Texas Association of Health Plans
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February 8, 2022

Dear Commissioner Young,

We are writing to share our concerns regarding HHSC's new interpretation of the federal regulations at 42 CFR Sections 438.210 and 457.1230(d), which require that services covered under managed care contracts must be furnished in an "amount, duration, and scope" that is no less than the amount, duration, and scope for the same services furnished in the state fee-for-service (FFS) plan. HHSC has issued the following directive:

> While MCOs may place appropriate limits on drugs, MCOs *may not use a standard for determining medical necessity that is more restrictive than what is used in the state plan*, i.e., developed by the Vendor Drug Program. For example, if a member is denied a clinician administered drug in managed care because of the MCO's prior authorization criteria, but would have received the drug under the criteria specified in the state plan, then the MCO's prior authorization criteria would violate the amount, duration, and scope requirements cited above. HHSC intends to amend the Managed Care Contracts at the next opportunity to include this requirement. *However, since this is a federal regulation, MCOs must comply now.* This same standard applies to CHIP formulary and CAD coverage.

This new requirement is a significant departure from HHSC's historical interpretation and regulation of MCOs under this federal regulation, and it would set an alarming precedent across the Medicaid program. This interpretation reflects a misunderstanding of the federal regulation. Requiring MCOs to mirror FFS prior authorization requirements and criteria does not align with CMS' interpretation of its regulations and fundamentally contradicts the concept and purpose of managed care. A key principle of managed care is MCOs using their expertise and experience to apply PA requirements for certain services and develop the specific clinical standards and criteria that best meet the needs of their Medicaid members.

CMS does not consider applying prior authorizations to be a limitation on the amount, duration, and scope of a service. A related regulation, 42 CFR §440.230, Sufficiency of Amount, Duration, and Scope, provides, "(a) The plan must specify the amount, duration, and scope for each service" and "(b) Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose." Most importantly, subsection (d) states, ***"The agency may place appropriate limits on a service based on such criteria as medical necessity or on***

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utilization control procedures." By requiring a sufficient amount, duration, and scope of a service, but allowing limits based on medical necessity criteria, CMS has made it abundantly clear that the agency does not consider the application of medical necessity requirements to be a limitation on the amount, duration, and scope of a service.

CMS also made its intent clear in its responses to comments on the 2016 Final Rule amending the federal regulation at issue, regarding service authorizations and appeals. CMS responded to a commenter that "§ 438.210(a)(2) provides that services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid. We believe this is an appropriate limitation, but are clarifying that any limits must be consistent with the approved state plan and § 440.230 ***and decline to completely remove the managed care plans' ability to define the amount, duration, and scope of covered services."***

Further, in response to a comment recommending that CMS set national utilization management standards and authorization criteria for Medicaid managed care plans in the regulation, CMS responded: ***"We do not believe it appropriate for us to set the utilization management standards and/or authorization criteria for managed care plans.*** The provisions in § 438.210(a) and (b) do provide a sufficient level of detail and will provide adequate consistency across states. ***We believe states and managed care plans have the expertise and experience to develop the specific standards and criteria that best meet the needs of their program."***

Other states also do not interpret the federal regulations as requiring the standardization of PAs and medical necessity criteria. In fact, 48 states, including Texas, allow managed care plans to develop their own criteria. Nevertheless, in its 1115 Waiver Application from July 2021, HHSC specifically affirmed that MCO enrollees "are provided benefits in the same amount, duration, and scope as in the Medicaid state plan." According to a NASHP policy brief on state strategies, only two states have actively adopted a policy to standardize medical necessity clinical criteria/guidelines for EPSDT services, and this was a deliberative state policy choice rather than a state Medicaid agency's interpretation of the federal requirements.

The courts have also provided no justification for this change. In *Coleman et. al. v. Wilson*, plaintiffs filed suit based on HHSC's use of fibrosis score as a criterion for access to direct action antiviral drugs. The plaintiffs were ultimately successful, as the case was settled through mediation and the legislature passed a resolution approving of the settlement. However, the outcome of this case does not require the changes the agency is now proposing. In its

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resolution, the legislature stated very clearly that the agency had been "discriminating among similarly situated Medicaid recipients on the basis of categorical restrictions **that are not based upon prevailing clinical standards**." Neither this case nor the resolution that followed requires MCOs to adopt the medical necessity conditions provided for in the FFS program—MCOs are merely required to use prevailing clinical standards, as they currently do, pursuant to Insurance Code §4201.153(b).

Given that this is not required by CMS, HHSC would be unilaterally making this drastic change to the Medicaid program. In the 86th Legislative Session, the Texas Legislature considered a bill that would have made similar changes. HB 2453 would have required HHSC to "align treatments and conditions subject to prior authorization to create uniformity among Medicaid managed care plans." The legislature specifically rejected that proposal, choosing to maintain the flexibility of managed care, instead passing SB 1207, which was very similar but excluded the uniformity requirement. "The deletion of a provision in a pending bill discloses the legislative intent to reject the proposal."[1] Not only has the legislature not passed a bill that would support these changes, but they've expressly rejected the idea just two sessions ago.

Simply put, this new interpretation is bad public policy. Requiring uniform medical necessity criteria would essentially turn MCOs into Administrative Services Only (ASO) plans. This would negate the advantage that managed care provides, which is saving state funds while ensuring beneficiaries receive exceptional care. Managed care only works if MCOs are granted the flexibility to develop innovative care delivery models. A one-size-fits-all model would undermine decades of progress that MCOs have made towards these efforts, and we hope that HHSC will reconsider its position before any permanent damage is done.

Sincerely,

Jamie Dudensing, RN
CEO
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[1] *See, e.g.,* Transp. Ins. Co. v. Maksyn, 580 S.W.2d 334, 338 (Tex. 1979); Grasso v. Cannon Ball Motor Freight Lines, 81 S.W.2d 482 (1935).

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