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Submitted via email to HHSRulesCoordinationOffice@hhs.texas.gov

re: *Proposed rules 1 TAC, Chapter 353, concerning Prior Authorization Timelines Reconsiderations and Information Accessibility*

To Whom it May Concern,

The Texas Association of Health Plans (TAHP) represents all but one of the managed care organizations (MCOs) that administer the Medicaid and CHIP programs in Texas. We appreciate the opportunity to comment on proposed rule 1 TAC, Chapter 353, Prior Authorization Timelines Reconsiderations and Information Accessibility. This rule is intended to implement portions of SB 1207 (86R), regarding prior authorization (PA) requests submitted with incomplete or insufficient information or documentation as well as requirements that MCOs post information related to PA requirements online.

We believe the rule does not fully align with language in SB 1207. The proposed rule:

- Reflects calendar days instead of business days for MCOs to make a final PA determination.
- Refers broadly to compliance with Texas Insurance Code Chapter 4201, yet federal and state Medicaid rules conflict in several instances.

TAHP spent a significant amount of time working with stakeholders on all of the components in SB 1207—especially on language related to the PA process when there is insufficient or missing information. This process is extremely complicated, and we discovered during language negotiations that even small changes have large impacts on the health plans and providers.

Use of Calendar Days

Proposed § 353.425(d)(4) states that an "MCO must make a final determination as expeditiously as the member's condition requires but no later than three days after the date the missing information is provided to an MCO." We believe the proposed rule is missing the word

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"business," to make it consistent with the existing "three business day" requirements in the HHSC Uniform Managed Care Manual Chapter 3.22, which states "the MCO must make a final determination of medical necessity within 3 Business Days after the date the missing information is provided to the MCO." Further, SB 1207 allows three business days to respond to a PA request, and the deadline for responding to requests with incomplete information should align with this requirement.

If the change from "three business days" to "three days" was intentional, we oppose this change, as it would alter the existing process of three business days, established by HHSC with the implementation of SB 1207. Thus, the discrepancy in the proposed rule is problematic for the MCO's utilization review staff, as well as the member and the member's physician. MCO utilization review staff are not currently required to be available to receive and process prior authorization requests on weekends and state-approved holidays. Similarly, providers' offices are not open for "normal business hours" on the weekends, and thus are neither requesting prior authorizations or responding to peer-to peer-consultations on the weekends. As it reads, the proposed draft rule will result in unnecessary denials—which is contrary to the intent of the goals of the Incomplete PA regulation. Increased adverse determinations will also result in unnecessary adverse determination appeals, delays in member access to care, and increased administrative burden on MCOs and providers.

Compliance with Texas Insurance Code Chapter 4201

Proposed § 353.425(c) states that MCOs must comply with Texas Insurance Code Chapter 4201. However, not all of Chapter 4201 is applicable to Medicaid. Further, SB 1207 makes no changes to Chapter 4201, which relates to utilization review agents, that would necessitate a reference in the proposed rule. The only reference to Chapter 4201 in SB 1207 is a provision in the Texas Government Code that expressly states that sections of Chapter 4201 do not apply to MCOs: Government Code 533.00282(a) states that "Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization." SB 1207 does not instruct HHSC to apply Chapter 4201 to Medicaid, nor has the agency ever codified this requirement in the past. This is not an appropriate precedent to set—therefore, we recommend the reference to Chapter 4201 be removed from the proposed rule entirely.

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Alternatively, if HHSC is going to set a new precedent of adding Chapter 4201 to Medicaid, we recommend the phrase "applicable provisions" be inserted directly before the reference to Chapter 4201, as not all of the chapter applies. The applicability of Chapter 4201 has long been a question of managed care plans. These questions often arise during program audits, when HHSC inconsistently applies the federal and state citations listed in the proposed rule. While requested, HHSC has never produced guidance that specifies which statutes apply, as has been previously requested. Given the inconsistency, lack of specific guidance by HHSC, and the fact that certain provisions of Chapter 4201 expressly do not apply to Medicaid managed care, the language requiring compliance with Chapter 4201 should mirror the language requiring compliance with Chapter 533: the "*applicable provisions of* Texas Government Code Chapter 533."

If HHSC keeps a reference to Chapter 4201 in the rules, HHSC should provide guidance that specifies what provisions of Chapter 4201 apply to Medicaid to the Medicaid MCOs.

To help ensure a more streamlined and successful implementation, it is imperative HHSC continues to work with the health plans to achieve the goals of the legislation. We appreciate your consideration of the recommendations we have outlined, and we look forward to working with the agency.

Sincerely,

Jamie Dudensing

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