By: \_\_\_\_\_\_\_\_\_

Introduced and read first time: \_\_\_\_\_\_\_\_\_\_

Assigned to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AN ACT concerning

Health Insurance – Psychiatric Collaborative Care Model service delivery method

FOR the purpose of carriers to reimburse for benefits covering mental illnesses, emotional disorders, drug misuse, and alcohol misuse provided through the psychiatric Collaborative Care Model service delivery method.

BY repealing and reenacting with amendments

Article – Insurance

Section – 15-802

Annotated Code of Maryland

(2011 Replacement Volume and 2018 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND,

That the laws of Maryland read as follows:

**Article — Insurance**

15-802

(a)    (1)   In this section the following words have the meanings indicated.

(2)   “Alcohol misuse” has the meaning stated in § 8–101 of the Health – General Article.

(3)   “Drug misuse” has the meaning stated in § 8–101 of the Health – General Article.

(4)   “Grandfathered health plan coverage” has the meaning stated in 45 C.F.R. § 147.140.

(5)   “Health benefit plan”:

(i)   for a group or blanket plan, has the meaning stated in § 15–1401 of this title; and

(ii)   for an individual plan, has the meaning stated in § 15–1301 of this title.

(6)   “Managed care system” means a system of cost containment methods that a carrier uses to review and preauthorize a treatment plan developed by a health care provider for a covered individual in order to control utilization, quality, and claims.

(7)  “Partial hospitalization” means the provision of medically directed intensive or intermediate short–term treatment:

(i)   to an insured, subscriber, or member;

(ii)   in a licensed or certified facility or program;

(iii)   for mental illness, emotional disorders, drug misuse, or alcohol misuse; and

(iv)   for a period of less than 24 hours but more than 4 hours in a day.

**(8) “THE PSYCHIATRIC COLLABORATIVE CARE MODEL” MEANS THE EVIDENCE-BASED, INTEGRATED BEHAVIORAL HEALTH SERVICE DELIVERY METHOD DESCRIBED AT 81 FR 80230.**

**[**(8)**] (9)**   “Small employer” has the meaning stated in § 31–101 of this article.

(b)   With the exception of small employer grandfathered health plan coverage, this section applies to each individual, group, and blanket health benefit plan that is delivered or issued for delivery in the State by an insurer, a nonprofit health service plan, or a health maintenance organization.

(c)   A health benefit plan subject to this section shall provide at least the following benefits for the diagnosis and treatment of a mental illness, emotional disorder, drug use disorder, or alcohol use disorder:

(1)   inpatient benefits for services provided in a licensed or certified facility, including hospital inpatient and residential treatment center benefits;

(2)   partial hospitalization benefits; and

(3)   outpatient and intensive outpatient benefits, including all office visits, diagnostic evaluation, opioid treatment services, medication evaluation and management, and psychological and neuropsychological testing for diagnostic purposes.

(d)    (1)   The benefits under this section are required only for expenses arising from the treatment of mental illnesses, emotional disorders, drug misuse, or alcohol misuse if, in the professional judgment of health care providers:

(i)   the mental illness, emotional disorder, drug misuse, or alcohol misuse is treatable; and

(ii)   the treatment is medically necessary.

(2)   The benefits required under this section:

(i)   shall be provided as one set of benefits covering mental illnesses, emotional disorders, drug misuse, and alcohol misuse;

(ii)   shall comply with 45 C.F.R. § 146.136(a) through (d) and 29 C.F.R. § 2590.712(a) through (d);

(iii)   subject to paragraph (3) of this subsection, may be delivered under a managed care system; and

(iv)   for partial hospitalization under subsection (c)(2) of this section, may not be less than 60 days.

(3)   The benefits required under this section may be delivered under a managed care system only if the benefits for physical illnesses covered under the health benefit plan are delivered under a managed care system.

(4)   The processes, strategies, evidentiary standards, or other factors used to manage the benefits required under this section must be comparable as written and in operation to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to manage the benefits for physical illnesses covered under the health benefit plan.

(5)   An insurer, nonprofit health service plan, or health maintenance organization may not charge a copayment for methadone maintenance treatment that is greater than 50% of the daily cost for methadone maintenance treatment.

(e)   An entity that issues or delivers a health benefit plan subject to this section shall provide on its Web site and annually in print to its insureds or members:

(1)   notice about the benefits required under this section and the federal Mental Health Parity and Addiction Equity Act; and

(2)   notice that the insured or member may contact the Administration for further information about the benefits.

(f)   An entity that issues or delivers a health benefit plan subject to this section shall:

(1)   post a release of information authorization form on its Web site; and

(2)   provide a release of information authorization form by standard mail within 10 business days after a request for the form is received.

**(G) ANY ENTITY THAT ISSUES OR DELIVERS A HEALTH BENEFIT PLAN SUBJECT TO THIS SECTION SHALL PROVIDE REIMBURSEMENT FOR MENTAL ILLNESSES, EMOTIONAL DISORDERS, DRUG MISUSE, AND ALCOHOL MISUSE BENEFITS THAT ARE DELIVERED THROUGH THE PSYCHIATRIC COLLABORATIVE CARE MODEL, WHICH SHALL INCLUDE THE FOLLOWING CURRENT PROCEDURAL TERMINOLOGY (CPT) BILLING CODES ESTABLISHED BY THE AMERICAN MEDICAL ASSOCIATION (AMA):**

**(1) 99492;**

**(2) 99493;**

**(3) 99494; AND**

**(4) THE INSURANCE ADMINISTRATOR SHALL UPDATE THIS LIST OF CODES IF THERE ARE ANY ALTERATIONS OR ADDITIONS TO THE BILLING CODES FOR THE COLLABORATIVE CARE MODEL.**

**(H) ANY ENTITY THAT ISSUES OR DELIVERS A HEALTH BENEFIT PLAN SUBJECT TO THIS SECTION MAY DENY REIMBURSEMENT OF ANY CPT CODE LISTED IN THIS SECTION ON THE GROUNDS OF MEDICAL NECESSITY, PROVIDED THAT SUCH MEDICAL NECESSITY DETERMINATIONS ARE IN COMPLIANCE WITH THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 AND ITS IMPLEMENTING AND RELATED REGULATIONS, AND THAT SUCH DETERMINATIONS ARE MADE IN ACCORDANCE WITH THE UTILIZATION REVIEW AND RELATED REQUIREMENTS FOUND IN SUBTITLES 10A, 10B, 10C, AND 10D OF THIS TITLE.**

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2019.