts to improve access to mental health care through telemedicine, for mental health providers who have medical training and psychiatric expertise.

HB0751: Prior Authorization - Requirements

Requiring certain insurers, nonprofit health service plans, and health maintenance organizations to accept a prior authorization from a certain entity for any prescription drugs, devices, or health care services for the lesser of the course of treatment or 90 days; requiring a certain entity, under certain circumstances, to provide documentation of the prior authorization within 10 days after a request by an insured or an insured's designee; etc. Prior authorization for medications interferes with the care of psychiatric patients in many ways. It delays the time when patients can receive their needed medications while awaiting "approval" from their insurance companies. It forces patients to try ineffective medications as a requirement of "step therapy" before they can get medication their physician feels is indicated for their condition. It denies patients receiving appropriate medication AT ALL if this medication is not on the insurer's formulary. It forces patients and doctors to submit to prior authorization requirements, including formulary restrictions and step therapy simply because the patient's employer has changed health plans or the patient has changed employers, even when the patient had been stable and doing well on an existing medication. It forces physicians and patients to apply for reauthorization of medication again and again when the patient has a chronic or lifelong condition that is well controlled by a medication or treatment.

This bill if enacted would address some but not all the problems patients and physicians face when dealing with prior authorization requirements by insurance companies and pharmacy benefit managers. When a patient changed insurers, it would require the prior insurer to provide information about the authorization to the new insurer and require the new insurer to accept this determination for at least 90 days. It would require 60 days' notice if an insurer changes

their utilization management restrictions that would deny the patient the treatment they are receiving. It would prohibit an insurer from requiring prior authorization for urgent care situations. It would prohibit insurers from requiring repeat prior authorizations for patients with chronic conditions that are stable and well on existing medications.

Our primary concern is with Section (E) number (2) of this bill.

This states that if a denial was based on the need for prior authorization, the entity will provide a list of the covered alternatives that are IN THE SAME CLASS OR FAMILY as the recommended treatment. We believe this needs to be changed to more precisely defined for this section of the law to be effective. Let us give one example of this. There is a class of drugs called "antipsychotic"; these are drugs that are used to treat schizophrenia and other psychotic disorders and acute mania. They are a class in that they (with rare exceptions) are antagonist at the dopamine d2 receptor. There is a subclass of these drugs that are d2 receptor antagonists but also exert action at a variety of other receptors including other dopamine receptors, several serotonergic receptors, histaminic receptors, cholinergic receptors, and others. There is also a recognized "class" of antipsychotics that, instead of being full antagonists at dopamine d2 receptors, are partial agonists at these receptors.

Each one of these drugs has different pharmacologic properties, has different side effect profiles, has indications for different psychiatric disorders based upon psychiatric literature and clinical trials, and approvals by the FDA for different psychiatric conditions. There are numerous algorithms published by different professional bodies that have different recommendations regarding appropriate therapy for psychiatric conditions. Even when a drug is FDA approved for a certain condition and there is ample evidence of its effectiveness, it may be effective in a minority of patients who receive the treatment. Thus, allowing insurance companies to allow substitution of drugs in the same "class" or "family" without more precise definition may allow them to substitute drugs that are ineffective or inappropriate for the patient's condition. Our members have had patients with Bipolar Disorder suffering from Depression for whom we have prescribed Lurasidone, which is FDA approved for the treatment of Depression in patients with Bipolar Disorder. We have been told they must try at least two alternative antipsychotics before approval would be granted for Lurasidone. One of the alternatives suggested was aripiprazole, an antipsychotic that is NOT approved for the treatment of bipolar depression, and for which double blind studies fail to show its effectiveness for this condition. Another medication suggested was clozapine. This is a drug that is generally used for treatment resistant schizophrenia. Because of its risk of blood dyscrasia it requires weekly blood testing for a patient to receive this drug. Both drugs are in the same "class" or "family", yet they are not indicated or appropriate for a patient with bipolar disorder suffering from depression.

[HB0837/ SB0761: Payments to Noncontracting Specialists](#)

Requiring a carrier to inform members and beneficiaries of the procedure to request a certain referral to certain noncontracting health care providers; requiring, under certain circumstances, certain insurers, nonprofit health service plans, and health maintenance organizations to pay a certain amount for certain services provided to a member by certain noncontracting healthcare providers when a referral is granted to the member. MPS strongly supports House Bill 837 (HB 837). Over the interim, MPS worked with the members of Parity Coalition who are the main proponents of this legislation to find an amicable middle ground on this issue. Looking specifically at page 6, lines 19 through 25 for mental health and substance use disorder services HB 837 wisely avoids the imposition of a mandate to accept an assignment of benefits at a

specified rate on specialists in this area. Instead, HB 837 sets up a dynamic that will increase the incentive for behavioral health specialists and payers to work out mutually agreeable contract terms, which the payers otherwise have no incentive to fix. In addition, MPS believes that HB 837 will provide patients with higher reimbursement amounts if the specialist does not accept assignment of benefits and balance bills, meaning that patients will now be better able to afford their behavioral health services

HB0941: Public Behavioral Health System - Workgroup

Requiring the Secretary of Health to convene a stakeholder workgroup to develop certain implementation plans to improve efficiency, accountability, and outcomes of certain specialty behavioral health services; requiring the workgroup to include certain representatives; requiring that certain implementation plans include certain recommendations for a certain timeline and certain necessary steps to achieve certain outcomes; requiring the Secretary of Health to submit certain reports on or before certain dates. The Maryland Psychiatric Society supports efforts to address gaps in our mental health and substance use disorder treatment system.

HB1007/SB0739: Child Advocacy Centers - Expansion

Requiring the Governor's Office of Crime Control and Prevention to ensure, to the greatest extent practicable, that every child in the State has access to a child advocacy center; requiring and authorizing child advocacy centers to assist in the response to or investigation of certain offenses against children; requiring the Governor's Office of Crime Control and Prevention to contract with an organization that meets certain requirements to establish a Maryland Statewide Organization for Child Advocacy Centers. The Maryland Psychiatric Society supports expansion of child advocacy centers in order to provide sensitive and developmentally appropriate interviews of child victims, and to provide mental health services to them.

HB1200: Telepsychiatry - Requirements

Altering certain coverage and reimbursement requirements for psychiatric health care services delivered through telemedicine under the Maryland Medical Assistance Program; requiring the Maryland Department of Health to provide coverage of and reimbursement for certain psychiatric health care services that are delivered through telepsychiatry; deeming a psychiatric health care service provided through telepsychiatry to be equivalent to a certain psychiatric health care service for a certain purpose.

SB0028: Behavioral Health Disorders - Short-Term Insurance

For the purpose of altering the definition of "health benefit plan" as it applies to certain provisions of law related to coverage requirements for the diagnosis and treatment of mental illness and emotional, drug use, and alcohol use disorders to include short-term limited duration health insurance. MPS supports Senate Bill 28 (SB 28), which requires short-term limited duration insurance plans to cover mental health and substance use disorder benefits. Under Maryland's Insurance Article, short-term limited duration insurance is explicitly excluded from the definition of "individual health benefit plan" as defined in §15-310. Furthermore, the section of the Insurance Article that governs mental health and substance use disorder coverage, namely §15-802, specifically cites section §15-310 when defining individual health benefit plans, which means that short-term limited duration insurance plans are currently exempted from covering mental health and substance use disorder benefits. In addition, even in the unlikely event that short-term limited duration insurance plans did cover some level of mental health and substance use disorder benefits, it is likely that the benefits would be grossly

inadequate, as these plans are not subject to the Mental Health Parity and Addiction Equity Act (MHPAEA) under federal law. SB 28 addresses both shortcomings by adding short-term limited duration insurance into Section §15-802 of the Insurance Code. Not only does this mean that these plans must cover a robust set of mental health and substance use disorder benefits but it also means that they must meet the requirements of MHPAEA, which is required of all plans subject to §15-802. MPS was pleased when the General Assembly passed House Bill 1782 (HB 1785) last session, which, among other things, specified that short-term limited duration insurance plans could cover no more than a three-month time period and could not be renewed. HB 1782 protected Maryland consumers from the dangerous new specifications for short-term limited duration insurance plans promulgated by the Trump Administration., which allows these plans to span 364 days and permits extensions of up to 36 months. The General Assembly took an important step last session by limiting the likelihood that junk health insurance plans would be purchased by consumers confusing them for legitimate policies with a full array of benefits. Now, the General Assembly must take the next step as presented in SB 28 to ensure that even if consumers do purchase short-term limited duration insurance plans, those plans will have the same level of mental health and substance use disorder benefits as any other plan sold in the state.

SB0506: Needs Assessment Studies

Requiring the Maryland Department of Health to conduct a certain study to determine the existing capacity and estimated unmet needs for mental health and substance use disorder services by region of the State; requiring that the study include a review of certain issues related to certain services; authorizing the Department to contract with an entity to conduct a certain study; requiring the Governor to include \$5,000,000 in the State budget in fiscal year 2021 for the study. MPS supports Senate Bill 506 (SB 506): Maryland Department of Health - Mental Health and Substance Use Disorder Services - Needs Assessment Study. Access to care for both mental health and substance use disorder services remains a critical concern in Maryland. MPS supports efforts to determine the extent and severity of this shortage. Both behavioral health and substance use treatment are needed to address the lingering problem with opioid deaths and the unnecessary institutionalization of people with mental illness.

SB0528/HB1170: Behavioral Health Services Matching Grants

Establishing the Behavioral Health Services Matching Grant Program for Service Members and Veterans; providing for the purpose of the Program; requiring the Maryland Department of Health to administer the Program; requiring the Program to award certain grants to nonprofit organizations to establish and expand certain community behavioral health programs; establishing a certain eligibility requirement; requiring an eligible nonprofit organization to secure certain contributions for the proposal. The Maryland Psychiatric Society supports efforts to provide competitive grants to community behavioral health nonprofits in order to improve access to psychiatric services to veterans and their families

SB0178/HB570: Behavioral Health - Medical Directors - Telehealth

This bill requires that regulations adopted under certain provisions of law regulating behavioral health programs include provisions authorizing a medical director of a behavioral health program located in a federally designated health professional shortage area to provide services through telehealth; and prohibiting a behavioral health program located in a federally designated health professional shortage area from requiring a medical director to provide services on-site. Maryland continues to suffer from a shortage of physicians, particularly on the

Eastern Shore and in Western Maryland. Maryland's physician shortage is particularly acute for psychiatrists. As a result, MPS supports any effort to increase access to meaningful mental health care. MPS believes, therefore, a bill such as SB 211 supporting the use of telehealth and removing restrictions upon the physical location of the physician, will achieve this goal. In addition, telehealth can further benefit the community and increase mental health access when used to provide consultation with medical specialists who are not usually available within institutions such as small jails and prisons located far from urban areas.