Public Comment Received for Chapter 12 and Chapter 19 Proposals

1. Alex Su, MD
2. Sendero Health Plans, Inc.
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7. America's Health Insurance Plans
8. EviCore Healthcare
9. Pharmaceutical Care Management Association
10. Drs. Bonnen, Buckingham, Campbell, and Oliverson
11. Quest Diagnostics
12. Texas Public Policy Foundation
13. Texas Medical Association
14. National Infusion Center Association
15. Harris Health System
16. US Oncology Network

1. **Alex Su, MD**

From: [redacted]
To: ChiefClerk
Subject: comments on TDI preauthorization Gold Card
Date: Friday, April 08, 2022 6:15:39 PM

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Recently, I've been getting denials for medications that patients have been taking and are stable, even though I've been using COVER MY MEDS and answering questions appropriately. When we appeal, they approve them. I suspect the insurance companies/Pharmacy benefit managers are anticipating this rule and are giving more denials so that physicians will be denied access to the prior authorization gold card

Alex Su, M.D
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2. Sendero Health Plans, Inc.

From: [redacted]
To: ChiefClerk
Cc: Sendero Compliance Mailbox; [redacted]
Subject: Comments on HB 3459 - Sendero Health Plans
Date: Friday, April 15, 2022 10:17:39 AM

Hello Chief Clerk,

Please see below Sendero Health Plans, Inc. comments regarding HB 3459.

DOCUMENT	SECTION	TDI PROPOSED/DRAFT LANGUAGE	COMMENTS FROM SENDERO	PROPOSED LANGUAGE OR SOLUTION
SUBCHAPTER R. UTILIZATION REVIEWS FOR HEALTH CARE PROVIDED UNDER A HEALTH BENEFIT PLAN OR HEALTH INSURANCE POLICY 28 TAC §19.1710 DIVISION 2. PREAUTHORIZATION EXEMPTIONS 28 TAC §§19.1730 - 19.1733	§19.1730. Definitions. (3) (B)	(B) with respect to a particular health care service for which a physician or provider has a preauthorization exemption, **a review of a random sample of claims** to determine the percentage of claims that would have been approved, based on the issuer's applicable medical necessity criteria at the time the service was provided, as applied under a retrospective review of claims submitted by the physician or provider during the most recent evaluation period, which is conducted for the purpose of TITLE 28. INSURANCE Proposed Sections Part I. Texas Department of Insurance Page 11 of 18 Chapter 19. Licensing and Regulation of Insurance Professionals evaluating whether to continue or rescind a preauthorization exemption and consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption.	• There is a loophole here that would enable a **referring provider who is not also the treating** provider to theoretically become perpetually exempt. Many referring providers do <u>not</u> perform the treatments and thus will never submit a claim for the service. There will be no way to pull a random sample of claims for exempt referring providers in this very common situation. Example: A referring Primary Care Physician orders a CT scan. The PCP will never submit a claim for a CT scan. Thus there will be no claims to evaluate for subsequent evaluation periods. • In situations where the referring and treating providers differ - **due to absence of an existing**	We recommend that TDI require all claims to include ordering provider information on the claims form - HCFA Box 17 (name) and Box 17B (NPI). Health plans can then use the ordering provider information from claims to 1. identify pertinent health care services for subsequent 6-month evaluations of exempt referring providers. and 2. Allow claims to pay from non-exempt treating providers when ordered by an exempt referring provider.

			authorization, health plans cannot possibly allow the claim to pay for a non-exempt treating provider if there is no reference on the claim to the exempt ordering (referring) provider. There are fields on the HCFA claims form where the ordering provider can be listed. This section of the claim form is rarely completed by treating providers.	
Same	§19.1730. Definitions. (4) (C)	(B) with respect to a particular health care service for which a physician or provider has a preauthorization exemption, a review of a random sample of claims to determine the percentage of claims that would have been approved, based on the issuer's applicable medical necessity criteria at the time the service was provided, as applied under a retrospective review of **claims submitted** by the physician or provider during the most recent evaluation period, which is conducted for the purpose of evaluating whether to continue or rescind a preauthorization exemption and consistent with Insurance code 4201.655, concerning Denial or Rescission of Preauthorization Exemption;	The term "claims submitted" is broad and could be interpreted to include incomplete claims, rejected claims, claims denied due to bundling/coding errors, etc.	We recommend language revision to "...a retrospective review of **payable** claims submitted by the physician or provider….
Same	§19.1730. Definitions. (3) (A)	(11) Random sample--A collection of **at least five** but no more than 20 claims for a particular health care service, selected without method or conscious decision, for the	Left unaddressed is the scenario in which an exempt physician or provider has less than five claims in the evaluation period. The rules give health plans no way to evaluate the	We recommend that TDI include in the allowable rescissions of exemption the situation where an Exempt provider has less than 5 claims in an evaluation period.

		purpose of evaluating a physician's or provider's continued eligibility for a preauthorization exemption.	safety and clinical appropriateness of services when an Exempt provider has less than 5 claims in the evaluation period. This is a barrier to health plans evaluating quality of care.	
Same	Section §19.1731	Subsection (b) states that the issuer must review the outcomes of no fewer than 20 preauthorization requests for a particular health care service in a given evaluation period and determine whether the physician or provider qualifies for an exemption. The department specifically seeks comments on this minimum threshold for review and whether it should be modified.	Responding to TDI's request for comment. The purpose of HB 3459 is to reduce the burden of an administrative preauthorization process for providers who are making clinically appropriate decisions about services requiring preauthorization. This would mean that the approval rate is statistically significant in that it inspires confidence that all of the physician or providers decisions about authorized health care services are appropriate. If a sample size is made up of too few records, the results will be unable to inform decisions. A sufficient number of observations is considered by statisticians to be an "n" of 30 or more records in order to have an appropriate confidence interval, e.g. to have confidence in the results. This is known as the "rule of 30".	We recommend that the minimum threshold should be raised to 30 requests.

Ashlea Tolbert, MS • Regulatory Program Specialist

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3. Texas Healthcare & Bioscience Institute

THBI
TEXAS HEALTHCARE & BIOSCIENCE INSTITUTE

THE TEXAS POLICY VOICE FOR HEALTHCARE AND BIOSCIENCE

April 27, 2022

Office of the Chief Clerk
MG-GC-CCO
Texas Department of Insurance
P.O. Box 12030
Austin, Texas 78711-2030

Via email: ChiefClerk@tdi.texas.gov

RE: THBI Comments related to new rules proposed by the Texas Department of Insurance amending 28 TAC Chapter 19, Subchapter R, and adding 28 TAC §12.4 Subchapter G, implementing House Bill 3459, 87th Legislature, 2021.

To Chief Clerk, Department of Insurance,

The Texas Healthcare and Bioscience Institute (THBI) is a trade association representing the life and biosciences industry in Texas. Our membership consists of biopharmaceutical companies, research institutions, medical device companies, economic development entities and service companies that make up the life science and bioscience industry. The Texas life sciences industry is committed to expanding the boundaries of science in healthcare by discovering, developing and delivering innovative and necessary therapeutics, diagnostics, and devices to patients and to leading efforts to improve the health care system for all Texans.

On behalf of our membership, we appreciate the opportunity to provide feedback on the proposed rules Implementing House Bill 3459. THBI strongly supports the proposed amendments to both 28 TAC Chapter 19, Subchapter R, and 28 TAC §12.4 Subchapter G. As you know the Texas Legislature passed HB 3459 in an effort to prohibit a health maintenance organization (HMO) and a preferred provider benefit plan insurer that used a preauthorization process for certain health care services from requiring a physician or provider to obtain a preauthorization if specified criteria were met. THBI believes that these rules present a responsible and balanced approach to implementation of HB 3459 and thanks the Department for all the effort that went into developing these rules.

Specifically, I want to address the assertion put forth by some stakeholders that HB 3459 was not intended and does not authorize the provisions of the bill to apply to drug benefits or prescription drugs. THBI disagrees with this assertion and believes that the Department has appropriately applied its authority in the draft rules. As you know, SECTION 5 of the

legislation specifically notes that "In this subchapter [*Subchapter N of Chapter 4201*] that, terms defined by Section 843.002, including "health care services," "physician," and "provider," **have the meanings assigned by that section**." (*Emphasis added*.) In Section 843.002 the definition of health care services specifically includes pharmaceutical services. Therefore, the assertion that HB 3459 was not intended to cover the drug benefits for these plans is not substantiated.

Overall, this bill was passed in an effort to correct the overreach by health plans which was creating unnecessary administrative burdens for providers and creating barriers to health care services for patients. The approach taken by the Department with these rules provides a clear and strong approach to implementation that will make those corrections and restore balance to this aspect of the health care system.

We extend our sincerest gratitude for the opportunity to provide feedback. If you have any questions or need additional information, please contact me directly at 512-708-8424 or at [redacted].

Sincerely,

Victoria Ford, MPA
President and CEO
Texas Healthcare and Bioscience Institute (THBI)

4. Oncology Consultants PA

Oncology Consultants
Overcoming Cancer.™

Luis T. Campos, M.D.
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Solly Chedid, M.D.
Ngoc Pham, M.D.
Ricardo H. Alvarez, M.D. MSc.

May 5, 2022

Cassie Brown
Commissioner
Texas Department of Insurance
Austin, Texas 787-9144

Via Email: LHLcomments@tdi.texas.gov

Re: "Preauthorization Exemptions," distinguish Division 2, Section, titled "Preauthorization Exemptions," supplements the 19.1730 – 191733 from existing rules related to utilization review and preauthorization procedures.

Dear Commissioner Brown:

Oncology Consultants P.A. appreciates the opportunity to submit these additional comments for the Texas Department of Insurance's (TDI) request for information to use to implement Houston Bill 3459 (RFI).

On behalf of Oncology Consultants, P.A., an independent community oncology practice with 34 Providers and 17 locations servicing cancer patients in Houston surrounding area for over 40 years in Texas. As Director of Managed Care Contracting and Business Development, I have worked for Oncology Consultants for more than 23 years along with 30 years of industry experience in Government, Medicare and Medicaid Advantage, and Private Insurance Plans.

Section 19.1732(as) states that an issuer must provide notice to the physician or provider when granting a preauthorization exemption and requires that an exemption be in place for at least six months before it can be rescinded. The department specifically seeks comments on this minimum duration for exemptions and the timeframe for issuing notices, and whether either should be modified.

Exemption Period

Oncology Consultants disagrees with the requirement of the duration of the six-months exemption period deemed cumbersome for both the health plan and provider. Industry standards already issues authorization for cancer patients and other chronic disease treatments for one year. In addition, necessary medical services aligned with the existing approved pre-authorization exemption period that meets medical necessity and clinical evidence-base guidelines.

The duration of extending the pre-authorization exemption period to an annual basis is a win-win, which results in savings both towards patients' benefits premiums dollars and the cumbersome costly workflow process for health plans and providers.

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Exemption Timeline for Issuing Notices

The comment on the timeframe and threshold percentage of accepted claims needed for an issuer to grant, deny, or rescind a preauthorization exemption; for subsequential 90 days notices from the health plan recommendations would shift to the provider to submit proof of 80% compliance of the "Particular Medical Services" widely accepted evidence-based guidelines 30 days before the expiring Prior-Authorization exemption period to the Health Plan.

The replacement of a 90-day delayed timeframe by the Health Plan above eliminates a provides who must reinstating authorizations approvals while waiting on a response from the Health Plans if next prior-authorization exemption period is denied or approved. Last, the exemption time period intent is for the patient to seamless medical services without unnecessary delays.

The health plan and provider would continue to have the right to retro audit after the exemption period. Along with the provider's right to appeal, the audit findings determine discrepancies from the data submitted by the provider.

Oncology Consultants appreciates the opportunity to comment to TDI. If you have any questions, please do not hesitate to contact Katherine Grigsby Director of Contracting and Development, at [redacted]

Respectfully,

Katherine Grigsby
Director of Contracting and Development
Oncology Consultants, P.A.

5. TSAOG Orthopaedics & Spine

May 6, 2022

Office of the Chief Clerk
MC-GC-CCO
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030
Via email: chiefclerk@tdi.texas.gov

RE: Division 2. Preauthorization Exemptions
28 TAC §§19.1730 – 19.1733 – Request for Comments

Dear Commissioner,

Thank you for requesting comments regarding the minimum threshold for review in section 19.1731, subsection (b) that states ***"the issuer must review the outcomes of no fewer than 20 preauthorization requests for a particular health care service in a given evaluation period and determine whether the physician or provider qualifies for an exemption".***

We are a group of 40 physicians in San Antonio, TX. We request authorization for thousands of procedures per year with hundreds of insurance plans. We appreciate the difficulty in creating the rules surrounding this legislation and are happy to offer comments for your consideration.

We believe there will be unintended consequences if ***each*** particular health care service requires ***no fewer than 20 preauthorization*** requests to be reviewed ***within a six-month period of time*** for determination on whether the physician or provider qualifies for an exemption. We see a few critical issues with this language.

1. A provider will likely not have a minimum of 20 pre-authorization requests of a ***particular health care service*** for each insurance carrier they interact with ***within a six-month period of time***. For example, if a Knee MRI is considered a "particular health care service", that provider for the six-month evaluation period would need to have ordered at least 20 Knee MRI's in that period **per insurance carrier**. And this repeats for every service listed on the insurance carrier website requiring pre-authorization.

2. In addition to each insurance carrier, there are several plans offered that have separate pre-authorization requirements under each carrier. For example, BCBSTX has a different set of pre-authorization requirements (Utilization Management | Blue Cross and Blue Shield of Texas (bcbstx.com)) for each of their plans:

    a. Fully Insured and Administrative Services Only (ASO) Plans
    b. Blue Cross Medicare Advantage (PPO) and Blue Cross Medicare Advantage (HMO)
    c. Designated Groups such as the Employee Retirement Groups of Texas (ERS)

    To continue the example, that physician would need to have seen at least 20 patients within the six-month evaluation period for each of these plans that all needed a Knee MRI in order to demonstrate good clinical decision making in order to qualify for an exemption for only one particular service!

The entire premise of the pre-authorization process is to determine if the ***provider*** who is ordering the necessary tests or procedures demonstrates good clinical judgement and evidence-based medicine in providing cost effective care to its patients. The Gold Card legislation was designed to remove the burden for those providers that demonstrate this behavior to the insurance carriers at least 90% of the time. The carriers should have a mechanism in place to easily identify the providers success rate across any and all requests to determine this percentage.

We believe that instead of requiring the provider to have a minimum of 20 request per particular health care service, it should be a review of **all requests in total of all health care services by provider that required prior authorization under the parent insurance carrier name** (not by individual plan, not by each particular health care service and no minimum number of requests). If the language is not altered to reflect this, the legislative effort and intent to address this problem is in jeopardy.

You also requested comment in section 19.1732, on the minimum duration for exemptions and the timeframe for issuing notices, and whether either should be modified. The new section would state ***"an issuer must provide notice to the physician or provider when granting a preauthorization exemption, and requires that an exemption be in place for at least six months before it can be rescinded"***.

We believe the exemption should last one year (instead of six) given the carrier will have up to 90 days to notify the provider of the determination, this would effectively be a 15 month cycle. This cycle will allow some predictability around the staffing levels required to perform the administrative functions of prior-authorization. For example, in our Group, we employ eight

team members that are exclusively dedicated to the prior authorization process. Determining how many staff we will need will be solely dependent on the number of providers in our Group that have met the requirements for exemption. It will be difficult enough to predict staffing levels annually given the rules surrounding the exemption process, having to adjust on a six-month basis and have the appropriate number of staff to support this will be nearly impossible.

Lastly, although comments were not specifically requested, we have concerns related to section **§19.1733. Retrospective Reviews and Appeals of Preauthorization Exemption Rescissions**.

Under item (b), it states "An issuer that is conducting an evaluation to determine whether a physician or provider still qualifies for a preauthorization exemption may request medical records or other documents, consistent with §19.1707 of this title (relating to URA contact with and Receipt of Information from Health Care Providers), and must provide at least 30 days for a physician or provider to provide the records. ***Medical records should be requested for no more than 20 claims for a particular health care service and may be requested only during an evaluation period or within 90 days following the end of an evaluation period. If the physician or provider fails to provide the records necessary for the issuer to make a determination, the issuer may determine that the claim would not have met the screening criteria.***

We have four concerns in the language of this section:

1. There is no mechanism to challenge the initial denial of Gold Card status. Any appeal process should include the initial evaluation period.

2. The language again references "particular health care service" which implies that up to 20 medical records requests **per particular health care service**, **per individual plan** per provider would need to be submitted to the insurance carrier during the evaluation period. We believe this could effectively require the provider to submit almost all patient medical record files to each insurance carrier during the review period. This would cause an extreme burden on the practice, increasing not reducing, the administrative burden this legislation set out to remove from responsible providers.

3. If the provider fails to provide the records, or if the review determines the provider did not meet the screening criteria, what happens to the payment for the service that was provided? Would the insurance carrier be allowed to request retroactive repayment of all services that would have required prior authorization in that evaluation period? The language that is used ***"the issuer may determine that the claim would not have met the screening criteria"*** is dangerously close to allowing the carrier to retroactively request payment for the services already rendered. We believe the carrier should have the right to rescind the exemption of the provider, but should not have the right to retroactively deny payment.

We respectfully request clarification of this section to avoid ambiguity or interpretation by the carriers whereby claims already submitted and paid during the exemption period could be clawed back.

4. We request the issuer be required to send medical records request via certified mail and the request be made within 30 days (instead of 90) following the end of the evaluation period. Our concern is we could receive a negative determination due to lack of medical records however we may not have ever received the request if it is not sent certified. Regarding the timeline, we would prefer to have any request for records be submitted timely (within 30 days) instead of prolonging the request period for up to three months as it is currently written.

Thank you again for your hard work in detailing the rules regarding utilization review in HB 3439. Should you have questions, please feel free to contact me directly at 210-889-5300.

Sincerely,

Christine Kean
Chief Operating Officer

6. Texas Association of Health Plans

Texas Association of Health Plans
1001 Congress Ave., Suite 300
Austin, Texas 78701
P: 512.476.2091
www.tahp.org

May 9, 2022

Office of the Chief Clerk
Texas Department of Insurance
Via email at: ChiefClerk@tdi.texas.gov

Re: Proposed amendments to 28 TAC §19.1710 and new 28 TAC §§19.1730 - 19.1733, concerning requirements prior to issuing an adverse determination and preauthorization exemptions; §12.4 and §12.601 concerning preauthorization exemptions for independent review organizations; proposed Form LHL011

Dear Texas Department of Insurance,

The Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, health maintenance organizations, and other related health care entities operating in Texas. Our members provide health and supplemental benefits to Texans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid.

We appreciate that the department obtained stakeholder input prior to a formal rule proposal. We offer the following comments to the proposed rules.

Minimum Threshold for Exemptions (§19.1731(b))

TAHP strongly supports the proposed provision requiring a minimum of 20 preauthorization requests for an exemption. A valid evaluation of a specific provider in relation to their capability to adequately perform a specific service must necessarily rely on review of multiple incidents of the service to establish a pattern of necessary and quality care. A review of a service that a provider has performed and submitted only a few times during an evaluation period would not be statistically valid, and therefore should not make the provider eligible for an exemption.

This threshold will dramatically decrease the number of unnecessary exemptions and exemptions that cannot be rescinded for services that physicians rarely use. As discussed in detail later, if a provider rarely submits claims after a service is exempted, that service will never meet the five-claim rescission threshold, and the exemption will therefore continue in perpetuity. The provider could move, retire, or otherwise stop providing the service, yet there will be no mechanism for an issuer to remove these obsolete exemptions from their records. This threshold

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is a key safeguard that will limit how many "deadwood" exemptions accumulate over time, allowing issuers to focus their resources on providers with appropriate exemptions.

Most importantly, the intent of HB 3459 is to reduce the administrative burden for physicians and providers that are considered exemplary in determining what care is medically necessary and appropriate for each patient's particular circumstances—in other words, providers who excel at directing their patients' care. It is impossible to determine whether a provider is exemplary without at least 20 claims. Any fewer than that, and the sample size will simply be too small to justify granting an exemption. There obviously needs to be some sort of threshold, and we firmly agree with the agency that 20 is appropriate.

Administrative Medical Licenses (§19.1710)

TAHP also strongly supports the department's statement that physicians holding Texas Administrative Medicine Licenses under the Medical Practice Act and Texas Medical Board rule 22 TAC §172.17 meet the requirement that "a physician licensed to practice medicine in the state" be available for peer-to-peer discussions. HB 3459 amended the statutory requirement for offering a "peer-to-peer" discussion before the denial of a preauthorization to require the health plan physician be licensed to practice medicine "in this state." Proposed amendments track the language of HB 3459, requiring a Texas license and the same specialty as a requesting physician.

This position is clearly supported by Texas statute, as well as Texas Medical Board and current TDI rules. Under TMB's current "active practice of medicine" requirement, Texas physicians employed full-time as health plan medical directors are ineligible for "full" TMB medical licenses. Therefore, requiring these physicians to obtain full "clinical" licenses rather than allowing administrative medical licenses would result in an unworkable situation, effectively prohibiting health plan physicians from performing any medical necessity reviews (even for services already received)—this would not be "a result feasible of execution" as required by principles of Texas statutory construction.[1] Requiring only an administrative license for utilization review is a long-standing regulatory requirement at TDI, and nothing in HB 3459 directs that to change.

Concurrent Review (§19.1730(8))

TAHP supports the proposed definition of preauthorization as not including concurrent utilization review, which is consistent with HB 3459's definition. Preauthorization requests and reviews for inpatient services generally occur prior to a patient entering an inpatient facility.

[1] Tex. Gov't Code §311.021(4).

TAHP
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Requests submitted while a patient is already inpatient for approval of additional days are "concurrent review" rather than preauthorization requests and, therefore, are outside the scope of preauthorized services. In the context of an inpatient stay, a preauthorization exemption should apply only to the number of days provided for in the health plan's applicable clinical screening criteria as publicly posted pursuant to Insurance Code sections 843.3481 and 1301.1351. A request to extend the stay for additional days is subject to concurrent review and is not a request for which an exemption is available under the new law.

Rendering Providers (§19.1731(d))

TAHP supports the proposed provision under which a treating physician or provider who inappropriately relies on another physician's exemption in violation of the rule may be considered by the issuer as failing to substantially perform the health care service. However, we are strongly opposed to the provision allowing a "rendering" provider that does not qualify for their own exemption to take advantage of an exemption held by the ordering physician or provider.

TAHP recommends that the rules clarify that a PA exemption (and its corresponding prohibition on retrospective reviews and claim denials based on lack of medical necessity) is available only to physicians and providers that order a particular health care service and submit the PA requests for that service as part of and directing the care of their patient. HB 3459 is aimed at reducing administrative burden for physicians and providers that are considered exemplary in determining what care is medically necessary and appropriate for each patient's particular circumstances; in other words, providers who excel at directing patient care. In many situations, the same physician or provider will order/direct, request a PA for, render, and bill for health care services. In these scenarios, the determination and application of a PA exemption (and its corresponding prohibition on reducing payment based on medical necessity) is fairly straightforward. But there are many scenarios where one provider is deciding what care is appropriate (and requesting a PA for the care) but another provider is rendering the services and billing for them. In that situation, the ordering provider who would typically be requesting a PA may be eligible for a PA exemption, but the rendering and/or billing provider(s) should not be.

On its face, this rule appears to make sense. However, when considering how it will operate practically, the rendering physician provision is simply unworkable. To understand the issue with this rule, it is important to understand the different types of claim forms, when they are used, and what information they include. There are two standard types of claim forms—CMS-1500 for physicians or noninstitutional providers and UB-04 for facilities/noninstitutional providers. Both

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forms were developed for the Centers for Medicare & Medicaid Services, but they are now the standard forms used in private insurance as well. CMS-1500 has field 17, which is for the name of the referring provider or other source. The instructions for the form state that the field should contain the name of either the referring provider, ordering provider, or supervising provider, *in that priority order*. In other words, the claim would identify the ordering provider only if there was no referring provider involved in the care. The issuer would typically be able to determine the ordering provider based on field 23, which requires the preauthorization number, but that will not be available when there is an exemption in place.

UB-04 is even more problematic. That form has fields 76-79, which are for the attending provider, operating physician, and two other providers, respectively. In some situations, an attending physician can place the order, but care is often passed off to a resident or some other type of provider who may submit an order. Again, the issuer would have no way to know who ordered the care. This form also has an authorization field, but there would not be an authorization tied to the claim.

When a third party renders the care and then bills for the service, there will be no way for the issuer to tie the claim back to a preauthorization exemption held by the ordering provider. The exemption will have to apply only to the ordering provider and only when they render the care, and in turn bill for the care. If issuers are assured that a rendering provider will not be billing under another provider's exemption, they will be able to tie the claim back to an exemption by using the billing provider's NPI number.

Further, state law precludes extending the exemption to a rendering provider. HB 3459 prohibits a health plan issuer that uses a preauthorization process from requiring "***a*** physician or provider" to obtain preauthorization if the issuer approved 90 percent of the preauthorization requests "submitted by ***the*** physician or provider for the particular health care service."[2] HB 3459 also prohibits a plan issuer from denying or reducing payment for service for which ***the*** physician or provider has qualified for an exemption.[3] The proposed provisions of this subsection therefore conflict with the enabling statute, and should not be adopted.

For these reasons, TAHP recommends that TDI rules clarify that the prohibition on reducing payment based on medical necessity does not apply to a rendering provider when an ordering provider has an authorization exemption.

[2] Tex. Ins. Code §4201.653(a).
[3] Tex. Ins. Code §4201.659(a).

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Retrospective Reviews and Independent Review (§19.1733)

TAHP supports the proposal that if a physician or provider fails to provide the records requested and necessary for the issuer to make a determination for a service, the issuer may presume that the claim would not have met the screening criteria. However, we ask that the agency reconsider the length of time that providers have to submit the records. Because the law prohibits rescission until after an independent review is finalized,[4] and prohibits retroactively denying a claim that was submitted during the appeal process,[5] there is a built-in incentive for a provider with an exemption to appeal every rescission determination. Even if the insurer's determination is ultimately deemed correct by an IRO, it could give providers with unsatisfactory claim records months of additional time under their existing exemption. To limit gaming of the system, we ask that the agency change the 30-day timeframe to submit requested records to 15 days so that providers do not intentionally slow the rescission process down.

Likewise, proposed §19.1733(f) requires issuers to communicate the determination of a review by an IRO to the physician or provider within 5 days. Proposed §12.601(g) provides that the general IRO notice requirements within current §12.206 do not apply, so there is no deadline provided for the IRO to notify the issuer of its decision. The longer the IRO takes, the longer an unwarranted exemption can remain in place. If a provider no longer meets the 90% threshold, rescissions need to happen quickly to ensure that patients are not harmed. Thus, we recommend that a requirement for timely IRO notice to the issuer be added to §12.601.

Further, we recommend that the rules clarify that independent review by an IRO is not available in rescission situations in which the physician or provider failed to return requested records within the timeframe required under 19.1733(b). Because issuers will be responsible for paying for the IRO process, allowing a provider to submit supporting records for the first time as part of an independent review would add substantial additional costs based on a failure to cooperate with the review process.

Finally, proposed subsection (e) (and proposed §12.601(e)) provides that when requesting an independent review, in certain circumstances the physician or provider may request that the IRO review another random sample of claims. The proposals do not indicate on which sample claims the IRO's decision should be based; however, the proposed Notice of Rescission of Preauthorization Exemption and Right to Request an Independent Review includes an instruction to the provider to indicate whether they would like the IRO to "review the issuer's random

[4] Tex. Ins. Code §4201.654.
[5] Tex. Ins. Code §4201.657.

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sample of claims, ***or*** a separate random sample of claims." TAHP objects to the implication that when another random sample is appropriately requested, the IRO will review only the claims in that second sample. HB 3459 states that the IRO will base its determination on the "claims reviewed by the health maintenance organization or insurer under Section 4201.655 ***and*** reviewed under this subsection."[6] The rules should clarify that the IRO will review a combination of both samples.

Minimum Threshold for Rescissions (§19.1731(c))

One addition that would improve the workability of these rules is a provision stating that an exempted provider must provide a minimum number of the exempted services to retain the exemption. Given that it is impossible to conduct a rescission review when fewer than five claims are present, exemptions may be unnecessarily maintained in perpetuity when providers retire or move without informing the issuer. It is not appropriate for a provider to maintain an exemption in perpetuity when they are no longer providing the service on a regular basis. Health plans should have the ability to ensure that exempted providers are continuing to follow updated clinical standards.

Alternatively, the agency should create a timeframe after which an exemption may be rescinded without an evaluation. Medicine is a constantly evolving field, and the standard of care can and does change over time. New treatments are developed regularly that replace old ones. Again, because these rules would require exemptions for unused treatments in perpetuity, issuers would essentially be forced to keep records of these unused exemptions, and the records would build over time without any way to "clear" treatments that will likely never be used again. Therefore, we recommend that the agency add language allowing an issuer to presume an exemption has expired or go through the rescission process without the required five claims after a reasonable length of time has passed without any new claims.

Prescription Drugs (§19.1730(6))

TAHP objects to the definition of a particular health care service as including prescription drugs. HB 3459 provides no statutory authority to apply the preauthorization exemption and payment requirements to **products** such as prescription drugs. Under the plain language of the law, the requirements apply only to "health care services." While pharmacy "services" would likely be included, prescription drugs by plain definition are not included within health care "services" or pharmacy "services"—they are supplies and products. Therefore, the HB 3459 requirements simply do not apply.

[6] Tex. Ins. Code §4201.656(d)

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Pharmaceutical "services" are not the same thing as prescription drugs. The American Medical Association created specific CPT codes for pharmaceutical services and procedures, while prescription drugs are billed using an entirely different coding system, National Drug Codes. The Insurance Code also recognizes "pharmacy procedures," and prohibits health plan denial of reimbursement to a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license if certain conditions are met. Further, such an interpretation would create a very dangerous and expensive new mandate to cover and pay for prescription drugs, including opioids and other dangerous narcotics, with no ability to check for dangerous drug interactions or to confirm that risky drugs are appropriate for certain patients.

Notice of Rescissions (§19.1732)

TAHP has concerns with the detail required by these rules for rescission notices. The statute only requires issuers to provide "the sample information used to make the determination."[7] These rules would require the principal reason for the determination, the clinical basis for the determination, a description of the sources of screening criteria used as guidelines, and the specialty of the determining provider.[8] The rule goes well beyond what is required by statute.

Facility Locations (§19.1731(a))

TAHP recommends that in addition to NPIs, facilities should also be identified by location. HB 3459 is aimed at reducing administrative burdens for physicians and providers that are considered exemplary in determining what care is medically necessary and appropriate for each patient's particular circumstances. Because this could vary by hospital location, an exemption should only be available if each location meets the prescribed standards. Therefore, a physical location should be required in addition to the NPI so that issuers can identify the appropriate facility. This requirement should be added to this rule and 28 TAC 12.601(c).

Evaluation Period (§19.1730(4))

The language used in this section, and particularly the language related to the rescission exemption period, is extremely confusing. Subdivision (c) says that "the evaluation period is the six-month period an issuer *determines* or the subsequent six-month periods that follow." At first glance, it would appear that the agency is giving issuers flexibility to determine a six-month period that could be used for the rescission evaluation period. In other words, any six consecutive months could be used. It is not clear whether the "period an issuer determines" instead refers to the initial six-month evaluation period. We recommend clarifying this language.

[7] Tex. Ins. Code §4201.655(a)(3)(B)(i).
[8] 28 TAC §19.1732(d)(3)(C).

TAHP
The Texas Association of Health Plans

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We appreciate the opportunity to comment on these rules, and we look forward to working with the department on these matters. Please contact us if you have any questions or concerns.

Sincerely,

Jamie Dudensing, RN, MPAff
CEO
Texas Association of Health Plans

7. America's Health Insurance Plans

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South Building, Suite 500
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May 9, 2022

Attention: ChiefClerk@tdi.texas.gov
Office of the Chief Clerk, MC-GC-CCO
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030

RE: AHIP Comments Proposed Rule 28 TAC §§19.1730 - 19.1733 on Preauthorization Exemptions

To Whom it May Concern,

On behalf of AHIP, I write today in response to the Texas Department of Insurance's (TDI) proposed rules to implement HB 3459, legislation that mandates a waiver of prior authorization (PA) for certain health care providers. Previously AHIP responded to TDI's Request for Information (RFI) where we provided responses to the Department's specific questions.

Health insurance providers work diligently to ensure that enrollees are getting the right care, at the right time, from the right provider. Utilization management tools, like prior authorization, are critically important to ensure enrollees receive safe, evidence-based, timely, and high quality care. These tools rely upon provider-developed clinical guidelines, consultation with specialists, input from medical associations, and nationally recognized care criteria to ensure consideration of the latest medical evidence based on the highest standards of care.

Under the supervision of medical professionals, prior authorization reduces inappropriate, unsafe and low value patient care – all of which contributes to potential harm to patients and unnecessary costs. The Medicare and Medicaid programs recognize the importance of prior authorization to seniors and taxpayers alike.

It is vital that policy makers recognize the essential role of these tools and refrain from dismantling prior authorization programs because they are highly effective in addressing the long-standing challenges to safe and affordable evidence-based health care for Texans. Thus, we request your consideration of our comments on the proposed rule:

Administrative Medical Licenses
AHIP is appreciative of the explanation of Section 19.1710, stating that physicians holding Texas Administrative Medicine Licenses under the Medical Practice Act and Texas Medical Board rule 22 TAC §172.17 meet the standards in statute that provide for peer-to-peer discussion between health care providers about treatment plans. As noted in our response to the RFI, we agree and requested the Department confirm and clarify that an Administrative Medical License satisfies the requirements of this section.

Health insurance providers employ physicians, nurses, pharmacists and other clinicians as utilization management reviewers with extensive knowledge and experience in evidence-based reviews, and who are well-positioned to have the necessary dialogue with prescribing/ordering providers. Chief medical officers within health plans oversee large teams of clinicians and experts to assure enrollees receive high quality and affordable health care. These clinical professionals understand industry trends and market dynamics and promote the practice of evidence-based medicine and population health. They provide senior medical leadership and direction for medical management, clinical quality improvement, and medical policy development.

Exemption Threshold
AHIP commends TDI for setting a minimum threshold of least 20 PA requests for a particular service in a given evaluation period to determine whether the physician or provider qualifies for a specific PA exemption. The provisions of HB 3459 do not specify a minimum number to qualify for an exemption, and AHIP requested clarity in our RFI response. This threshold provides guardrails for low-volume providers, who are most likely to benefit from the utilization management under the PA process.

Also, as the statute provides that a recission of the exemption can only be done on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims, this clarification avoids the scenario where a provider could qualify for or maintain a PA exemption indefinitely, without performing a statistically significant amount of procedures to maintain it, and without accountability that the provider is adhering to evidence-based standards of patient care. Without such a clarification, a provider who continually has less than five PA claims could maintain an exemption, regardless of whether or not they meet the 90% approval threshold—thus jeopardizing the important patient safety and cost containment measures inherent in the PA process. Such guardrails are necessary to ensure that providers who receive exemptions continue to deliver consistent patterns of high-quality performance to the patients they serve.

Health Care Services
The proposed rule defines "health care service" in Section 19.1730 to include a prescription drug that is subject to PA as listed on the issuer's website. As mentioned in our response to the RFI, there are no references to prescription drugs in HB 3459, and a plain language reading of the bill shows the exemption requirements apply only to health care services provided, and not for products (prescription drugs or devices).

Further, AHIP's prior authorization survey also shows that specialty drug services are the most common treatments with PA requirements. For these complex drugs, health plans use nationally recognized care criteria, the input of a pharmacy and therapeutics committee composed of specialty clinicians for specific medical protocols, and consideration of the latest medical evidence based on the highest standards of care. Medical evidence usually links efficacy of drugs and services to a specific population or subpopulation and condition, so it is important that a prescribed drug is safe and effective for the individual patient's specific condition.

With prescription drugs, PA is also vitally important in circumstances where risk of addiction looms large, such as opioids for chronic pain, where interaction with another drug can be dangerous, where unnecessary treatment can be harmful, and where a drug or service (which otherwise may have a high rate of PA approval) is being prescribed for non-standard use. Health insurance providers have the benefit of a 360-degree view of the health care system, evidence-based resources, and insight into patients' medical claims histories to prevent dangerous or inappropriate prescription drug utilization. AHIP requests that rules remove the language including prescription drugs in the definition of health care services.

Notifications
HB 3459 and the proposed rule dictate major changes to health plan programs designed to promote patient safety and best practices, and therefore, plans need flexibility to modify their programs. AHIP would request TDI allow for permissive language in the notices of denials and granting of exemptions. Health insurance providers need to see and understand the result of the health care provider evaluations and until then - health insurance providers need flexibility in choosing to send notices only when an exemption is denied or granted for a particular health care service. Some health care providers may be eligible for exemptions for multiple PA health care services but may not qualify for all those services. Additionally, we recommend clarification that insurance providers be allowed to provide these notices electronically.

Evaluation Period

AHIP appreciates that the rule clarifies in Section 19.1730(4)(C) that for rescissions, the evaluation period is the six-month period an issuer determines or the subsequent six-month period that follows. In our response to the RFI, AHIP requested flexibility on the six-month evaluation period for rescissions of exemptions as health insurance providers work to implement the requirements of HB 3459. The language in the bill specified that rescissions of exemptions can only occur in January or June of each year, which only allows for an evaluation period of five months.

We appreciate TDI's consideration of our comments, and the flexibilities provided for health insurance providers. Exemptions to PA should not be taken lightly, and broadly limiting the ability to review medical necessity and appropriateness of care before care is delivered will lead to higher premiums and eliminate clinical safety edits designed to ensure patient safety. AHIP stands ready to work with you as rulemaking moves forward. Please contact me at [redacted] or 202-578-8765 with any questions or to discuss these issues further.

Sincerely,

Mara C. Osman, J.D.
Senior Regional Director, State Affairs
America's Health Insurance Plans
[redacted] / (202) 578-8765

cc: Billy Phenix

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

8. eviCore healthcare

From: [redacted]
To: ChiefClerk
Cc: [redacted]
Subject: Comments on Proposed Amendments to 28 TAC §§19.1710 and 19.1730-19.1733
Date: Monday, May 09, 2022 1:41:21 PM

Good afternoon,

Thank you very much for the opportunity to submit follow up questions and comments related to the recent proposed amendments to 28 TAC §§19.1710 and 19.1730-19.1733 required by the passage of HB 3459.

We would like to congratulate the TDI on your detailed and thorough handling of this complicated topic. I am writing to voice our support for the following rules:

- Chapter 19, §19.1731: Establishing a minimum of 20 similar cases to qualify for an initial gold card is sufficiently stringent and aligned with the principles in the bill.
- Chapter 19, §19.1733: Limiting the IRO review to the cases subject to the rescission evaluation is a fair and true second opinion of the health plan's rescission decision. Further, the exception to extend the original sample only when the health plan based its decision on more than the cases in the random sample is fair.

We would like to request further clarification and provide suggestions for improvement to the following areas:

- Chapter 19, §19.1710:
  - This section requires that the physician performing the peer discussion with the ordering physician have "the same or similar specialty as the physician".
  - This language has the unintended consequence of preventing the health plan or URA from providing a specialty expert in the patient's condition who has a higher level of specialty knowledge than the ordering physician, which is not the intent of the legislation.
  - We recommend changing this wording to "similar specialty expertise as the physician in managing the patient's condition".
- Chapter 19, §19.1730 subsection (6), definition of "particular health care service":
  - This section defines "particular health care service" as a health care service, including a prescription drug, that is subject to preauthorization as listed on the issuer's website under §19.1718(j).
  - As written, this definition of "particular health care service" removes critical patient protections because reasons for requesting a particular health care service can vary.
  - For example, services ordered as a combination of services code performed at the same time are different clinical services than each code ordered individually.
    - One real-world example is the use of three oncology drugs for the treatment of cancer.

        - The current evidence supports two of the drugs together, or the third drug alone, but not all three in combination.
        - Limiting service codes to the single code level could allow unsafe and inappropriate use of that third drug in combination with the other two because the prior authorization had been exempted for that drug based on very different clinical scenarios.
    - For this reason, we recommend amending the definition of "particular health care service" to mean "a specific individual or combination of health care services, including prescription drugs, that is subject to preauthorization as listed on the issuer's website, used for a specific clinical indication."
- Chapter 19, §19.1730, subsection (13):
    - This section implies that the exemption applies to the *treating provider*, which covers both rendering and referring.
    - We encourage TDI to consider limiting this definition to the referring physician or provider, as the rendering provider generally does not evaluate the patient or determine the course of treatment.
    - For example:
        - A patient with acute back pain goes to see their primary care physician for evaluation.
        - The physician orders an MRI of the spine and sends the patient to a standalone imaging facility for the test.
        - The radiologist at the facility oversees the MRI scan.
        - The precertification exemption must be tied to the primary care physician who evaluated the patient and made the decision to request the service, not the physician who conducted the MRI and did not participate in the clinical decision making to order the service for the patient.
- Chapter 19, §19.1731, subsection (d):
    - This section states that a provider cannot leverage another provider's exemption for a service.
    - Does this mean, for example, that a referring physician without an exemption cannot rely on the rendering physician's exemption when ordering a service for a patient?
    - If so, please also provide clarity on how this should be tracked.
- Chapter 19, §19.1732:
    - This section sets forth notification requirements to physicians or providers regarding their exemption status.
    - We propose that, for the initial exemption, notification only be required for: (1) physicians or providers that receive an exemption and; (2) exemption status for services where the physician or provider expressly requested an exemption, and that notification not be required for denial of preauthorization exemption for services which the physician or provider did not expressly request an exemption.
- Chapter 19, §19.1733, subsection (b):
    - This subsection requires an issuer conducting an evaluation to determine whether a physician or provider still qualifies for a preauthorization exemption may request medical records or other documents must provide at least 30 days for a physician or provider to provide the records.

- We support the need for a time limit for providers to submit requested records, but as worded, the language is not sufficiently clear as to require submission of records in a timely manner.
- As the health plans only have 60 days to complete their rescission evaluations, we request that the phrase "at least" be removed and the physician or provider's timeframe to submit records be capped at 30 days to ensure that the reviewing organization has adequate time to conduct the evaluation.

- Chapter 19 §19.1733, subsection (e) and Chapter 12, §12.601, subsection (e):
  - Limiting the IRO review to the cases subject to the rescission evaluation is a fair and true second opinion of the health plan's rescission decision.
  - Further, the exception to extend the original sample only when the health plan based its decision on more than the cases in the random sample is fair.
  - However, the language used here introduces some ambiguity that can be read by some as allowing the provider to request a second random sample.
  - We request that TDI make a minor amendment to confirm that the only reason a physician or provider can request a new sample for the IRO is if the issuer based the rescission on cases that were outside the random sample, and that the physician or provider cannot request review of a second random sample without reason.
- Chapter 12, §12.601, subsection (g):
  - Please provide clarity on when rescissions become effective.
  - Does the rescission become effective after determination is rendered to revoke the gold card or does the payer or delegated entity have to wait for the IRO to render a decision?
- HB3459, section 4201.656:
  - Independent Review of Exemption Determination states that a health maintenance organization shall pay for any appeal or independent review organization (IRO) of an adverse determination regarding a preauthorization exemption.
  - In order to reduce the number of frivolous IRO appeals, we suggest that TDI promulgate rules that providers should be responsible for IRO fees in the event the IRO upholds the rescission.

Thank you very much for the opportunity to provide commentary during this critical rulemaking effort.

Thank you,

Eric J. Gratias, MD, FAAP
Chief Medical Officer

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9. Pharmaceutical Care Management Association

May 9, 2022

Office of the Chief Clerk
MC-GC-CCO
Texas Department of Insurance
P.O. Box 12030
Austin, TX 78711-2030
EMAIL: ChiefClerk@tdi.texas.gov

SENT VIA EMAIL

Re: Proposed Rule – Preauthorization Exemptions for Certain Providers (28 TAC §§ 19.1710; 19.1730 – 19.1733)

Dear Chief Clerk:

We write on behalf of Pharmaceutical Care Management Association ("PCMA") in response to the proposed rule that would create preauthorization exemptions for certain providers in the Texas Administrative Code ("TAC"). Specifically, as proposed by the Texas Department of Insurance ("TDI"), the rule would amend existing law (28 TAC § 19.1710) and add new law (28 TAC § 19.1730 – 19.1733) concerning requirements prior to issuing an adverse determination and preauthorization exemptions. PCMA has concerns over some of the language in this proposed rule that is intended to implement House Bill ("HB") 3459 from 2021.

PCMA is the national trade association representing pharmacy benefit managers ("PBMs"). PCMA's member companies administer drug benefits for more than 266 million Americans who have health insurance through employer-sponsored health plans, commercial health plans, union plans, Medicare Part D plans, managed Medicaid plans, and others. On behalf of our member companies, we respectfully request that the following changes be made to the proposed rule.

§ 19.1730. Definitions

(6) Particular health care service

PCMA opposes the inclusion of prescription drugs under definition of a "particular health care service." As enacted in 2021 and now codified in the TAC, the provisions of HB 3459 contain no language that would expand the purview of these preauthorization exemptions to prescription drugs. Specifically, HB 3459 provides no statutory authority to apply the preauthorization exemption and payment requirements to products such as prescription drugs. Under the plain language of the law, the requirements apply only to "health care services." While pharmacy "services" would likely be included, prescription drugs by plain definition are not included within health care "services" or pharmacy "services"—they are supplies and products. Therefore, the HB 3459 requirements simply do not apply.

Pharmaceutical “services” are not the same thing as prescription drugs. The American Medical Association created specific current procedural terminology (“CPT”) codes for pharmaceutical services and procedures, while prescription drugs are billed using an entirely different coding system, National Drug Codes. The Texas Insurance Code also recognizes “pharmacy procedures,” and prohibits health plan denial of reimbursement to a pharmacist for the provision of a service or procedure within the scope of the pharmacist's license if certain conditions are met. Because “services” and “procedures” clearly differ from and do not include products and supplies such as prescription drugs, HB 3459 should not be interpreted to require “gold-card” exemptions from preauthorization and payment mandates for prescription drugs. Such an interpretation would create confusion and more questions. For example, the prescribing physician generally submits a preauthorization request for prescription drugs, but the claim is submitted by and paid to the dispensing pharmacy. In addition to creating practical questions about application of an exemption in such a scenario, this further demonstrates that prescription drugs are not “services.”

Applying 3459’s preauthorization exemption requirements to prescription drugs would create a very dangerous and expensive new mandate to cover and pay for prescription drugs, including opioids and other dangerous narcotics, with no ability to check for dangerous drug interactions or to confirm that risky drugs are appropriate for certain patients. For example, the “Houston Cocktail”—a mix of prescribed drugs (an opioid, hydrocodone, and a Xanax) that react with one another to become toxic and deadly—highlights the need for prior authorization checks to remain. When a clinical edit was added to prohibit prescribing this mix of prescriptions, it reduced this deadly interaction by 89%.

Safety and cost issues

Prior authorizations for prescription drugs protect patients from opioid abuse and severe drug interactions or reactions. According to a study by the Institutes of Medicine, most adverse drug events (“ADEs”) that patients experience are cause by prescriber errors. These ADEs account for more than 3.5 million physician office visits and 1 million emergency department visits each year. It is believed that preventable medication errors affect more than 7 million patients and cost almost $21 billion annually. About 30% of hospitalized patients have at least one medication error at discharge. Medication errors and ADEs are an underreported burden that adversely affects patients, providers, and the economy. A study from Johns Hopkins suggests that medical errors, including “unwarranted variation in physician practice patterns that lack accountability,” are now the third leading cause of death in the U.S. Prior authorization not only ensures appropriate health care, but they also save lives and protect patients. The overuse of prescription drugs and unsafe care in health care is rampant, resulting in harm to patients and wasted money. Doctors themselves believe that up to 30% of all ordered medical care is unnecessary or unsafe.

Additionally, health plans often suggest more appropriate interchanges during the preauthorization process when there are safety or clinical concerns. This typically results in an approval for a different drug, and so a denial for the initial request would not be appropriately accounted for in calculating the provider’s denial rates.

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Outstanding Questions

Were the exemptions to apply to prescription drugs, additional questions must be answered:

- Will high risk medications be exempted from this "gold-carding" program?
- Are PBMs expected to determine a provider's approval rate for prescription drugs by: evaluating all requests for all drugs, requests for a specific drug, requests for a particular drug class, or requests for some other grouping of medications?
- Does this analysis by PBMs include consideration of prescriber behavior for each health plan?
- Will there be allowances for additional considerations such as clinical appropriateness and patient safety? For example, the criteria that if 90% of claims pay, then all claims should be paid is not based on clinical appropriateness considerations and may not reflect a complete rational basis to allow coverage. Moreover, what if that 10% of drug claims which are not being paid are opiate drugs that are being prescribed inappropriately. If the provider is then "gold-carded," then the drugs being allowed to pay could have safety consequences for the member and provider.
- If "gold-carding" is granted to a prescriber specific to each drug, would application of "gold-carding" be permitted at the generic product identifier ("GPI") level of the drug (e.g., GPI of 14, 12, 10 – all)?
- Are management of formulary exceptions by PBMs included in the evaluation of "gold-card" status when determining a provider's exceptions approval?
- The time-frame of auditing denials may require additional attention by TDI. PCMA is concerned as the timing of denials does not appear to line up with the six-month look back period as denials are only allowed in January and June.
- Are reviews for provider exemption for Medical Benefit Drugs and Pharmacy Benefit Drugs to be conducted separately if the preauthorization requirements are different, and preauthorization determinations are made by different entities?

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- If a provider is exempt, does the exemption extend to anyone that may submit an authorization under the provider's authority (e.g., physician's assistant, nurse, practice partner, etc.)?

Again, PCMA appreciates the opportunity to provide comments on the TDI's proposed rule that would make changes to preauthorization exemptions. However, we oppose efforts to limit the use of necessary tools that discourage the development of quality, cost effective prescription drug benefits. The fundamental goal of these tools is to promote the appropriate and cost-effective use of medications. Applying the proposed rule's exemption requirements to prescription drugs would create a very dangerous and expensive new mandate to cover and pay for prescription drugs. No part of these preauthorization exemptions should apply to prescription drugs. Therefore, PCMA respectfully requests that prescription drugs be removed from the definition of a "particular health care service."

Please feel free to contact me with any questions or for further discussion.

Sincerely,

Peter Fjelstad

Peter Fjelstad
Director, State Regulatory and Legal Affairs

CC: James Person
General Counsel, Texas Department of Insurance

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10. Drs. Bonnen, Buckingham, Campbell, and Oliverson

May 9, 2022

Commissioner Cassie Brown
Texas Department of Insurance
333 Guadalupe Street
Austin, TX 78701

Dear Commissioner Brown:

The Texas Department of Insurance (TDI) recently issued draft rules for use in the implementation of House Bill 3459 (87R) which became effective January 1, 2022. We appreciate the attention to detail the agency has given to the nuances of the bill in advance, as well as the opportunity for stakeholders to comment and participate in both the September 20, 2021 and the upcoming May 12, 2022 meeting. The purpose of this letter is to further clarify the legislative intent and provide feedback in order to effectively implement the bill without further delay.

As physicians across multiple specialties, my colleagues and I are familiar with the prior authorization process — both the purpose it serves, and the reality of how it is conducted. While this additional step intends to make certain that all services ordered are medically necessary, it has become an unfortunate barrier to timely and appropriate patient care as determined by a provider. HB 3459 was passed to ensure that those most familiar with patients and their respective courses of treatment are involved in the prior authorization process.

More specifically, the bill provides an opportunity to physicians to request a review of a prior authorization request before an adverse determination. This process statutorily requires the participation of a Texas-licensed physician of the same or similar specialty. TDI has interpreted this to include physicians holding an administrative medicine license (AML). While those holding an AML are required to meet nearly the same standards as a fully licensed physician, they are not required to meet the "active practice" standard. In implementing this specific provision of the bill, this requirement is the most important to preserving provider input in the prior authorization process. A physician who is actively practicing is more aware of the true standard of care than an administrator. Although TDI states that this position has been long held, the agency should further consider the perspective of providers who have firsthand knowledge of this issue in practice.

We would also like to take this opportunity to specifically address a few points of contention as outlined below:

(1) *The definition of "full and final approval" of a prior authorization request.* Unfortunately, it is not uncommon for a prior authorization request to return from the insurer with modifications. By including this qualifier in the definition, insurers may

choose to engage in this practice more frequently in order to delay or prevent any exemption from being granted entirely. Rather than adding a safeguard, the addition of this language would incentivize further delays in patients' access to care and could pose unnecessary risk should insurers choose to routinely modify requests. Additionally, this impacts the number of claims able to be considered when granting or denying an initial exemption as no pending requests may be included. If this is not how the definition was intended to be interpreted, it should be further clarified.

(2) *The deadline for notification of initial exemptions*. Although an insurer can notify a physician of their approval or denial of an initial exemption for a service earlier, they are only required to do so by October 1 — four months after the evaluation period ends. If the data necessary to evaluate is readily available, there should be no reason this excessive amount of time is necessary.

(3) *Minimum number of claims*. As HB 3459 was written and passed, it does not contain a minimum number of claims for a particular healthcare service that must be met for the initial granting of a prior authorization exemption. Imposing such a requirement at all, but certainly one that requires a minimum of 20 claims, would undercut the goal of the legislation by reducing the intended scope of its application.

(4) *Clarification that the right to appeal to an Independent Review Organization (IRO) exists for initial exemptions.* While the bill itself and the proposed rules clearly provide the right to appeal a determination to rescind an existing exemption to an IRO, the same right as it relates to the initial denial of an exemption is not addressed. In accordance with legislative intent, a physician should have the opportunity to appeal in the event they do not receive an exemption for a particular healthcare service as expected.

Texas has made significant advances in protecting patients and increasing access to healthcare in recent legislative sessions, and we am pleased to see that pattern continued in the passage of bills such as HB 3459. We implore you to consider input from those with knowledge of the process in order to successfully implement this legislation and, in doing so, allow other states to look to Texas as an example when considering similar efforts.

Sincerely,

Greg Bonnen, M.D.

Dawn Buckinham, M.D.

Donna Campbell, M.D.

Tom Oliverson, M.D.

11. Quest Diagnostics

May 9, 2022

Office of the Chief Clerk
MC 112-2A
Texas Department of Insurance
PO Box 149104
Austin, Texas 78714-9104

RE: Proposed Rules Regarding Preauthorization Exemptions

Dear Chief Clerk:

On behalf of Quest Diagnostics, I am writing to respectfully express concerns about the Texas Department of Insurance's proposed rule implementing House Bill 3459, relating to preauthorization requirements for certain health-care services and utilization review for certain health benefit plans. This bill passed last year during the 87th Legislature.

Quest is the world's leading provider of diagnostic information services and serves one in three adult Americans and half the physicians and hospitals in the United States annually. We are proud to serve Texas and are committed to powering affordable care that reduces health disparities. With our infrastructure in the state of over 4,969 employees and 176 patient service centers, we service over 45,500 physicians and 223 hospitals.

Quest Diagnostics supported the passage of HB 3459, as the bill improved patient care by providing exemptions for certain providers from preauthorization requirements. Quest is concerned, however, with the lack of specificity in its definitions. Thus, we strongly encourage TDI to specifically include clinical laboratories as part of the definition of "health-care providers," and laboratory and pathology services as part of the definition of "health-care services." Quest asks that this language be amended to be precise and avoid improper interpretations and applications of the law.

Quest also strongly encourages TDI to (1) mandate it acceptable for preauthorization requests to be made by clinical laboratories for laboratory services, and (2) permit clinical laboratory claims to be measured to grant or deny preauthorization exemption requests. These modifications would ensure that clinical laboratories are evaluated fairly and able to obtain the exemption stated in the law.

Thank you for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact David Reiner, Executive Director, Government Affairs, at [redacted]

Sincerely,

David M. Reiner

David M. Reiner
Executive Director, Government Affairs

12. Texas Public Policy Foundation

Comment on Rules Regarding HB 3458 on Preauthorization Exemption

For the Texas Department of Insurance

Right on Healthcare, with the Texas Public Policy Foundation, offers the following comments on the proposed rules regarding HB 3458 from the 87th Texas Legislature:

Comments specifically requested by the department:

1. Revision of the minimum threshold for review

Response: Placing the minimum threshold for review at 20 claims is too high and would prevent far too many capable physicians from receiving exempt prior authorization status. We recommend lowering the minimum threshold for review to 5 claims, allowing the maximum number of physicians to gain exempt status without removing prior authorization requirements all together.

Reference: **Section 19.1731. New §19.1731 describes the initial preauthorization exemption process. Subsection (a) clarifies that for purposes of Division 2, a "physician" or "provider" should be identified using the National Provider Identifier under which a physician or provider makes preauthorization requests. Subsection (b) states that the issuer must review the outcomes of no fewer than 20 preauthorization requests for a particular health care service in a given evaluation period and determine whether the physician or provider qualifies for an exemption. The department specifically seeks comments on this minimum threshold for review and whether it should be modified.**

2. Revision of the minimum duration for exemptions and timeframe for issuing notices

Response: Exemption should be determined by an annual evaluation period. Due to the seasonal nature of healthcare, a physician may preform a procedure or prescribe a treatment which require prior authorization far more often in one six-month time period than another. We recommend setting the minimum duration for exemptions at one year.

Reference: **New §19.1732(c) provides a required timeframe for issuing notices of exemption or denial following the initial and subsequent evaluation periods and clarifies that such notices are required with respect to a particular health care service only if the physician or provider had submitted at least 20 preauthorization requests during the evaluation period. The department specifically seeks comments on this minimum duration for exemptions and the timeframe for issuing notices, and whether either should be modified.**

David Balat | Director, Right on Healthcare | [redacted]
Noelle Collins | Policy Analyst, Right on Healthcare | [redacted]

Additional comments:

1. Clarification on length of time an IRO has to process review and return to issuer

Explanation: As the rules stand, the issuer has 5 days to give an IRO determination to a physician; however, there is no clarification for how long the IRO has to preform and complete the review before returning a verdict to the issuer. We recommend adding a 30-day limitation on the length of time an IRO has to process an appeal. This would ensure that a physician denied their exemption experiences no delay in their appeal process.

Reference: **New §19.1733(e) states that a physician or provider may request that the independent review organization review another random sample of claims. New §19.1733(f) states that an issuer must communicate the determination of a review by the independent review organization to the physician or provider within five days.**

2. Clarification on how random sample is compiled and number of claims required

Explanation: A review claim should be based on a percentage of all prior authorizations for a particular procedure or treatment rather than on a random sample. Allowing a random sample to be the determinant for a physicians exemption from prior authorization would leave room for delay in approval and unfair oversight over any appeals. We recommend exemption reviews be based off a percentage of the total claims submitted.

Reference: **New §12.601(e) requires that the IRO use the same random sample of claims used in the issuer's initial determination to rescind the preauthorization exemption and that only claims that did not meet the screening criteria are subject to independent review. A physician or provider can request that the IRO review another random sample of claims under Insurance Code §4201.656(d) to the extent that the issuer conducted a retrospective review of more claims than were included in the original random sample.**

(11) Random sample--A collection of at least five but no more than 20 claims for a particular health care service, selected without method or conscious decision, for the purpose of evaluating a physician's or provider's continued eligibility for a preauthorization exemption.

3. Clarification on appeal process for physicians originally denied

Explanation: As the rules stand now, there is no clear process of appeal for a physician who is originally denied prior authorization exemption; there is only an appeal process for a physician whose exemption status is revoked. We recommend that the agency clearly defines whether or not there is a different process for an original denial, or if the process of appeal is the same as if exemption was revoked. If it is the same, the rules must clarify how the sample of claims for the appeal would be determined.

Reference: Not mentioned.

David Balat | Director, Right on Healthcare | [redacted]
Noelle Collins | Policy Analyst, Right on Healthcare | [redacted]

13. Texas Medical Association

May 9, 2022

Chief Clerk
Texas Department of Insurance
Austin, Texas 78744-9104

Via email: ChiefClerk@tdi.texas.gov

Re: Proposed amendments to 28 TAC §19.1710 and proposed addition of new 28 TAC Chapter 19, Subchapter R, Division 2, §§19.1730 and 19.1733, concerning requirements prior to issuing an adverse determination and preauthorization exemptions; and proposed amendments to 28 TAC §12.4 and to add new Subchapter G, consisting of §12.601, concerning preauthorization exemptions for independent review organizations (IROs).

Dear Chief Clerk:

The Texas Medical Association (TMA) and the undersigned specialty societies (hereinafter "the Associations"), which together represent more than 55,000 physicians and medical students, appreciate the opportunity to submit these comments on the Texas Department of Insurance's (TDI)'s proposed:

- amendments to 28 TAC §19.1710;
- new 28 TAC Chapter 19, Subchapter R, Division 2, §§19.1730 and 19.1733, concerning requirements prior to issuing an adverse determination and preauthorization exemptions; and

- amendments to 28 TAC §12.4 and addition of new Subchapter G, consisting of §12.601, concerning preauthorization exemptions for independent review organizations (IROs).

As TDI is aware, the Associations have a well-demonstrated interest in reducing the burdens and increasing the transparency of health plan preauthorization requirements. Accordingly, we strongly supported HB 3459 last regular legislative session. While we do have continuing concerns with the rule proposal, we appreciate TDI's efforts thus far to implement this important legislation. Our specific comments on each of the proposed rules are included, below. **Please note that we reserve the right to amend or otherwise modify our comments as the rulemaking process continues.**

I. Proposed §19.1710. Requirements Prior to Issuing an Adverse Determination

First, in proposed amendments to §19.1710, TDI seeks to implement changes concerning the peer-to-peer call occurring prior to an adverse determination. More specifically proposed §19.1710 reads as follows:

§19.1710. Requirements Prior to Issuing an Adverse Determination.

> In any instance in which the URA is questioning the medical necessity, the appropriateness, or the experimental or investigational nature of the health care services prior to the issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician licensed to practice medicine in Texas. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. If the health care service was ordered, requested, or provided, or is to be provided, by a physician, then the opportunity must be with a physician licensed to practice medicine in Texas and who has the same or similar specialty as the physician.
>
> (1) The URA must provide the URA's telephone number so that the provider of record may contact the URA to discuss the pending adverse determination.
> (2) The URA must maintain, and submit to TDI on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

As reflected in the preamble, changes in SECTION 4 of HB 3459 (i.e., amendments to Section 4201.206, Texas Insurance Code) were the apparent impetus for these proposed amendments. While we ***strongly*** support the language of HB 3459 regarding peer-to-peer calls and do not object to the underlined proposed amendment language, above, we also strongly disagree with TDI's assertion in the preamble that a full Texas medical license is not needed to act as the URA "peer" on the call.

As TMA has stated previously in response to TDI Requests for Information (RFIs), we strongly contend that: (1) limitations placed on this type of Texas license make the license ill-suited for the functions performed by the Texas-licensed physician who conducts the peer-to-peer call; and (2) use of a limited license for the

practice of administrative medicine is inconsistent with both the statutory intent and public policy goals of HB 3459 (thereby reflecting that TDI's "long-standing position" should, indeed, change).

A. An administrative license is not appropriate for the functions performed in a peer-to-peer call

More specifically, under Section 155.009, Texas Occupation Code and 22 Tex. Admin. Code § 172.17, the Texas Medical Board (TMB) is authorized to issue a license that is limited to administrative medicine. "Administrative medicine" is defined under the rule as "administration or management utilizing the medical and clinical knowledge, skill, and judgment of a licensed physician, and capable of affecting the health and safety of the public and any person." However, the rule continues by stating that "[a]n administrative license ***does not include the authority to practice clinical medicine***, ***prescribe dangerous drugs or controlled substances, or delegate medical acts or prescriptive authority***." (emphasis added).

We are concerned with these administrative medical licensure limitations regarding clinical practice, given that under the applicable Insurance Code provision (i.e., Section 4201.206), the physician reviewer would be performing very clinically driven functions. For example, the physician will be discussing the patient's treatment plan and the clinical basis for the agent's determination concerning the medical necessity, appropriateness or the experimental or investigational nature of a health care service. Thus, for the functions performed by the physician to truly be "peer-to-peer," the reviewing physician must have full authority to practice clinical medicine in this state.

Peer reviews in other medical contexts are traditionally performed by individuals who have the authority to engage in the same type of practice as the physician or health care professional being reviewed. TMA policy 225.019 acknowledges this and, therefore, expressly provides that:

> [t]he Texas Medical Association advocates that physicians who conduct review for health care decisions in Texas should (1) be in an active practice; (2) possess a nonrestricted license to practice in Texas; and (3) be experienced in the procedures or treatment under review. (For example, not all orthopedic surgeons perform spinal surgery.)

In the context of conducting utilization reviews, maintaining full regular licensure to practice medicine in Texas as a requirement is equally important. While the physician is not being peer reviewed for disciplinary purposes under Section 4201.206, Insurance Code, the physician reviewer can significantly impact the enrollee/patient's care. Thus, TMA policy 160.107 provides, in part, that "… adverse utilization review determinations [should] be made only by physicians who are ***fully licensed*** by the Texas Medical Board … ." (emphasis added).

For a reviewing physician on a peer-to-peer call to recommend denying coverage to an enrollee/patient based upon a determination that a drug being prescribed is medically unnecessary when that physician has no authority to prescribe that drug himself or herself makes little sense from either a clinical or a public policy perspective. And, if an adverse determination is issued due to this disconnect in clinical authority, it is likely to cause unnecessary delay in the patient's care, as the ordering physician would then have to appeal the determination. **Time is of the essence for many patients who are seeking preauthorization for medical services. Injecting further delay into the system is wasteful, at best, but harmful to patient care, at worst.**

B. An administrative medicine license does not reflect the statutory intent of HB 3459 for a peer-to-peer call

Furthermore, the use of a limited administrative medicine license is inconsistent with the statutory intent of HB 3459. HB 3459 was designed to ensure that physicians who perform peer-to-peer calls are: (1) generally accountable to and vetted by the Texas Medical Board; and (2) those who are the most familiar with the standard of care/delivery of care in this state. A limited license to practice administrative medicine in Texas might aid, to a limited extent, in promoting the first goal. But it does not support the second goal (and certainly does not to the extent that a full unrestricted Texas medical license would).

The bill author's/sponsor's statement of intent for HB 3459 expressly provides that:

> [t]here are concerns that the preauthorization and utilization review processes for health care benefit plan coverage may be burdensome to physicians and providers and may have the potential to prevent patients from receiving the care they need. ***H.B. 3459 seeks to address this issue by ensuring that physicians who are the most familiar with the delivery of health care in Texas are involved in utilization reviews for health benefit plan coverage.*** (emphasis added).

Put simply, requiring physicians who perform peer-to-peer calls under Section 4201.206, Insurance Code, to have a full Texas medical license is most aligned with legislative intent in adding the Texas licensure requirement to the peer-to-peer requirements under the law. The Legislature's goal in amending Section 4201.206 was not to reduce the licensure requirements under prior law (i.e., to move it from a full license in one state to an administrative medicine only license in another), but to make it a ***Texas-specific full*** licensure requirement. We recommend that TDI act consistently with this intent, which will promote access to timely, medically appropriate patient care.

For all the foregoing reasons, we recommend that TDI include express language in §19.1710 requiring a full license to practice medicine in Texas for a physician performing the peer-to-peer call under Section 4201.206, Texas Insurance Code, consistent with the intent, language and goals of the underlying legislation.

More specifically, the language should be amended to read as follows:

§19.1710. Requirements Prior to Issuing an Adverse Determination.

> (a) In any instance in which the URA is questioning the medical necessity, the appropriateness, or the experimental or investigational nature of the health care services prior to the issuance of an adverse determination, the URA must afford the provider of record a reasonable opportunity to discuss the plan of treatment for the enrollee with a physician licensed to practice medicine in Texas. The discussion must include, at a minimum, the clinical basis for the URA's decision and a description of documentation or evidence, if any, that can be submitted by the provider of record that, on appeal, might lead to a different utilization review decision. If the health care service was ordered, requested, or provided, or is to be provided, by a physician, then the opportunity must be

with a physician licensed to practice medicine in Texas and who has the same or similar specialty as the physician.

(1) The URA must provide the URA's telephone number so that the provider of record may contact the URA to discuss the pending adverse determination.
(2) The URA must maintain, and submit to TDI on request, documentation that details the discussion opportunity provided to the provider of record, including the date and time the URA offered the opportunity to discuss the adverse determination, the date and time that the discussion, if any, took place, and the discussion outcome.

(b) **In this section, a "physician licensed to practice medicine in Texas" means an individual with a full unrestricted license to practice medicine in Texas issued by the Texas Medical Board.**

II. Definitions.

A. Denial of preauthorization exemption

Next, in proposed §19.1730(2), TDI proposes the following definition for a "denial of a preauthorization exemption":

> Denial of preauthorization exemption – A determination that a physician or provider does not qualify for a preauthorization exemption based on the issuer conducting an evaluation of preauthorization requests and demonstrating that the physician or provider received full and final approval for fewer than 90% of the preauthorization requests made for a particular health care service during the most recent evaluation period.

We recommend that TDI clarify a couple of points in the definition. First, the denial of preauthorization exemption under Section 4201.655(c), Insurance Code, can only occur with regard to a particular health care service for which the physician or provider does not currently have a preauthorization exemption. Thus, to avoid confusion, we recommend more specifically referencing the component of the "evaluation" definition that is in §19.1730(3)(A) in the definition of a "denial of a preauthorization exemption."

Second, we are also concerned that it is unclear what TDI means by "full" approval and ask for TDI clarification of this language. For example, TMA has noted in its prior comments that prior authorizations are generally reviewed on a Current Procedural Terminology (CPT®) code basis, either the specific CPT code or groups of CPT codes within the same family (i.e., inpatient E/M codes). Therefore, it makes sense to review on the basis of the primary CPT code. It is unclear whether the "full" approval language is intended to affect this this type of primary CPT code review.

TMA has also previously stated (in response to TDI RFI's on this topic) that for a three-drug regimen, each drug should be treated as a separate service. Thus, we query: Is the language concerning "full"

approval intended to apply so that a denial of any part of a three-drug regiment results in the service not being approved for granting a preauthorization exemption?

If either of these stated concerns reflects TDI's intent for including the proposed "full" language in the definition, then Associations would object to the "full" qualifier and ask for TDI to strike "full and" from the definition.

Alternatively, if "full" approval means that the issuer is not using preauthorization denials that are currently being appealed to justify its denial of a preauthorization exemption, then we would obviously have less concern with this language. We generally agree that a denial or grant should be based upon final determinations.

Taking into consideration all of our above recommendations, the revised language (aside from addressing the term "full") would read as follows:

> Denial of preauthorization exemption – A determination that a physician or provider does not qualify for a preauthorization exemption based on the issuer conducting an evaluation**, as defined in §19.1730(3)(A),** of preauthorization requests and demonstrating that the physician or provider received full and final approval for fewer than 90% of the preauthorization requests made for a particular health care service during the most recent evaluation period.

B. Evaluation

Next, in proposed §19.1730(3), TDI proposes a definition for an "evaluation" of a preauthorization exemption. Our primary concern with the current drafting of §19.1730(3)(B) is that the language needs to be clearer in terms of specifying that the retrospective review for a continuation/recission analysis is based on a retrospective review of a random sample of claims (as is reflected and intended in Section 4201.655(2) and (3)(b), Insurance Code). We are concerned that the rule language as currently proposed could be erroneously construed as permitting additional claims selected by the issuer to be reviewed as part of the retrospective review to assess continuation or recission of a preauthorization exemption.

To address our concerns, we recommend the following amendments to proposed §19.1730(3)(B):

> (B) with respect to a particular health care service for which a physician or provider has a preauthorization exemption, a **retrospective** review of a random sample of claims **submitted by the physician or provider during the most recent evaluation period** to determine the percentage of claims that would have been approved, based on **meeting** the issuer's applicable medical necessity criteria at the time the service was provided**,[** ~~**as applied under a retrospective review of claims submitted by the physician or provider during the most recent evaluation period,**~~**]** which is conducted for the purpose of evaluating whether to continue or rescind a preauthorization exemption and consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption;

C. Evaluation Period

1. **Proposed §19.1730(4)(A) and Proposed §19.1732(c))**

a. **Proposed §19.1730(4)(A)**

Next, in §19.1730(4), TDI proposes a definition of "evaluation period," which includes an initial evaluation period of January 1, 2022-June 30, 2022. As stated previously, we believe that a reasonable reading of the bill's timing requirements (under SECTION 6 of the bill and Section 4201.655, Texas Insurance Code) would permit plans to grant preauthorization exemptions based upon a review of requests submitted prior to January 1, 2022, since the status of any preauthorization requests would not be impacted until the first exemption is granted. This would be a preferred approach, as we feel that a rapid implementation of the bill would best serve the health of Texans. In passing this bill, the Legislature recognized that patient health can't wait.

However, we understand the proposed evaluation period is likely based upon a more conservative reading of SECTION 6 of the bill. Thus, (as stated previously) we are generally supportive of that time frame, but we would strongly object to any further delay in defining the initial evaluation period.

b. **Proposed §19.1732(c)**

More concerning than the initial timeframe referenced in proposed §19.1730(4)(A) is the additional delay that TDI has added onto this evaluation period under proposed §19.1732(c) with regard to timeframes for notices of grants and denials of preauthorization exemptions. More specifically, §19.1732(c) states the following:

> (c) For the initial evaluation period of January 1 through June 30, 2022, an issuer must provide notice granting or denying a preauthorization exemption **no later than October 1, 2022**. For subsequent evaluation periods during which a physician or provider does not have a preauthorization exemption, an issuer must provide notice to the physician or provider granting or denying a preauthorization exemption **no later than two months** following the day after the end of the evaluation period. Notice need only be provided for a particular health care service if the issuer was able to complete an evaluation of at least 20 preauthorization requests, as provided in §19.1731(b) of this title (relating to Preauthorization Exemption). **(emphasis added).**

Put simply, the Associations oppose the language in 19.1732(c) as currently drafted. If TDI moves forward with the proposed initial January 1- June 30, 2022 evaluation period for granting or denying of preauthorization exemptions, the law would technically require issuers to provide initial notices granting exemptions no later than five days after the physician or provider qualifies for the exemption. *See* Tex. Ins. Code §4201.659(d).

We believe this statutory five-day timeframe (after the close of the evaluation period) is generally reasonable for both grants and denials of preauthorization exemptions, because for the granting or denial, the issuer's review is of the outcomes of actual and final preauthorization requests (which requires no requests for medical records and should involve no additional burdens to physicians or providers). Instead, it requires issuer compilation of statistics and data/information to demonstrate whether the 90 percent approval threshold was satisfied or not satisfied.

However, we understand that TDI's publication of rules in June or early July may inhibit compliance with this timeframe for the initial grant or denial of a preauthorization exemption. Thus, if TDI intends to move forward with a longer period for the initial notice granting or denying a preauthorization exemption (to account for the adoption of final rules), we recommend that TDI require the notice of the initial granting or denial to be provided no later than August 1, 2022. This would provide ample time for issuers to provide the notice, as reflected in the amendments to §19.1732(c), below (while also accounting for TDI's rule adoption). We would then ask that the statutory five days' notice requirement be applied for the subsequent periods, as noted, below.

> (c) For the initial evaluation period of January 1 through June 30, 2022, an issuer must provide notice granting or denying a preauthorization exemption no later than **August** **[~~October~~]** 1, 2022. For subsequent evaluation periods during which a physician or provider does not have a preauthorization exemption, an issuer must provide notice to the physician or provider granting or denying a preauthorization exemption no later than **five days** [~~**two months**~~] following the day after the end of the evaluation period. [~~**Notice need only be provided for a particular health care service if the issuer was able to complete an evaluation of at least 20 preauthorization requests, as provided in §19.1731(b) of this title (relating to Preauthorization Exemption).**~~][1] (emphasis added).

2. **Proposed §19.1730(4)(C)**

Next, it is unclear how the Department intends to implement (C) of Proposed §19.1730(4). In (C), the Department proposes the following:

> (C) for a notification of a preauthorization exemption rescission as provided in Insurance Code §4201.655(a), the evaluation period is the six-month period an issuer determines or the subsequent six-month periods that follow, but there may not be more than two months between an evaluation period ending and the provision of notice under §19.1732 of this title (relating to Notice of Preauthorization Exemption Grants, Denials, or Rescissions).

We assume that the intent is that for proposed recissions, in accordance with §4201.655(a), Insurance Code, the issuers could only provide notices of recission in January and June of each year. Then, the proposal would permit plan-determined six-month evaluation periods for the recissions, provided that notice of recission (in either January or June of the year) is no more than two months after the evaluation period ends. We have some concerns regarding plan-determined evaluation periods, as this could promote issuer manipulation of the preauthorization exemption results and lead to shorter preauthorization exemption durations. Thus, if TDI moves forward with this framework, TDI must: (1) make it clear that a plan cannot duplicate any months from an evaluation period that was already reviewed; and (2) adopt language similar to that in proposed §19.1732, which states that a preauthorization exemption lasts for at least six months

[1] Note that our additional comments on §19.1732(c), regarding the lack of notice required unless the issuer was able to complete 20 preauthorization requests, are discussed separately later in this letter.

before it can be rescinded; Otherwise, we are concerned that issuers may attempt to shorten the exemption beyond the minimum intended under the law (and may duplicate claims reviews).

D. Particular health care service

Next, in §19.1730(6), TDI proposes the following definition of a "particular health care service":

> A health care service, **including a prescription drug**, that is subject to preauthorization as listed on the issuer's website under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans). (emphasis added)

1. Comments on the inclusion of "prescription drugs" in the "particular health care service" definition

First, we thank TDI for expressly referencing "prescription drugs" in the language concerning "a particular health care service" with regard to the health care services subject to a preauthorization exemption under the law. We **strongly support** retaining an express reference to prescription drugs in the "particular health care service" definition as: (1) prescription drugs are covered by the plain language of the law; and (2) health plan stakeholders argued (during the TDI request for information process) that prescription drugs were ***not*** included (thus, clear direction is needed from TDI in the rules).

In case health plan stakeholders continue to argue that prescription drugs or medical equipment/supplies are not included, we strongly disagree and note the following for TDI's consideration, once again.

HB 3459's preauthorization exemption applies when an HMO or insurer has approved or would have approved not less than 90 percent of the preauthorization requests submitted by the physician or provider for a particular "health care service." *See* Section 4201.653, Insurance Code. "Health care services" are defined under the bill (i.e., Section 4201.652, Insurance Code) as having the same meaning as the same term under Section 843.002, Insurance Code. Notably, Section 843.002's definition of "health care services" is ***very*** expansive. That definition is as follows:

> "Health care services" means services provided to an individual to prevent, alleviate, cure, or heal human illness or injury. The term includes:
>
> (A) pharmaceutical services;
>
> (B) medical, chiropractic, or dental care;
>
> (C) hospitalization;
>
> **(D) care or services incidental to the health care services described by Paragraphs (A)-(C);** and
>
> (E) services provided under a limited health care service plan or a single health care service plan. (emphasis added).

Importantly, the above definition begins with an extremely broad general definition of "health care services," which is followed by an inclusive (not exclusive) itemized example list that the term "includes." Under the

Section 311.005, Government Code, "includes" is a "[term] of enlargement and not of limitation or exclusive enumeration, and use of the [term] does not create a presumption that components not expressed are excluded." Thus, "health care services" includes, ***but it not limited to***, medical care, pharmaceutical services, hospitalizations, and the other care and service listed in the definition. For this reason, the bill applies not only to the listed services but also **all other care or services captured by the general definition**.

TAHP's September 20, 2022 letter on TDI's RFI argued, however, that prescription drugs fall outside the definition of the statutory term of "health care services" because they differ from "pharmaceutical services" (i.e., an enumerated service under Paragraph (A)).

The Associations continue to strongly disagree with this interpretation for multiple reasons. First, TAHP's argument in its letter seemed to be largely grounded upon: (1) a distinction between pharmaceutical services and prescription drugs found in coding conventions, which is technical in nature and not determinative of a plain reading of the statute when determining the scope of the exemption; and (2) citations to certain laws and definitions that are not applicable to HB 3459. Two of the provisions cited in TAHP's letter are not in the same subchapter/chapter of the Insurance Code as the gold carding provisions of HB 3459 or Chapter 843 and have nothing to do with this legislation. In other words, those statutory citations are not controlling and should have no bearing on TDI's interpretation of a term used under HB 3459.

For example, TAHP cited to HB 2090 as support for its argument that "health care services do not include products like drugs." But, the definition referred to by TAHP in HB 2090 is in Chapter 1662 of the Insurance Code (not the preauthorization exemption subchapter of chapter 4201) and does not use the same definition of "health care services" as is used under HB 3459. Thus, we strongly contend that HB 2090's definition of health care services is inapposite in the context of HB 3459.

TAHP also cited to a TDI rule concerning "basic health care services" to support its argument that prescription drugs and products are not included in the definition of "health care services" under HB 3459. This is an interesting citation, because TDI's basic health services rule (i.e., 28 TAC §11.508), which is a subset of the definition used under HB 3459, actually includes some express references to drugs (see, e.g., 11.508(a)(J)(2) listing inpatient hospital services as including "drugs, medications, biologicals…" and also separately listing immunizations. **Thus, we contend that this citation actually militates against TAHP's argument**. (Notably, an HMO can provide health care services other than "basic health care services." See, 28 TAC 11.512 (listing among optional benefits/services, prescribed drugs and medicines incident to outpatient care; and durable medical equipment for home use). It was clearly the Legislature's intent to capture these other services in the expansive definition used under HB 3459.

Second, even if TAHP's argument of differentiating between pharmaceutical services and prescription drugs were taken as true in this context (which, as noted above is highly questionable in our opinion), the health plan conclusion that drugs or products, therefore fall outside the scope of the "health care services" definition does not follow for the following two reasons:

- **TAHP's argument fails to recognize the Code Construction Act's principle that an item does not have to be expressly enumerated in an inclusive list in order to be captured by a definition**. Again, the list in the term is inclusive, not exclusive. We strongly argue that prescription drugs and supplies/products are captured by the general definition. In other words, prescription drugs are

services provided to an individual to prevent, alleviate, cure or heal human illness or injury. Thus, express enumeration (through the example list) is unnecessary for prescription drugs or supplies/products to be captured by the definition.

- **Next, TAHP's argument fails to recognize that Paragraph (D) of the definition includes "care or services incidental to the health care services described by Paragraphs (A)-(C)."** Clearly, prescription drugs, supplies and other products are "care or services incidental to" pharmaceutical services and medical care. Thus, these drugs, supplies and products fall within the plain language of Paragraph (D) of the definition.

Finally, we also disagree with TAHP's (previously stated) purported public policy rationale for arguing that prescription drugs should not be included in the bill (i.e., TAHP's argument concerning opioid drugs). The Texas Legislature has placed many other checks on prescribing medications (including regulation by licensing agencies and for opioids, benzodiazepines, barbiturates, and carisoprodol, required prescription drug monitor program checks). Thus, this is not a compelling reason to limit a plain language application of the law.

For all the foregoing reasons, we strongly contend that preauthorization exemption provisions of HB 3459 must apply to health care services, including prescriptions, supplies, products and procedures. **We, therefore,: (1) strongly support TDI's express reference to "prescription drugs" in the definition of "particular health care services"; (2) ask that TDI include prescription drugs expressly in any adopted definition of "particular health care service"; and (3) ask that TDI further clarify the intended broad application of the bill, consistent with the plain language of the bill, by also expressly referencing x-rays, labs, products, medical equipment, and supplies as being part of the definition of a "particular health care service."** Anything less than an expansive application of the term "health care services," would thwart the Legislature's goal of removing unnecessary barriers to patient access to care.

With this in mind, we recommend modifying the proposed definition as follows:

> A health care service, **as defined by 4201.651(2), Insurance Code,** including a prescription drug**, lab, x-ray, medical equipment, product, or supply,** that is subject to preauthorization as listed on the issuer's website under §19.1718(j) of this title (relating to Preauthorization for Health Maintenance Organizations and Preferred Provider Benefit Plans). (emphasis added)

2. Comments on tying the "particular health care service" definition to issuer website postings

With regard to the cross reference to the issuer's website, while we can understand from a consistency standpoint (with common definitions of "health care services" being used in §§843.002 and 843.3481, Insurance Code), why TDI would tie the definition of a "particular health care service" to what is posted on the plan's website, we do have some concerns about transparency and how this affects the implementation of HB 3459's requirements.

First, for example, if a plan makes a health care service subject to preauthorization (i.e., still imposes a preauthorization requirement) but violates §19.1718(j) by failing to post that requirement as required in §19.1718(j), the physician or provider should still be eligible for a preauthorization exemption. A plan's failure to post on its website should not be a method for an issuer to unilaterally circumvent HB 3459's

requirements. Rather, the failure to post should instead, evidence multiple violations on the plan's parts (both of the posting requirement law and the gold carding exemption law).

Second, we are concerned that although §19.1718(j) includes requirements for conspicuous posting of the preauthorization information, compliance with those requirements is difficult to assess as health plan websites are challenging to navigate.

For example, 19.1718(j)(2)(D) requires that plans post an accurate list of medical or health care services for which the HMO or preferred provider benefit plan requires preauthorization that includes the following information specific to each service:

(i) the effective date of the preauthorization requirement;

(ii) a list or description of any supporting documentation that the HMO or preferred provider benefit plan requires from the physician or health care provide ordering or requesting the service to approve a request for that service;

(iii) the applicable screening criteria, which may include CPT codes and ICD codes; and

(iv) statistics regarding the HMO's or the preferred provider benefit plan's preauthorization approval and denial rates for the service in the preceding calendar year, including statistics in the following categories:

(I) physician or health care provider type and specialty, if any;

(II) indication offered;

(III) reasons for request denial;

(IV) denials overturned on internal appeal;

(V) denials overturned by an independent review organization; and

(VI) total annual preauthorization requests, approvals, and denials for the service.

In attempting to survey several plan websites (e.g., Aetna, UnitedHealthcare, Cigna and BCBSTX) to see what was posted, we note that it appears that only BCBSTX clearly specified that the preauthorization requirements were for fully insured plans. The others had broader applicability, which was difficult to follow. And, in our initial search, we didn't come across the statistics referenced above regarding approval and denial rates on any of the sites.

From an initial review, it looks like issuers are generally listing prescription drugs and health care services subject to preauthorization on their websites in some form but there is some variation in format. Some appear to be listing drug dosages, at least in some limited instances, and others do not. Most seem to be using HCPS codes generally.

This all underscores a lack of uniformity and a need for TDI to do a deeper dive on postings and to set clearer parameters on the definition of a "particular health care service," as it is important to avoid any potential plan manipulation of preauthorization exemption qualification based upon how the service is posted.

For example, requiring a particular dosage to constitute a "particular health care service" would be problematic and greatly reduce the application of HB 3459 (if TDI's proposed 20 minimum preauthorization request submission language, discussed later, moves forward). The Associations contend that for drug approvals, the drug should be the basis for the preauthorization exemption determination (rather than the dosage). Although medications may have different indications for different dosages and there may be different dosages used for different conditions, dosing will be more difficult to parse and apply in the context of HB 3459. Dosing issues will also be addressed by the standard of care, which is enforceable through other mechanisms outside of preauthorization (e.g., the Texas Medical Board and medical professional liability).

In summary, while we do not necessarily oppose tying the definition of a particular health care service to the website posting ***in theory*** (if done right and with clearer parameters developed by TDI and more transparency), we think TDI first needs to: (1) adopt clearer regulatory parameters for a "particular health care service" posting to avoid any potential gamesmanship and promote transparency; (2) conduct additional monitoring of plan websites for compliance with statutory and regulatory requirements on posting of preauthorization requirements; and (3) make sure that goals of HB 3459 would be addressed through this tying to website posting;

E. Preauthorization exemption (§19.1730(9), treating physician §19.1730(11), and §19.1731(d))

Next, in §19.1730(9), TDI proposes the following definition of a "preauthorization exemption":

> (9) Preauthorization exemption--A privilege obtained under this division in which a physician or provider is not subject to a preauthorization requirement that otherwise applies with respect to a particular health care service. The preauthorization exemption applies both to care rendered by a treating physician or provider and to care ordered by a physician or provider who is acting in his or her capacity as a treating physician or provider.

In response to this proposed language, we first recommend that TDI replace the word "privilege" with "exemption." As there are rights and payment protections associated with a preauthorization exemption granted under the law, we are concerned that the word "privilege" fails to accurately reflect the legal status of an exemption.

Next, we appreciate TDI's inclusion in the preauthorization exemption clarifying language stating that the preauthorization exemption applies both to care rendered by a treating physician or provider and to care ordered by a physician or provider who is acting in his or her capacity as a treating physician or provider. Inclusion of treating physicians/providers on both sides of ordering/referring and rendering is critical for appropriate functioning of the preauthorization exemptions under the bill.

However, we are concerned that the language in the "treating physician or provider" definition is too restrictive, as it defines, in part, the "treating physician or provider" as "the physician or other provider who is ***primarily responsible*** for a patient's health care for ***an illness or an injury***." (emphasis added). It then continues to say that a "treating provider" includes a rendering physician or provider or a referring physician or a provider.

The "primarily responsible" language and the "illness" or "injury" language could (inappropriately) be construed to significantly narrow the scope of the law's application and eligibility for a preauthorization exemption (as the law has no such limitation on granting of the preauthorization exemption and does not use the term "treating physician or provider"). This will have a major impact and cause great confusion in its implementation, particularly given the proposed language in 19.1731(d), which significantly affects physician and provider payment:

> (d) Other than care ordered by a treating physician or provider that has a preauthorization exemption that is then rendered by a physician or provider that does not have an exemption, a treating physician may not rely on another physician's preauthorization exemption. If a treating physician does not have a preauthorization exemption and relies on another physician's preauthorization exemption in violation of this subsection, an issuer may consider that treating physician as failing to substantially perform the health care service under Insurance Code §4201.659, concerning Effect of Preauthorization Exemption, and may reduce or deny payment for that service on that basis.

We, therefore, oppose the language as currently drafted and ask that TDI modify the proposed definition of "treating physician or provider" as follows:

> (13) Treating physician or provider—**A** [~~**The**~~] physician or other provider who is [~~**primarily**~~] **treating or** responsible for a patient's health care for an illness**, physical or mental condition, disease, or disorder,** [~~or~~] injury**, physical deformity, or providing preventative care**. A "treating physician or provider" includes a rendering physician or provider or a referring **or ordering** physician or provider.

We also recommend that:

- § 19.1731(d) be modified throughout to also apply to treating providers. The first phrase in subsection (d) includes the defined term "treating physician or provider" but the later references appear to inadvertently omit the other component of that defined term (i.e., "provider").
- TDI strike the last sentence of subsection (d), as providing a service in erroneous reliance on another physician or provider's exemption is not the same as failure to substantially perform a service from a plain language standpoint. Further, the language under Insurance Code §4201.659 applies when the physician or provider has qualified for a preauthorization exemption and the first sentence of subsection (d) would imply that a preauthorization exemption is not in effect for (and could not be used by) the physician or provider to whom the issuer attempts to reduce or deny payment.

Our recommended amendments would, therefore, read as follows:

> (d) Other than care ordered by a treating physician or provider that has a preauthorization exemption that is then rendered by a physician or provider that does not have an exemption, a treating physician **or provider** may not rely on another physician's **or provider's**

preauthorization exemption. [~~If a treating physician **or provider** does not have a preauthorization exemption and relies on another physician's **or provider's** preauthorization exemption in violation of this subsection, an issuer may consider that treating physician **or provider** as failing to substantially perform the health care service under Insurance Code §4201.659, concerning Effect of Preauthorization Exemption, and may reduce or deny payment for that service on that basis.~~]

However, if TDI, over our stated objections, moves forward with the language in (d), we strongly recommend that TDI, at the very least, include additional language in (d) limiting the ability of the issuer to utilize Insurance Code §4201.659 in this scenario, as follows:

(d) Other than care ordered by a treating physician or provider that has a preauthorization exemption that is then rendered by a physician or provider that does not have an exemption, a treating physician **or provider** may not rely on another physician's **or provider's** preauthorization exemption. If a treating physician **or provider** does not have a preauthorization exemption and relies on another physician's **or provider's** preauthorization exemption in violation of this subsection, an issuer may consider that treating physician **or provider** as failing to substantially perform the health care service under Insurance Code §4201.659, concerning Effect of Preauthorization Exemption, and may reduce or deny payment for that service on that basis. **However, an issuer may not consider the treating physician or provider as failing to substantially perform the health care service under Insurance Code §4201.659 and may not reduce or deny payment on that basis if the treating physician or provider violates the subsection after making a good faith attempt to confirm the physician or provider's ability to rely on another physician or provider's preauthorization exemption and either receiving no timely response from the issuer or receiving a response from the issuer indicating that the physician or provider could rely on another physician's or provider's preauthorization exemption. A noncommittal response from an issuer shall be considered no timely response for purposes of this subsection.**

Finally, as we are not clear on TDI's intent with this language or its application in certain potential fact patterns, we ask that TDI provide more information on this issue, including illustrative/hypothetical examples to aid understanding its application and impact. We also ask for another opportunity to revise or amend our comments on this section as more information is gathered on the intended impact.

F. Random sample

Next, in §19.1730(11), TDI proposes the following definition of a "random sample":

(11) Random sample—A collection of at least 5 but not no more than 20 claims for a particular health care service, selected without method or conscious decision, for the purpose of evaluating a physician's or provider's continued eligibility for a preauthorization exemption.

The Associations are concerned that this proposed definition of "random sample" does not sufficiently: (1) reflect what a true "random sample" is; (2) set parameters to avoid gamesmanship or cherry picking

in issuer selection of random samples; and (3) address TDI's prior questions regarding what happens if there are fewer than 5 total claims for a particular health care service during the relevant evaluation period.

We, therefore, oppose the current definition of "random sample." To address these concerns, we recommend that TDI:

- modify the language to reflect that the sample must be selected through a method that gives each claim an equal probability of being chosen for the sample;
- specify that (consistent with the equal probability of selection requirement and language in Section 4201.655, Insurance Code) the issuer is required to review the maximum amount of claims available within the "at least 5 to no more than 20" range submitted by the physician or provider for the relevant evaluation period. For example, if only five claims have been submitted by the physician or provider during the relevant period for the particular service, five claims would be reviewed and would be sufficient for the determination. If twenty or more claims have been submitted for the particular service during the relevant evaluation period, then the issuer should be required to review twenty claims prior to making the determination. This will promote having that most robust data set within the statutory range reviewed while capping the sample (as is reflected by the law at 20) to avoid any unnecessary burden on the physician involved with the retrospective review of the up to 20 claims in the random sample;
- specify that any selection of the sample from a pool of more than 20 claims must be generated through simple random sampling (using randomly generated numbers to select the sample) and expressly state that an issuer may ***not*** select based upon specific metrics (e.g., patient cohorts or site of service); and
- provide language to deter cherry picking in the selection of the random sample by expressly: (1) requiring an issuer to maintain records demonstrating compliance with the law and rule's random sample selection requirements; and (2) stating that if the issuer does not maintain records meeting this burden, TDI must presume the sampling was not random and automatically continue any preauthorization exemption that was being reviewed using a non-random sample.

To accomplish these recommendations, we propose the following amendments to TDI's proposed language:

(11) Random sample—A collection of at least 5 but no more than 20 claims for a particular health care service, selected **through a method that gives each claim an equal chance of being chosen for the sample** [~~**without method or conscious decision**~~], for the purpose of **conducting an evaluation, as defined by 19.1730(3)(B) of [**~~evaluating a~~] physician's or provider's continued eligibility for **or recission of** a preauthorization exemption. **The random samples must be selected as follows:**

(A) If only five to 20 claims were submitted by the physician or provider during the most recent evaluation period, all of the claims submitted by the physician or provider during the most recent evaluation period will constitute the random sample;

(B) If more than 20 claims were submitted by the physician or provider during the most recent evaluation period, 20 of those claims will constitute the random sample but those claims must be selected through simple random sampling, which requires using

randomly generated numbers to choose a sample. Specific metrics may not be applied by the issuer in selecting a random sample, such as specific patient cohorts or site of service, which may favor the issuer's decision-making. An issuer must maintain records demonstrating the simple random sampling used for each sample under this paragraph. If an issuer does not maintain records and the physician or provider files a complaint with the department or the department performs an audit or review regarding the sample selection, the department shall presume that the sampling was not random and automatically continue any preauthorization exemption that was being reviewed using a non-random sample.

G. Recission of preauthorization exemption

Next, in §19.1730(12), TDI proposes the following definition of a "recission of preauthorization exemption":

> (12) Recission of preauthorization exemption – An adverse determination regarding a preauthorization exemption based on an evaluation of claims by an individual licensed to practice medicine in this state in which the issuer would have fully approved fewer than 90% of claims for a particular health care service.

The Associations are concerned that the language in the definition of a "recission of preauthorization exemption" as currently proposed in §19.1730(12) fails to: (1) clearly reference that a recission must be based on a random sample of claims under §4201.655, Insurance Code; and (2) reflect other limitations or conditions imposed on recissions under the law and the proposed rules. For example, the proposed language references the requirement under Section 4201.655(b), Insurance Code that an individual licensed to practice medicine in this state must make the determination. However, it omits statutory language specifying that if the determination is in regard to an exemption for a physician, the decision must be made by an individual licensed to practice medicine in this state ***who has the same or similar specialty as that physician***. This is a serious oversight.

We, therefore, recommend the following changes to this proposed definition as reflected below:

> Recission of preauthorization exemption – An adverse determination regarding a preauthorization exemption**'s continuation** based on an evaluation**, as defined in (3)(B) of this section,** of **a random sample of** claims **and determination made** by an individual licensed to practice medicine in this state in which the issuer would have **[~~fully~~]** approved fewer than 90% of claims for a particular health care service**. For a determination under this paragraph with respect to a preauthorization exemption held by a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as the physician.**

The Associations also recommend that some of the above language be repeated in the body of the rule to encourage compliance with the law and to aid in readability.

III. Proposed §19.1731. Preauthorization Exemption

Next, in proposed 19.731(b), TDI proposes the following:

(b) With respect to a particular health care service for which a physician or provider does not have a preauthorization exemption, an issuer must conduct an evaluation of all preauthorization requests submitted by the physician or provider during the most recent evaluation period that were finalized prior to the evaluation and may not include a request that is pending appeal at the time the data is analyzed. **The evaluation must be based on no fewer than 20 preauthorization requests**. (emphasis added)

A. Proposed §19.1731(b)

While we agree that to make an assessment of an initial grant or denial of a preauthorization exemption, an issuer must conduct an evaluation of all preauthorization requests submitted by the physician or provider during the most recent evaluation period, we are ***gravely*** concerned that TDI has proposed a minimum threshold of 20 preauthorization requests for an evaluation under that subsection **(which effectively makes those submitting fewer than 20 final preauthorization requests in a particular period ineligible for an exemption)**. We strongly oppose this language because: (1) it conflicts with the letter and the spirit of the law; and (2) it will have a negative impact on physicians and their patients, as set forth below.

1. Objections Based Upon Lack of Statutory Authority/Conflict with the Plain Language of the Law

First, the Associations emphasize that the law does NOT contain such a requirement concerning 20 preauthorization requests in order to be eligible for a review for a grant or denial of an exemption, nor is TDI authorized to impose such a requirement via rulemaking. To illustrate, a brief review of the statutory language, as well as the legislative history on this bill, may be helpful.

To that end, Section 4201.653, Insurance Code is a logical starting place. In Section 4201.653, Insurance Code, the Legislature sets forth the standard to grant a preauthorization exemption (as well as the timeframe under which evaluations that must be conducted). More specifically, it states the following:

(a) A health maintenance organization or an insurer that uses a preauthorization process for health care services may not require a physician or provider to obtain preauthorization for a particular health care service *if,* in the most recent six-month evaluation period, as described by Subsection (b), the health maintenance organization or insurer has **approved** or would have approved ***not less than 90 percent of the preauthorization requests submitted by the physician or provider for the particular health care service*.**

(b*)* Except as provided by Subsection (c*),* a health maintenance organization or insurer shall evaluate whether a physician or provider qualifies for an exemption from preauthorization requirements under Subsection (a) once every six months.

(c) A health maintenance organization or insurer may continue an exemption under Subsection (a) without evaluating whether the physician or provider qualifies for the exemption

Notably, subsection (a) provides a straight 90 percent approval threshold of the requests (meaning **all** the requests) submitted by the physician or provider for the particular health care service during the relevant period. In other words, it includes no limiting language regarding a minimum number of preauthorization requests/services that must be reviewed for eligibility during a particular evaluation period.

Similarly, in order to deny a preauthorization exemption, Section 4201.655(c), Insurance Code states the following (cross referencing back to the straight 90 percent approval rate of all preauthorization requests listed in Section 4201.653, Insurance Code):

> (c) A health maintenance organization or insurer may deny an exemption from preauthorization requirements under Section 4201.653 only if:
>
> (1) the physician or provider does not have the exemption at the time of the relevant evaluation period; and
>
> (2) the health maintenance organization or insurer provides the physician or provider with actual statistics and data for the relevant preauthorization request evaluation period and detailed information sufficient to demonstrate that the physician or provider **does not meet the criteria for an exemption from preauthorization requirements for the particular health care service under Section 4201.653**. (emphasis added).

Again, this statutory language includes no reference to basing an evaluation on a minimum number of preauthorization requests reviewed during a particular evaluation period. It, therefore, follows that (under the law) an issuer ***must*** review and grant a preauthorization exemption to a physician or provider for a particular health care service if the statutory 90 percent approval threshold is met, ***regardless of the number of preauthorization requests a physician or provider has submitted during the relevant evaluation period*** (**i.e., even if it is only one**). The issuer must also provide the required notice in such an instance.

To further illustrate, if a physician had four requests during a relevant evaluation period and all were approved for that particular service, the plain language of the law dictates that (when an existing preauthorization exemption is not in place): (1) the issuer must evaluate these claims for the relevant evaluation period; and (2) the physician must be granted a preauthorization exemption for that service, because the physician would have a 100 percent approval rate.

For TDI to propose a rule that would systematically and categorically deny a preauthorization exemption to physicians or providers who meet the 90 percent approval standard set forth in Section 4201.653, Insurance Code (i.e., meet ***all*** the required statutory requirements) yet have fewer than 20 preauthorization requests (or any other arbitrarily selected minimum) submitted during the relevant evaluation period for that service would be tantamount to TDI rewriting the law. This is an authority the agency simply does not have.

The Associations note that the Texas Legislature knows how to create a minimum preauthorization request submission (and review) number threshold for a preauthorization exemption if it had wanted one to apply to this law. In fact, the filed version of this very bill (HB 3459 itself) included such a minimum (which was set at five). More specifically, see Section 843.3483(b) of the filed version of HB 3459, which states as follows:

> Each exemption from preauthorization requirements described by (a) shall last for one calendar year ***and is only available for a health care service for which the physician or provider submitted at least five preauthorization requests in the preceding calendar year***. (emphasis added).

Importantly, neither this language from the filed version of the bill nor any similar statutory language creating or permitting TDI to create such a minimum may be found in HB 3459, as passed into law. The removal and conspicuous absence of this language from the law, as passed, reflects the Texas Legislature's clear rejection of any minimum.

Yet, TDI has decided not only to unilaterally write such a provision back into the law (via rulemaking), but to double down on its rewrite by making the language many times more restrictive than that which was included (and rejected by the Texas Legislature) in the filed version of the bill (i.e., rather than imposing a minimum of 5 preauthorization requests over a one year period, TDI now proposes a minimum of 20 preauthorization requests over half the time – a six month period).

Due to this clear conflict with/lack of authority under the law, the Associations strongly oppose this proposed language. **It is important to reiterate that we would strongly oppose any minimum (whether it is 20 or any lesser number) being promulgated by TDI due to a lack of statutory authority. However, we are vehemently opposed to such a high minimum due to its particularly harsh impact on physicians and patients. Thus, if TDI moves forward with this proposal over our stated objections and despite a clear lack of statutory authority, we urge TDI to still reexamine and significantly reduce this number to reduce its negative impact on patients and physicians.**

2. Objections Based Upon Public Policy Considerations and the Proposal's Impact on Patients and Physicians

If TDI moves forward with its proposed (or some other proposed) minimum prior authorization review requirements, the proposal could severely reduce the number of physicians eligible to receive a preauthorization exemption (and will, therefore, result in harm to both patients and physicians). A TDI-created minimum will negatively impact all enrollees of the issuer treated by physicians for the relevant services who would have otherwise benefitted from the physician's exemption status. The result will be adding back into the system unnecessary delays in care and waste. This is at cross purposes with very goals that prompted the Legislature to pass this legislation.

We remind TDI not to read the 20 minimum in isolation, but to understand the impact of the 20 minimum when read with other provisions in the rule proposal. For example, the 20 minimum becomes even more difficult to satisfy when reading the language in conjunction with the requirement for the review to be based upon requests that were both submitted and finalized (not pending appeal) during the relevant six-month period.[2]

[2] We are also concerned that health plans may be able to game the twenty minimum by taking other actions, e.g., listing prescription drugs by doses (to each constitute a separate health care service), thus making the twenty threshold in six months unachievable.

These two provisions, working in concert, could enable issuers to potentially game the system in order to determine which physicians or providers are eligible for preauthorization exemptions, ultimately at the expense of timely access to medically necessary care.[3] To wit, this language (when combined) encourages issuers to initially deny preauthorization requests in order to delay and reduce the number of finalized requests available to be reviewed during the relevant evaluation period (i.e., to ensure the 20 minimum review threshold is not satisfied).

Note that we agree that it would be common sense to assess eligibility for a preauthorization exemption grant or denial based upon the final preauthorization decision (i.e., after appeals) approval rates. An initial denial that is subsequently overturned should still count as an approval for preauthorization exemption purposes, because the physician or provider was ultimately found to be providing medically necessary and appropriate care. Thus, we would generally support such a requirement without a minimum request threshold.

However, applying the minimum prior authorization request review that TDI created in §19.1731(b) in conjunction with this final approval requirement only makes it: (1) more difficult for physicians to obtain a preauthorization exemption request; (2) easier for issuers to game the process; and (3) invites abuse and improper initial denials of preauthorization requests, thereby unnecessarily delaying medically necessary care and harming patients. For all the foregoing reasons, we therefore, strongly recommend that TDI retain the final approval language in subsection (b), but strike the minimum threshold language (and not replace it with any other minimum threshold) as reflected below:

> (b) With respect to a particular health care service for which a physician or provider does not have a preauthorization exemption, an issuer must conduct an evaluation**, as defined by 19.1730(A),** of **outcomes of** all preauthorization requests submitted by the physician or provider during the most recent evaluation period that were finalized prior to the evaluation and may not include a request that is pending appeal at the time the data is analyzed. [~~**The evaluation must be based on no fewer than 20 preauthorization requests.**~~**]**

3. Objection to the 20 minimum language on other grounds

Finally, we have also heard concerns that some stakeholders might read the no fewer than 20 prior authorization requests language in TDI's proposal not just an additional limitation on eligibility on preauthorization grants (and eligibility reviews), but also as authorization for the issuer to select a sample of 20 preauthorization request outcomes if there were more requests during that time. We do not believe that was TDI's intent with regard to initial grants and denials, as the first sentence in subsection (b) says the evaluation must be of **all** preauthorization requests submitted by the physician or provider during the most recent evaluation period.

But, if that is what TDI intended with this language, we would oppose that language as well. Reviews to grant or deny preauthorizations, under the law, are to be based upon a review all the actual outcomes for the relevant evaluation period (without using a sample). This should be a fairly simple data tracking/compilation process using the actual outcome statistics and data (because the outcomes are already completed through the plans normal processes) to assess whether the 90% approval threshold is met. Thus, a sample is not only

not authorized by the law in this context (unlike where it is expressly required for recission determinations) but is also not needed to conduct a quick assessment of the physician or provider's eligibility status.

The Associations ask that, if TDI believes there is any continuing confusion in this area, TDI provide more direction to this effect in its rulemaking (which could also be added on to subsection (b) as explanatory language).

B. **Proposed §19.1731(c)**

Next, in proposed 19.1731(c), TDI discusses evaluations to determine whether to rescind a preauthorization exemption. Previously, during the RFI process, it appeared (based upon questions TDI was posing) that there was some confusion regarding when random samples are used under HB 3459. Thus, before commenting specifically on proposed §19.1731(c), we reiterate that under the bill, the random sampling of claims comes into play when an issuer is attempting to rescind a preauthorization exemption that has already been granted (not for a granting or denial of a preauthorization exemption).

More specifically, Section 4201.654, Insurance Code, provides that an HMO or insurer may rescind an exemption from preauthorization requirements under Section 4201.653 ***only if*** certain requirements are met. One of those requirements is that the HMO or insurer must have made a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted by the physician or provider during the most recent evaluation period, that less than 90 percent of the claims for the particular health care service met the medical necessity criteria that would have been used for the service.

If there is an insufficient number of claims to constitute a random sample (e.g., four or fewer claims), *ipso facto,* this recission criterion cannot be satisfied and the physician or provider's gold card exemption continues for that particular service. This is made clear through the language in Section 4201.654, Insurance Code, which provides that "[i]f a health maintenance organization or insurer does not finalize a recission determination as specified in Subsection (a) [which is an impossibility given the inadequate sampling number in cases of 4 or fewer claims], then the physician or provider is considered to have met the criteria under Section 4201.653 to continue to qualify for the exemption."

The bill's default status of a continuation of an exemption (when the bill's the basic sample requirements cannot be satisfied – e.g., when four or fewer claims are submitted in a six-month evaluation period) makes sense from a policy perspective, because the physician has already had a history of submitting claims that met the 90 percent approval threshold for that particular service and there are too few claims to present a waste or abuse concern. (Note that fraud should not be a concern either, because even with an exemption in place, there is a separate provision designed to address fraud under the law (i.e., Section 4201.659).

We understand that some stakeholders have sought a higher number of minimum claims in order to select a "random sample" for recission purposes. For example, the Texas Association of Community Health Plans states in its comment letter to TDI, dated September 20, 2021 the following in response to RFI No. 3:

> **TACHP Response**: For consideration of a denial or rescission, Sec. 4201(a)(2) [sic] refers to a random sample of between 5-20 claims. For an independent review of an exemption determination, 4201.656(d) says a provider may request consideration of *another random*

sample of between 5 – 20 claims. That means for determination of an exemption for preauthorization, there must be enough claims to have TWO different random samples of between 5 – 20 claims. A random sample is a SUBSET THAT REPRESENTS the entire population of claims. A random sample is NOT the entire population of claims. Therefore, the number of claims used in the determination of an exemption, denial/rescission and reconsideration of a denial/rescission MUST BE CONSIDERABLY MORE THAN 5 – 20 claims. **Only providers that have enough claims for a random sample of TWICE 5 – 20 claims should be eligible for an exemption**.[4]

In response to this comment, we reiterate again that Section 4201.655(a)(2), Insurance Code, does ***not*** apply to denials, only to recissions. And, as TAHP stated in its letter, "HB 3459 does not specify the minimum number of services needed for calculation of the 90% standard for an initial determination of whether an exemption should be granted or denied." Thus, TACHP's argument in its response to RFI No.3 is, in our opinion, fundamentally flawed from the first sentence. If TDI were, therefore, to move forward with TACHP's logic regarding random sampling (and read it in conjunction with the language of the bill in Section 4201.654 described above), then it would follow that there would be no minimum threshold of claims for the initial granting of the preauthorization, but at least twice the 5-20 claims would be required for an HMO or insurer to rescind a preauthorization exemption. Otherwise, the exemption would continue. We assume this would not be TACHP's desired result.

With all of the foregoing in mind, we recommend that TDI amend proposed §19.1730 (regarding preauthorization recissions) to:

- underscore that an issuer "may" but is not required to conduct an evaluation to determine whether to rescind a preauthorization exemption. As provided under Section 4201.653(c), Insurance Code, an issuer may also choose to continue an exemption without conducting an evaluation for a particular evaluation period.
- explicitly note what the effect is when there is an insufficient number of claims needed to constitute a "random sample" of claims after applying Section 4201.654, Insurance Code, as stated above (i.e., the preauthorization exemption shall automatically continue without conducting an evaluation of claims for that evaluation period and shall not be subject to a recission based on that evaluation period, as the physician or provider would be considered as having met the criteria under Section 4201.654, Insurance Code to continue to qualify for the exemption).
- cross reference our modified definition of "evaluation" to make it clear that a recission is based on a retrospective review of a random sample of claims (as reflected in our recommended changes to the definitions of evaluation and random sample). More specifically, the amendments recommended by the Associations are provided, below:

(c) With respect to a particular health care service for which a physician or provider has a preauthorization exemption, an issuer may conduct an evaluation**, as defined in §19.1730(A), of a random sample of claims** to determine whether to rescind a

[4] *See* TACHP letter to TDI Re HB 3459 comments, dated September 20, 2021 at p. 3.

preauthorization exemption consistent with Insurance Code §4201.655, concerning Denial or Rescission of Preauthorization Exemption. In order to determine whether to rescind an exemption, the issuer must conduct a retrospective review of a random sample of at least five and no more than 20 claims submitted during the most recent evaluation period. **Notwithstanding the foregoing, an issuer may continue an exemption without conducting an evaluation of a random sample of claims to determine whether to rescind a preauthorization exemption for the particular evaluation period, as authorized by Section 4201.653, Insurance Code. If fewer claims were submitted by the physician or provider for a particular health care service during the relevant evaluation period than is needed for the random sample that forms the basis of the evaluation, a preauthorization exemption shall automatically continue without conducting an evaluation of claims for that evaluation period and shall not be subject to recission based upon that evaluation period.**

The Associations also remind TDI that we made many recommended amendments to the proposed definition of a "random sample." This subsection (c) would be another area of the rules where our recommendations regarding how to further define a random sample could be incorporated. We, therefore, urge TDI to review our comments on the definition of both "evaluation" and "random sample" while reviewing our comments on this section.

C. **Proposed §19.1731(d)**

For our comments on proposed §19.1731(d), please refer to Section II.E. of this letter (entitled Preauthorization exemption (§19.1730(9), treating physician §19.1730(11), and §19.1731(d)), which is hereby incorporated by reference.

IV. Proposed §19.1732. Notice of Preauthorization Exemption Grants, Denials, or Recissions

A. Preferred Contact Method and Preferred Contact Information – Requiring Solicitation and Use by Issuer

First, we strongly recommend that TDI add a new subsection to proposed §19.1732, which should be drafted to require issuers to:

- solicit from physicians and providers their preferred contact method (e.g., email, mail, fax, etc.) and preferred contact information (i.e., name, email address, office address, etc.) for receipt of notices provided under the law and rules; and
- use the preferred contact information to provide the required notices.

Given the importance (as well as the large volume) of the notices that will be received from issuers under the law and rules (on a per issuer/per service basis), it is imperative that physicians and other providers be able to specify their preferred contact method and contact information (and for issuers

to comply with that preference). Otherwise, there is great risk that the rule will be implemented in an overly burdensome manner and that even the most meticulous physicians and providers will be unable to keep track of these numerous, important notices (with adverse consequences if an appeal needed to be requested in a short timeframe).

If TDI implemented this recommendation, a physician could, for example, more easily dedicate one preferred email account or mailing address to receive exemption-related notices. This would enable all notices to be captured, collated, and processed more easily from a central location. It would also be beneficial for protecting any patient health information included in recission notices.

Given that TDI has proposed many flexibilities for issuers to relieve burdens associated their efforts to comply with HB 3459 in the proposed rules (e.g., flexibility in recission evaluation periods, extra time beyond that statutorily allowed to provide the first notices, etc.), we think this would be a very small but meaningful step that TDI could take to reduce the burden on physicians and providers. We also note that it would promote the Texas Legislature's goals in removing unnecessary barriers to care and implementing an effective preauthorization exemption process. Further, it would aid TDI in assessing issuer compliance with the law's requirements, which is TDI's charge from a consumer protection standpoint. We, therefore, urge TDI to accept this recommendation.

We also urge TDI to adopt rule language to provide that if an issuer notifies a physician or provider using a method other than the preferred notice method and contact information, any attempted notice of a recission would be defective and the exemption would continue on.

Further, (similar to TDI's proposed medical record retention requirement imposed on non-TDI regulated entities under the rules), we recommend that TDI promulgate a rule to require issuers to retain records to demonstrate that they provided timely and effective notice through the preferred method and contact information. If an issuer does not retain the record demonstrating its provision of notice, then TDI should expressly state in its rule that any notice of recission shall be deemed ineffective for that evaluation period and cannot be rescinded again until the next six-month evaluation period is reviewed. If an issuer fails to retain a record of notice of granting a preauthorization exemption (via the preferred contact method and preferred contact information), then TDI should promulgate a rule providing that the six-month period before an exemption may be rescinded is extended to be counted from the date the issuer provides effective notice.

B. Proposed §19.1732(a) –Notice of granting a preauthorization exemption; time before recission may begin

Next, in proposed §19.1732(a), TDI proposes the following:

> (a) When granting a preauthorization exemption, an issuer must provide notice to the physician or provider, consistent with Insurance Code §4201.659(d), concerning Effect of Preauthorization Exemption. The exemption begins on the date the notice is issued and must be in place for at least six months before it may be rescinded. If an issuer subsequently receives a preauthorization request from the physician or provider for a particular health care service for which an exemption has been granted, the issuer must provide a notice consistent with Insurance Code §4201.659(e).

1. Notice Letter Content under §4201.659(d)

First, the proposed language requires issuers to provide notice consistent with Insurance Code §4201.659(d). We note that the cited statutory provision requires this notice to "include" certain elements. The word "includes", however, is a word of enlargement, not of limitation under Texas law. We, therefore, ask that TDI expand upon these listed statutory elements in its rulemaking in order to specifically require the notice to include a plain language explanation of what the impact of the exemption is/what it means; and to require the issuer to provide the contact information for TDI and the issuer, which will enable physician or provider may ask any questions concerning the grant of an exemption.

Further, we strongly recommend that TDI standardize these notices (similar to the sample notice TDI proposes for recissions) **and require plans to use the TDI form** so that the notices are more uniform, easy to identify, and easy to read. It is important for these forms to be conspicuously labeled and to look "official" so they are not potentially misidentified as solicitations or junk mail and discarded.

2. Timeframe before a notice can be rescinded

Next, proposed §19.1732(a) states that "The exemption begins on the date the notice is issued and must be in place for at least six months before it may be rescinded." **We strongly support requiring the exemption to be in place for at least six months before it can be rescinded and strongly contend that any shorter period of time would be contrary to both the express language of the law and the spirit of the law**. However, we ask that the language be clarified as follows so that there must be at least six months before the issuer attempts to initiate recission (not between the issuance of notice of grant and the final recission): "The exemption begins on the date the notice is issued and must be in place for at least six months before **a notice attempting to rescind the exemption may be sent under subsection (d)[~~it may be rescinded~~]."**

3. Notice Letter Content under Insurance Code §4201.659(e).

Next, proposed §19.1732(a) states: "If an issuer subsequently receives a preauthorization request from the physician or provider for a particular health care service for which an exemption has been granted, the issuer must provide a notice consistent with Insurance Code §4201.659(e)."

The Associations note that Insurance Code §4201.659(e), much like the required notice under §4201.659(d), must "include" certain elements. Once again, we note that the word "include" is a word of enlargement, not of limitation under Texas law. Thus, we recommend that TDI include the same additional required elements in this notice as referenced in our comments with regard to the notice required under §4201.659(d), above. And we again ask for TDI to create (and require issuer use) of a standardized form for this notice for all the same reasons, as stated above.

C. **Proposed §19.1732(b) - Notice of denial of preauthorization exemption**

Next, in proposed §19.1732(b), TDI proposes the following:

(b) When denying a preauthorization exemption, an issuer must provide notice to the physician or provider that demonstrates that the physician or provider does not meet the criteria for a preauthorization exemption, consistent with Insurance Code §4201.655(c)(2), concerning Denial or Rescission of Preauthorization Exemption.

The Associations again recommend that TDI promulgate (and required issuers to use) a standardized form for this purpose. Further, we recommend that the notice be required to also include notice of physician or provider appeal rights. Physicians need to know how to challenge the denial information, if improper.

D. <u>Proposed §19.1732(c) – Timing and other requirements for notices of grants and denials of preauthorizations</u>

Next, in proposed §19.1732(c), the Associations recommend the following amendments:

(c) For the initial evaluation period of January 1 through June 30, 2022, an issuer must provide notice granting or denying a preauthorization exemption no later than **<u>August</u> [~~October~~]** 1, 2022. For subsequent evaluation periods during which a physician or provider does not have a preauthorization exemption, an issuer must provide notice to the physician or provider granting or denying a preauthorization exemption no later than **<u>five days</u>** [**~~two months~~**] following the day after the end of the evaluation period. [**~~Notice need only be provided for a particular health care service if the issuer was able to complete an evaluation of at least 20 preauthorization requests, as provided in §19.1731(b) of this title (relating to Preauthorization Exemption).~~**]

1. Association comments on the first two sentences of subsection (c)(timeframes for notice)

For the sake of brevity, we incorporate by reference all our comments regarding the timeframe for notices (i.e., discussing the first two sentences on proposed subsection (c)) from Section II.C.1.b of this letter (concerning "evaluation period".

2. Association comments on the last sentence of subsection (c) (minimum threshold of preauthorization request reviews)

Next, we ***strongly*** oppose the last sentence of proposed subsection (c), which states that "notice need only be provided for a particular health care service if the issuer was able to complete an evaluation of at least 20 preauthorization requests, as provided in §19.1731(b) of this title (relating to Preauthorization Exemption). This language, along with the language in proposed §19.1731(b**<u>)</u>** effectively creates a minimum prior authorization submission threshold of 20 requests for reviewing, granting or denying, and notifying of a grant or denial of a preauthorization exemption, which is in clear conflict with the plain language of the law and the intent of HB 3459. For the sake of brevity, we incorporate by reference all of our comments from Section III.A. of this letter (concerning §19.1731(b)) as if those objections were expressly stated here. This language remains a top concern of the Associations in the rule proposal and we ask that TDI carefully weigh our comments on this issue.

E. <u>Proposed §19.1732(d) – Notice when rescinding a preauthorization exemption</u>

Next, in proposed §19.1732(d), TDI proposes notice requirements when an issuer is rescinding a preauthorization exemption. The Associations make the following suggestions with regard to proposed subsection (d) and TDI's proposed sample form (Form LHL011), below:

The Associations recommends that TDI:

- **Require use of LHL011 (with our recommended amendments).** Issuers should be required to use LH011, rather than having the form function as a sample (as is currently proposed). Required use of the form would standardize the information among issuers and ensure that physicians and providers may more easily and quickly digest the information in the form. We note that in other contexts with significant consumer implications (e.g., surprise billing), TDI requires use of a TDI form, rather than allowing it to be a sample. The same should apply here as a recission of a preauthorization exemption will significantly impact patient access to timely care.
- **Make required action clearer in Form LH1011**. In Form LH1011, we recommend modifying the language in the form to state, "Unless you request an appeal to an independent dispute resolution organization as set forth below, [t]he preauthorization exemption for [health care service] will be rescinded effective _____." This will make the required action on behalf of the recipient clearer from the outset.
- **Clarify the date to be entered for the rescission "effective date" and the "date of notice".** In (d)(1), TDI requires the notice to include identification of the health care service for which a preauthorization exemption is being rescinded and the date the recission is effective, consistent with Insurance Code §4201.654, Concerning Duration of Preauthorization Exemption.

  The Associations note that the Insurance Code §4201.654(1) provides that an exemption remains in effect until the 30th day after the date issuer notifies the physician or provider of the issuer's determination to rescind the exemption under Section 4201.655, *if the physician or provider does not appeal the issuer's determination*. We are unclear, however, if it is TDI's expectation that field for the recission effective date on the form be completed with whatever the date is that is 30 days from the date of notice (also entered on the form), or if TDI has some other expectation. We request clarification on TDI's expectations on this point, particularly given confusion over this issue (and the timeframe for appeal) in the RFI stage of rulemaking.

  The Associations also ***would strongly oppose*** any period shorter than 30 days from the date of notice being included as the effective date, because the physician or provider must have a meaningful opportunity to file an appeal for an independent review organization (IRO). To that end, we also recommend that in (d)(2), the "date of notice" be clarified.

  If the expectation is for the effective date to be calculated from the "date of notice," then we recommend that TDI clarify that the "date of notice" is the date notice is reasonably expected to be received by physician or provider, not date the issuer sends the notice. This will help to ensure delays caused by slower delivery methods used by issuers do not

unfairly penalize physicians who would like to request an appeal. It would also make the date of notice more accurately reflect the date the physician received notice.

- **Require identification of an electronic means for the physician to return the IRO appeal request**. In (d)(2), in addition to requiring the issuer to include the company's address and contact information for returning the form to request an appeal, require the issuer to include an email address, fax and any or other electronic method the physician prefers to use to return the form so that a physician or provider may more quickly exercise their appeal rights. Also, require the issuer to inform the physician or provider that they may file their appeal via the electronic means in order to expedite return.

  Make corresponding changes to form LHL011. In the form, TDI instructs in the fourth bullet point the following:

  "To request an independent review of your preauthorization exemption, you must return this completed form to the issuer ***at the address listed below*** before the recission effective date listed on this notice. Make a copy of this form for your records and remember do not return this form to the Texas Department of Insurance (TDI)."

  This language makes it sound as if the form has to be mailed to be returned. It would be helpful for TDI to clarify "at the **mailing, email or fax address** below" and for TDI to expressly require the issuer to complete all of these fields so that they could not force a physician to mail the return notice.

  If an issuer enters a mailing address for receipt of the form, the mailing address should be one that is capable of receiving mail overnighted, in case the physician needs to expedite an appeal request.

- **Require the notice/form to state conspicuously that the issuer is required to pay for any IRO (consistent with Section 4201.656, Insurance Code)**. Physicians and providers will be more likely to exercise their appeal rights if they know that it is at no cost to them. For example in the third bullet on LHL011, we recommend it be modified to read as follows:

  "You can now request that your preauthorization exemption be reviewed**, at no cost to you,** by a health care provider who is totally independent of the health maintenance organization or insurer that is subject to Insurance Code Chapter 4201, Subchapter N (issuer). This is called an independent review by an Independent Review Organization, or "IRO."

- **Revise the language concerning the retrospective review of additional claim information from (d)(3)(A).** For all the reasons stated in the section of this comment letter discussing §19.1733(e), we are very concerned that (d)(3)(A) also references additional claims to be reviewed (as if claims outside the original sample could be reviewed by the issuer during a retrospective review, rather than at the physician's request for the first time at the IRO level). We ask that TDI make amendments to (d)(3)(A) and

the form to address this concern and conform to the express language of Section 4201.656(d), Insurance Code as discussed in more detail in §19.1733(e).

- **Amend the rule to state the correct reviewer in (d)(3)(C)(iv) and make conforming amendments to LHL011**. In (d)(3)(C)(iv), TDI proposes requiring that for any claim determined not to have met the issuer's screening criteria, the issuer must list the professional specialty of the physician, doctor, or other health care provider that made the determination. Note, however, that under §4201.655(c), Insurance Code, a determination made under §4021.655(a)(2) concerning the recission and sample must be made by an individual licensed to practice medicine in this state; and for a determination under subsection (a)(2) with respect to a physician, the determination must be made by an individual licensed to practice medicine in this state who has the same or similar specialty as that physician. Thus, proposed (d)(2)(iv) should be modified to state the following: "the professional specialty of the individual licensed to practice medicine in the state who made the determination." The other "doctor, or other health care provider" language should be struck as conflicting with the plain language in HB 3459.

- **Clarify the "date that the appeal is being requested"**. In proposed (d)(4)(c), it states that the recission form must include "the date the appeal is being requested." The Associations seek clarification as to the intended meaning of this phrase. In the context of LHL011, is the "date the appeal is being requested" the same thing as the signature date of the physician completing the appeal form? We assume that is the intent, as there is no specific field for "the date the appeal is being requested."

  If our assumption is correct, then we would contend that the date signed by the physician should stop the recission from going into effect under Insurance Code Section 4201.654 even if the insurer receives the form after that date. Please confirm that this is also TDI's interpretation and that TDI views this as being true even if (d)(5) instructs the physician or provider to return the form to the issuer before the date the recission becomes effective.

  We think this clarification is important in order to ensure the physician understands the physician's appeal rights and to ensure the physician has sufficient time to request an independent review organization appeal. We also think it would be consistent with the intent of the law.

  TDI's interpretation on this language will also impact §19.1733(c), which states that "after receiving a notice of recission, a physician or provider may request an independent review of the adverse determination regarding a preauthorization exemption at any time before the recission becomes effective." Once again, we read this as indicating that signing the request line constitutes a "request" provided that is done before the recission effective date. A "request" should not require the issuer's ***receipt*** to stop the recission, as that is not the same think as a "request" or "return." This provides another reason why it is important for TDI to clarify the application of this language.

  Finally in LHL011, the fourth bullet provides that "to request an independent review of your preauthorization exemption, you must return the completed form to the issuer at the address below before the recission effective date listed on this notice." Does the date the form was mailed/emailed; or faxed constitute "returning" before the recission date, even

if it is received later? We strongly contend that it should. The sender cannot verify when the receiver opens a later/email or checks a fax, and a requirement to do so places an unfair burden on the sender. If there is a time/date stamp when the form is sent demonstrating it was sent prior to the effective date, the recission should be stopped, pending appeal. We, again, ask TDI to clarify this point.

V. Proposed §19.1733. Retrospective Reviews and Appeals of Preauthorization Exemption

A. Proposed §19.1733(b)

Next, the Associations that TDI make the following changes to its proposed subsection (b):

> (b) An issuer that is conducting an evaluation**, as defined in proposed §19.1730(B), of a random sample of claims** to determine whether a physician or provider still qualifies for a preauthorization exemption may request medical records or other documents **as minimally necessary and** consistent with §19.1707 of this title (relating to URA contact with and Receipt of Information from Health Care Providers) **to review the claims in that sample**. **An issuer** [~~and~~] must provide at least 30 days for a physician or provider to provide the records. Medical records **may not be** [~~**should be**~~] requested**, and a retrospective review may not be conducted,** for **any claims that are outside the original random sample of 5 to 20 claims that is being reviewed** [~~**no more than 20 claims**~~] for a particular health care service **unless a physician or provider provides a specific written request or signed consent to a review of additional claims. Records** [~~and~~] may be requested only during an evaluation period or within 90 days following the end of an evaluation period. **If** the physician or provider fails to provide the records **minimally** necessary for the issuer to make a determination the issuer may determine that the claim would not have met the screening criteria.

The changes referenced above, are designed to:

- Clarify that the records request is referring to an evaluation conducted for the purpose of deciding whether to rescind or continue a preauthorization exemption;
- Ensure that records are only requested for the random sample of at least 5 and no more than 20 claims that are being reviewed for the relevant evaluation period; and
- Ensure that the records requested are the minimum necessary to conduct the review.

Additionally, the Association incorporates by reference our concerns (stated in more detail in the section of this comment letter discussing §19.1733(e)) regarding what appears to be TDI's implied interpretation that Section 4201.656(d) permits a review of more than an original random sample of claims at the issuer level for a recission determination. We again disagree with this assessment. Thus, we only offer the highlighted language, above, as an alternative if TDI moves forward with its implied position (over our objections).

The Associations also recommend that TDI:

- Require the issuer to provide a physician or provider with a reminder request for any outstanding records needed for the assessment at least 15 days before the end of the deadline;
- Require the issuer's notice to have enough specificity that a reasonable physician could identify the needed records.
- Require the issuer to inform the physician or provider of the effect of a failure to provide records in the reminder request; and
- Expressly make it a violation for an issuer to: (1) request more information than is needed to conduct the review; (2) fail to provide a request with sufficient specificity to permit the physician to identify the needed records; or (3) fail to provide the follow-up request. If an issuer fails to take any of the required steps, the issuer should not be able to determine that the claim would not have met the screening criteria.

B. **Proposed §19.1733(e)**

Next in subsection (e), TDI proposes the following:

> (e) If the notice of recission of preauthorization exemption identified that retrospective review was conducted for additional claims that were not included in the random sample, the physician or provider, when requesting an independent review, may request that the independent review organization review another random sample of claims.

The Associations have serious concerns with this subsection, as currently drafted. As stated previously, a retrospective review for purposes of determining the continuation/recission of a preauthorization exemption is statutorily required to be based on a random sample of not fewer than 5 and no more than 20 claims. (*See* Section 4201.655(2), Insurance Code.)

Section 4021.655(2), Insurance Code, does ***not*** reference an issuer conducting a review of a claims outside of this 5-to-20 random sample of claims when conducting a continuation/recission review. Moreover, nothing in the statutory language permits an issuer's recission determination to be based upon any claims other than those in the random sample.

This is evidenced by the express language of Section 4021.655(2), Insurance Code, which plainly states:

> (2) the health maintenance organization or insurer ***makes a determination, on the basis of a retrospective review of a random sample of not fewer than five and no more than 20 claims submitted by the physician or provider during the most recent evaluation period described by Section 4201.653(b),*** that less than 90 percent of the claims for the particular health care service met the medical necessity criteria that would have been used by the health maintenance organization or insurer when conducting preauthorization review for the particular health care service during the relevant evaluation period; (emphasis added).

Section 4201.655(3)(B)(i), Insurance Code, affirms that the recission decision is limited to the aforementioned random sample information by stating that the recission notice must include "the sample information used to make the determination under Subdivision (2)."

Notably, the only time another random sample is referenced by the law is under Section 4201.656(d), Insurance Code. There, the statutory provision only allows the physician or provider to request another random sample review at the independent review organization level. The current drafting of §19.1733(e**)** departs from the language and intent of this statutory provision.

Specifically, Section 4201.656(d) states as follows:

> A physician or provider may request that the independent review organization consider another random sample of not less than and no more than 20 claims submitted to the health maintenance organization or insurer by the physician or provider during the relevant evaluation period for the relevant health care service as part of its review. If the physician or provider makes a request under this subsection, the independent review organization shall base its determination on the medical necessity of claims reviewed by the health maintenance organization or insurer under Section 4201.655 and reviewed under this subsection.

From the plain language of this provision, we believe that the Legislature intended for independent review organization to review the "another random sample" of claims referenced in Section 4201.656(d) as a first-time review (not as part of a re-review of claims reviewed by the issuer) when assessing whether the 90% approval threshold would have been met for continuing a preauthorization exemption. Nothing in Section 4201.656 references that the additional random sample had to have first been reviewed by the issuer. Rather, it only requires the claims to have been submitted to the HMO or insurer by the physician or provider during the relevant evaluation period for the relevant health care service.

Furthermore, Section 4201.656(b)(2) requires a health plan to pay a reasonable fee determined by the Texas Medical Board for any copies of medical records or other documents requested from a physician or provider during an exemption review requested under independent review section. We believe this statutory language was intended, in part, to address any of the additional medical records that an IRO might need for the claims that have not previously been reviewed by issuer. The IRO's review must be conducted in a short time frame (i.e., 30th day after the date a physician or provider files the request for a review), which is presumably part of the reason why the review of the additional random sample only occurs at the physician or provider's request (since they may need to provide additional records in that short timeframe).

However, if the Legislature did intend (as TDI seems to imply and with which we disagree) that the random sample referred to in Section 4201.656(d), Insurance Code, was to be a re-review of claims already reviewed by the issuer, then we ***strongly contend*** that the Legislature did ***not*** intend: (1) for these claims (which are outside the operative sample used to make a recission determination) to be reviewed at the issuer's discretion (without the physician or provider's expressed request or consent) or (2) to provide issuers with free reign to review any and/or all claims during the evaluation for the recission.

Rather, any additional claims reviewed, ***if*** authorized to be reviewed by the Legislature during the evaluation for continuation or recission of a preauthorization exemption (and we do not believe any were authorized), would have had to be limited and at the physician's request/with the physician's consent. To reach any other conclusion would lead to an absurd result and render other language in the law mere surplusage.

To illustrate this further, if TDI were to ***erroneously*** interpret the law to permit or require issuers to review all claims submitted during an evaluation period when making a recission determination, then there would have been no point in the Legislature including the statutory language that requires the issuer to make its recission determination based upon a random sample of not fewer than five and no more than 20 claims. Any efficiencies would be lost and the entire purpose of the bill would be undermined, as this would merely move all the burdens of preauthorizations to the backend. And, if TDI were to erroneously interpret the language as permitting issuers to review any subset of the other claims without the physician or provider's advance request/consent, then this would allow for cherry picking and render the "random sample" language of 4201.656(d), Insurance Code, meaningless. There would be no purpose in allowing the physician or provider to have "another random sample" reviewed by the IRO if the physician or provider's request for a "random sample" meant a "random sample" from a sample first selected by the issuer. Put simply, this wouldn't be "random" at all. This would effectively flip language in Section 4201.655(d), Insurance Code, which was clearly intended to counter any bias in the initial sample reviewed by the issuer and turn it into baked-in bias in favor of issuers (i.e., to stack the deck in the IRO review and undermine the first, actual random sample). Thus, it would be unclear why any physician or provider would ever request that the IRO also consider this "another random sample" in reviewing an adverse determination.

Furthermore, such an interpretation would have numerous negative public policy implications, including increasing administrative burdens, taking physicians' time away from direct clinical care, and injecting more waste into the system (i.e., having issuers request medical records for and review claims that may ***never*** be considered in any decision-making under the bill). Thus, the only purpose of the review, without the physician or provider's express request and consent, would be to create administrative burdens or to harass physicians or providers so that they don't challenge other recissions in the future. TDI should not be promoting such goals and certainly the Legislature did not intend that result in a bill that was supposed to reduce administrative burdens

For all the foregoing reasons, we strongly contend that an issuer does **not** have any authority to choose to review claims that are not part of the operative sample contemplated by Section 4021.655(2) when conducting a review of whether to continue or rescind a preauthorization exemption for a particular health care service much less unilateral authority to do so.

We, therefore, oppose the language in subsection (e), as currently drafted and recommend that TDI make amendments to address the concerns stated in this section.

VI. Proposed §12.601(e)

Next, we oppose the language in proposed §12.601(e) due to concerns with lack of alignment with the statutory language. For the sake of brevity, we hereby incorporate by reference our discussion from proposed §19.1733(e) regarding the review of additional claims.

We recommend again, that TDI implement the language of Section 4201.656(d) according to its express terms (which does not contemplate an IRO re-review of an additional random sample of claims, but rather a first-time request for the IRO's review). To that end, we recommend the following amendments to proposed (e):

(e) The IRO must review the same random sample of claims on which the issuer's recission was based **[~~, unless the physician or provider requests another random sample. Only the claims that the issuer's retrospective review determined did not meet the screening criteria are subject to independent review~~]**. If requested by the physician or provider, the IRO may **also** review another random sample of claims under Insurance Code §4201.656(d), concerning Independent Review of Exemption Determination**[~~, to the extent the issuer conducted a retrospective review of more claims than were included in the original sample~~]**.

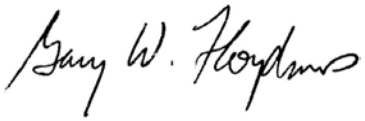
Alternatively, if over our previously stated objections, TDI insists on moving forward with the position that for the additional sample to be reviewed by an IRO, an issuer must have first conducted a review, we recommend TDI revise the language as follows

(e)The IRO must review the same random sample of claims on which the issuer's recission was based**[~~, unless the physician or provider requests another random sample~~]**. Only the claims that the issuer's retrospective review determined did not meet the screening criteria are subject to independent review. If requested by the physician or provider, the IRO may review another random sample of claims under Insurance Code §4201.656(d), concerning Independent Review of Exemption Determination, to the extent the issuer conducted**, at the physician or provider's specific written request or signed consent,** a retrospective review of more claims than were included in the original sample.

Conclusion

Once again, the undersigned Associations thank you for the opportunity to provide these comments. If you should have any questions or need any additional information, please to contact me or following staff of the TMA: Kelly Walla, Associate Vice President and Deputy General Counsel; or Clayton Stewart, Vice President and Chief Lobbyist at TMA's main number 512-370-1300.

Respectfully,



Gary W. Floyd, MD
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John Hinchey, MD
President, Texas Orthopaedic Association

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Mary Nguyen, MD
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Eddie L. Patton, Jr., MD, MS, MBA, FAAN
President, Texas Neurological Society

Maxim Eckmann, MD
President, Texas Pain Society

Sterling Overstreet, MD, FACEP
President, Texas College of Emergency Physicians

Susan Baer, MD

President, Texas Society of Pathologists

14. National Infusion Center Association

NATIONAL INFUSION CENTER ASSOCIATION

The Nation's Advocacy Voice for In-Office Infusion

3307 Northland Dr, Ste 160 ▪ Austin, TX 78731
www.infusioncenter.org ▪ info@infusioncenter.org

May 9, 2022

Texas Department of Insurance
333 Guadalupe
Austin TX 78701
Submitted electronically to RuleComments@tdi.texas.gov

Re: TDI proposed rule for preauthorization exemptions

The National Infusion Center Association (NICA) is a nonprofit organization formed to support non-hospital, community-based infusion centers caring for patients in need of provider-administered medications. To improve access to medical benefit drugs that treat complex, rare, and chronic diseases, we work to ensure that patients can access these drugs in safe, more efficient, and cost-effective alternatives to hospital care settings. NICA supports policies that improve drug affordability for beneficiaries, increase price transparency, reduce disparities in safety across care settings, and foster patient access to the highest-quality, lowest-cost setting.

We thank the Texas Department of Insurance (TDI) for its willingness to gather stakeholder input related to the draft rule implementing a new process for granting, denying, and rescinding preauthorization exemption requests as added by House Bill 3459 last year. Overall, NICA asks that a final rule explicitly and clearly outline the updated process to ensure Texas providers are well aware of the exemption process.

§19.1730. Definitions
(13) Treating physician or provider

The providers that NICA represents often render infusion services that were prescribed by an external referring provider. In doing so, infusion providers rendering these services work with both prescribing providers and insurers to verify that ordered services have been authorized in order to ensure claims will be reimbursed. Margins for infusion services are often thin, and

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ensuring claims payment is imperative to maintaining the viability of providing our members' services.

The proposed rule successfully accomplishes this in defining a treating physician or provider as including "a rendering physician or provider." This allows our members assurances that their services will be protected from retrospective denial of claims payment that fall under the umbrella of the treating or referring provider's exemption as provided by this rule at HB 3459. **NICA encourages the department to finalize this language.**

Subchapter R. Utilization Reviews for Health Care Provided Under a Health Benefit Plan or Health Insurance Policy.

NICA supports TDI's language to require that "peer to peer" review to include a physician that is licensed to practice medicine in the state of Texas. The patients our providers treat rely on highly complex biologics that require strict monitoring before, during, and after administration. Any discussions about these specialized medications should be with a physician that has the same or similar specialty as outlined in the rule. We believe the inclusion of this language is critical in ensuring justified discussions during utilization review. This would help protect against any adverse decision where the reviewing physician does not have knowledge or experience in prescribing the medication in question.

Division 2. Preauthorization Exemptions. New §19.1733(f) states that an issuer must communicate the determination of a review by the independent review organization to the physician or provider within five days.

NICA requests further clarification in defining the response time for an insurer to communicate the determination of a review by the independent review organization (IRO) to the physician or provider. NICA recommends that the language of this section clearly define the five (5) days as "business" days. This clarification provides clear expectations for notice between providers and insurers.

Thank you for your consideration. If I can provide any additional information, please do not hesitate to contact me.

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Sincerely,

Brian Nyquist, MPH
Chief Executive Officer
National Infusion Center Association

15. Harris Health System

From: [redacted]
To: ChiefClerk
Cc: [redacted]; [redacted]
Subject: HB 3459 Addendum Comments
Date: Monday, May 09, 2022 5:02:00 PM

Regarding addendum to HB 3459 'gold card' created 3/25/2022, we have the following questions / comments for consideration:

Question 1
From the Facility perspective regarding the Physician Gold Card status and OP prior authorizations. Considering our current processes for submissions, we are curious about whether the data included in the review to determine Exemption eligibility would include claims data and actual Prior Authorization submissions? We ask because not all payor Prior Authorization web portals include both the ordering physician NPI and the Facility NPI.

Question 2
Facilities request prior authorizations for the Facility charges, but they are not the actually ordering the service. Will facilities be awarded an exemption status of their own? If not, how will an affiliated facility know of exemption status awarded to physicians?

Question 3
Associated to question 2 above, if facilities are awarded their own exemptions status, how will determinations be made? What are the qualifications?

Question 4
Will there be a data repository that identifies all physicians/providers that have been awarded a 'gold card exemption' status?

Question 5
We feel very strongly that physicians / providers be permitted to designate a specific award/rescission notification address.

Question 6
Under the proposed amendment the initial exemption/denial of an exemption is expected to be announced no later than October 1, 2022. Can providers count on all aspects of this law to be operationalized by 10/1/2022? Or is there another date for implementation?

Question 7
If a exempted service is provided, and said service transitions into a more complicated services or surgery, will all associated services also be exempt?

Thanks and best regards, Ruben.

F. Ruben Escamilla
Contract Specialist ~ Revenue Integrity
Harris Health System
4828 Loop Central Drive, Suite 300
Houston, Texas 77081

Office: (713) 566-6465
Email: [redacted]

Important Notification:
Please don't forget to contact the **Contracting Team** for any questions related to medical/pharmacy contracts and/or credentialing. Our contact information is:

Contracting Phone: (713) 566-6925 (8:00-5:00 Monday thru Friday and 8:00-4:30 Thursday and Friday)
Contracting Fax: (832) 487-2037
Contracting E-mail: ManagedCareInquiries@harrishealth.org

16. US Oncology Network

May 9, 2022

Texas Department of Insurance
Commissioner Cassie Brown
PO Box 12030
Austin, TX 76711

Dear Commissioner Brown,

On behalf of Texas Oncology, we appreciate the opportunity to submit comments and participate in the stakeholder meeting regarding the implementation of House Bill 3459.

Texas Oncology is an independent, physician-led practice conducting innovative research and delivering leading-edge technology and treatment options. Texas Oncology's community-based approach of integrated sub-specialty oncology care enables patients to receive leading-edge treatment while living at home and receiving critical support of family and friends. Texas Oncology has over 500+ physicians in over 210 locations across the state of Texas treating more than 55,000 new cancer patients annually.

The rising use of prior authorization continues to burden physicians and clinical staff, increase practice operating costs, and delay time-sensitive care for patients. Such policies are a direct threat to integrated care. Texas took a huge step in amending the Insurance Code 4201.26 to require physicians participating in a peer-to-peer review on behalf of a health benefit plan issuer to be Texas-licensed physicians with the same or similar specialty as the physician or provider requesting the service. We applaud Senator Buckingham for her leadership on this legislation.

We are grateful for the opportunity to provide input for TDI's consideration when promulgating rules to satisfy the following requirements of HB 3459:

Section 19.1731. *New §19.1731 describes the initial preauthorization exemption process. Subsection (a) clarifies that for purposes of Division 2, a "physician" or "provider" should be identified using the National Provider Identifier under which a physician or provider makes preauthorization requests. Subsection (b) states that the issuer must review the outcomes of no fewer than 20 preauthorization requests for a particular health care service in a given evaluation period and determine whether the physician or provider qualifies for an exemption.*

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The department specifically seeks comments on this minimum threshold for review and whether it should be modified.

Texas Oncology commented in September of 2021 that if a provider fails a 5-chart review, they should be able to request a review of up to 20 charts. We are supportive of TDI's proposal that an issuer must review the outcomes of no fewer than 20 preauthorization requests as this will give physicians a better opportunity to meet the 90% threshold.

Section 19.1732. *New §19.1732(a) states that an issuer must provide notice to the physician or provider when granting a preauthorization exemption and requires that a subsequently receives a preauthorization request from the physician or provider for a service for which the physician or provider has been granted an exemption, the issuer must provide notice in accordance with Insurance Code §4201.659(e). For denials of preauthorization exemptions, new §19.1732(b) states that an issuer must provide notice and list the reasons for a denial in accordance with Insurance Code §4201.655(c)(2). New §19.1732(c) provides a required timeframe for issuing notices of exemption or denial following the initial and subsequent evaluation periods and clarifies that such notices are required with respect to a particular health care service only if the physician or provider had submitted at least 20 preauthorization requests during the evaluation period.*

The department specifically seeks comments on the minimum duration for exemptions and the timeframe for issuing notices, and whether either should be modified.

Texas Oncology commented in September of 2021 that we agree and support that payers must provide an initial communication to all providers that clearly states what services the provider will or will not be exempt from submitting prior authorization. We feel a provider should be notified for example on 12/15/20xx or 5/15/20xx of the notice to rescind an exemption. Providers need notification early enough to make sure we have the processes in place prior to recission. This is important communication that will establish a baseline with each provider.

Texas Oncology supports the proposed rules that an issuer must also provide notice when exemptions are both either granted or denied. This protects the provider from inadvertently thinking they are exempt, ordering tests, and not requesting prior authorization. Payer notifications are inevitably lost or sent directly to the provider and not forwarded to the people who need them to adjust workflows. If they receive advance notice of the exemption, the practice can retain that documentation and protect themselves against possible denials due to lack of prior authorization.

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Thank you for your consideration of our comments regarding the implementation of House Bill 3459. We appreciate the opportunity to be a resource for you. Please let us know if we can provide additional information.

Sincerely,

Debra Patt, MD
Executive Vice President, Policy and Strategic Initiatives, Texas Oncology
[redacted]

Angela Storseth
Associate Director, Government Relations, The US Oncology Network
[redacted]