TAHP
The Texas Association of Health Plans

Texas Association of Health Plans
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May 20, 2024

Re: Rendering Provider Element

Health and Human Services Commission,

We are reaching out to respectfully request that the Texas Health and Human Services Commission (HHSC) add back the rendering provider element to standard prior authorizations as a critical data element, as its absence is creating significant problems for the MCOs. It is straightforward for a provider to include this information, and it is absolutely necessary for the MCOs to have it. Providers are already required to include this element in the private market, so it is already included on a majority of claims. Despite previous agreements on its importance, HHSC's decision to remove the rendering provider from prior authorization requirements with little discussion or explanation is causing significant operational inefficiencies and increased costs. Adding this information is not difficult for a provider's office, and it avoids unnecessary administrative costs.

Without this critical information, MCOs are unable to verify the network and enrollment status of the rendering provider. At best, this leads to delays in care, as the patient waits for the MCO to engage in additional outreach to the requesting provider to obtain the name and specialty of the rendering provider. At worst, prior authorization timelines will force the MCO to approve the request with a 'placeholder' provider, which may result in care being provided to a Medicaid member by a provider that is not enrolled or credentialed in the Medicaid Program, or a provider that is not appropriate to deliver the requested service, which presents potential safety issues for managed care members. Additionally, there are many services for which MCOs only require an authorization when the rendering provider is out-of-network. When the MCO receives the rendering provider information, they are able to inform the requesting provider immediately if the service does not require authorization. When this information is omitted, an authorization must be created, and outreach must be done for the missing information. Effectively, this forces MCOs to treat all requests without rendering provider information as out-of-network until proven otherwise. This policy is a detriment to the patient, the provider, and the MCO.

Rendering provider information is also necessary to ensure enrollees receive quality and value-based care, while preventing fraud, waste, and abuse. The absence of rendering provider information significantly hampers MCOs' ability to ensure that the provider is qualified

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to render a particular service and that the care provided is appropriate and high-quality. Likewise, rendering provider data allows the state to monitor and assess the effectiveness and efficiency of the care provided. This is essential information for implementing value-based care models that reward providers for delivering high-quality care and achieving positive member outcomes. Conversely, MCOs also conduct searches through the Office of Inspector General (OIG) and the Excluded Parties List System (EPLS) by rendering providers to prevent fraud, waste, and abuse. The EPLS lists individuals and organizations excluded from receiving federal contracts or federally funded healthcare services. Without the rendering provider's name, the Medicaid program becomes vulnerable to fraudulent activities.

Providers are already used to submitting this information in the private market, and there is now a process in place to deal with incomplete prior authorizations. The Texas Department of Insurance (TDI) Standardized PA Form requires *both* requesting and servicing providers. In other words, this policy would misalign the Medicaid program and the private market, despite the fact that MCOs are required to accept the TDI standardized form for Medicaid PA requests. The burden on providers to include the information would also be very low, as it is required information outside of the Medicaid program and it's been required for Medicaid PAs in the past. Further, with HHSC's adoption of rules relating to incomplete prior authorization requests earlier this year, there is already a process to deal with missing information. **If a provider fails to include the necessary rendering provider information in the prior authorization request, MCOs would not deny care to the beneficiary**. Instead, the MCO would utilize the reconsideration process established by SB 1207 to obtain any insufficient documentation. This would ensure that care delivery is not interrupted while helping MCOs maintain the documentation they critically need.

Including rendering provider information in the prior authorization process is critical for Medicaid MCOs to ensure the delivery of high-quality, efficient, and cost-effective healthcare services to its beneficiaries while also supporting broader goals of integrity and innovation. Requiring the information does not create a new burden for providers, while eliminating the requirement leads to delays in care and potential "surprise bills" for enrollees. We ask that the agency reinstate this requirement, and allow the provisions of SB 1207 to function as intended, as soon as possible to avoid any further complications.

Sincerely,

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