TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

September 30, 2021

Cassie Brown
Commissioner
Texas Department of Insurance
Austin, Texas 78744-9104

Via email: LHLcomments@tdi.texas.gov

Re: TDI Request for information to use in implementation of House Bill 3459

Dear Commissioner Brown:

The Texas Medical Association (TMA) appreciates the opportunity to submit these supplemental comments on the Texas Department of Insurance's (TDI)'s "Request for information to use in implementation of House Bill 3459" (RFI). These supplemental comments are in addition to TMA's September 20, 2021 comment letter and oral comments provided by TMA representatives at the September 23, 2021 TDI stakeholder meeting on the RFI, which are hereby incorporated by reference.

**RFI No. 1: Insurance Code Section 4201.206(a) requires that before an adverse determination is issued, the ordering health care provider be given the opportunity to discuss the treatment plan with a licensed physician. Please provide input on TDI's consideration of a rule providing that an Administrative Medical License could satisfy the requirements of Section 4201.206(a).**

**TMA Supplemental Comments on RFI No. 1**:

In response to RFI No. 1, we note that the Texas Association of Health Plans (TAHP) states, in part, the following, in its September 20, 2021 letter, arguing against TDI requiring a full Texas medical license to satisfy the requirements of Section 4201.206(a), Texas Insurance Code:

> Additionally, 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 'Catch-22' 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 for Texas statutory construction. HB 3450 should not be interpreted

> to require health plan employed physician reviewers to hold a license that they are prohibited from obtaining under TMB rule.[1]

Later on page 6 of the same letter, TAHP provides an excerpt of the active practice of medicine rule (i.e., 22 TAC § 163.11(a)), but omits the full text of the rule (linking to the rule and focusing only on subsection (a) in the body of its letter). A review of the full rule is necessary, however, as language in subsection (c) counters TAHP's assertions.

Importantly, subsection (c) of 22 TAC § 163.11 provides ***three other pathways*** for an applicant to obtain an unrestricted license without satisfying the subsection (a) and (b) active practice requirements, which TAHP states would hinder medical director obtainment of a full medical license.

The full provision of 22 TAC § 163.11, including subsection (b) and (c) states as follows:

> (a) All applicants for licensure shall provide sufficient documentation to the board that the applicant has, on a full-time basis, actively diagnosed or treated persons or has been on the active teaching faculty of an acceptable approved medical school, within either of the last two years preceding receipt of an application for licensure.
> (b) The term "full-time basis," for purposes of this section, shall mean at least 20 hours per week for 40 weeks' duration during a given year.
> **(c) Applicants who do not meet the requirements of subsections (a) and (b) of this section may, in the discretion of the executive director or board, be eligible for:**
> **(1) an unrestricted license if the applicant:**
> **(A) completes remedial education, including but not limited to a mini-residency, fellowship or other structured program;**
> **(B) presents evidence from a member board of the American Board of Medical Specialties, American Osteopathic Association Bureau of Osteopathic Specialists, American Board of Oral and Maxillofacial Surgery, the Royal College of Physicians and Surgeons of Canada, or any other certifying board that is recognized by the Texas Medical Board, of passage, within the two years prior to date of applying for licensure, of a monitored examination; or**
> **(C) completes other remedial measures that, in the discretion of the board, are necessary to ensure protection of the public and minimal competency of the applicant to safely practice medicine.**
> **(2) a license subject to one or more of the following conditions:**
> **(A) limitation of the practice of the applicant to specified activities of medicine and/or exclusion of specified activities of medicine; or**
> **(B) such other restrictive or remedial conditions that, in the discretion of the executive director or board, are necessary to ensure protection of the public and establish minimal competency of the applicant to safely practice medicine.** (emphasis added).

[1] See TAHP comments to TDI Re: Request for Information on Implementation on HB 3459, dated September 20, 2021 at p.3.

Thus, health plan medical directors would ***not*** be categorically prohibited from obtaining a full license to practice medicine in Texas under 22 TAC § 163.11. Rather, they would be required to qualify under one of the subsection (c)(1)(A)-(C) alternative pathways (at the discretion of the executive director or TMB). These alternative pathways are directed at providing non-active practice avenues to obtaining a full medical license, while promoting the safe and competent practice of medicine. While utilizing one of the alternative pathways in subsection (c)(1)(A)-(C) could require additional effort for a health plan medical director to obtain a full medical license versus a limited administrative medicine license in Texas, it does not create a total, express bar on their obtainment of a full license.

Thus, we disagree with assertions that requiring a full medical license would result in a "Catch-22" and would not be "a result feasible of execution." And for all the reasons stated in our prior comment letter, we reiterate our recommendation that an administrative medicine license be interpreted as ***not*** satisfying the requirements of Section 4201.206(a), Insurance Code.

**Preauthorization requests**

**2. Insurance Code Section 4201.653(a) exempts physicians and other health providers from preauthorization requirements for certain services if the HMO or health plan "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."**

**a. When determining a provider's approval rate for preauthorization requests, should requests for a certain quantity (such as five days of inpatient care) be counted as a single request or multiple requests? What is the approval rate if, using the inpatient care example, three days were approved and two days were denied.**

**TMA Supplemental Comments on RFI No. 2a:**

Next, it is important to address stakeholder comments related to concurrent review versus preauthorization review under HB 3459. In response to TDI's RFI No. 2, TAHP states the following, in part, in its September 20, 2021 letter to TDI, regarding inpatient preauthorization requests:

> Additionally, TDI rules should confirm that HB 3459 applies only to PA requirements, and not to concurrent reviews. PA requests and reviews for inpatient services generally occur prior to a patient entering an inpatient facility. Requests submitted while a patient is already inpatient for approval of additional days are 'concurrent review' rather than PA requests and, therefore, are outside the scope of applicability to 'preauthorization' services. The rules should therefore clarify that the PA exemption applies only to preauthorizations and not inpatient concurrent reviews that are extensions of ongoing services. …[2]

TMA disagrees with the arguments made by TAHP regarding their purported distinction between preauthorization and concurrent review for inpatient care for purposes of HB 3459. TMA contends that the there clearly are requests for proposed services while a patient is already inpatient that the Texas

[2] *Id*. at p. 7.

Legislature views as preauthorizations, not concurrent reviews. This is reflected in the Texas statutory preauthorization provisions that generally provide HMOs and insurers three days from receipt of a request to issue a determination indicating a service is preauthorized (i.e., Section 843.348(d)) and Section 1301.135(c), respectively) but only 24 hours to issue a determination on a preauthorization request "if the proposed services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed" (i.e., Section 843.348(e) and section 1301.135(d)).

For ease of reference, the full text of Section 843.348(e) is included below:

> (e) If the proposed health care services involve inpatient care and the health maintenance organization requires preauthorization as a condition of payment, the health maintenance organization shall review the request and issue a length of stay for the admission into a health care facility based on the recommendation of the patient 's physician or provider and the health maintenance organization's written medically accepted screening criteria and review procedures. **If the proposed health care services are to be provided to a patient who is an inpatient in a health care facility at the time the services are proposed, the health maintenance organization shall review the request and issue a determination indicating whether proposed services are preauthorized within 24 hours of the request by the physician or provider**. (emphasis added).

The inpatient preauthorization distinction applicable to HMOs under Section 843.348(e) and its analog applicable to insurers under Section 1301.135(d) would be unnecessary and misplaced if the Texas Legislature viewed these requests to be concurrent reviews, not preauthorization reviews. The plain language of these statutory provisions, therefore, make it clear that the Texas Legislature deems these inpatient requests to be ***preauthorization*** requests.

This conclusion is further supported by noting that the definition of "preauthorization" used in HB 3459 under Section 4201.651 of the Insurance Code is expansive and closely tracks (with additions to encompass those who perform reviews on behalf of insurers and HMOs) the definition used under Section 843.348, Insurance Code. Thus, the Legislature likely intended a consistent application of the inpatient preauthorization statutory language in the context of HB 3459.

TMA notes that, in its September 20, 2021 letter, TAHP through its "background" information appears to attempt to use limiting language from a TDI definition of "preauthorization" in a rule (i.e., 28 TAC § 21.2406 (28)) on an ***entirely different subject*** (i.e., mental health and substance use disorder parity) to support its argument, apparently seeking to trump express statutory language and definitions that are directly applicable to HB 3459.[3] If this was TAHP's intent, we note that a rule does not and cannot control when there is express statutory language (in this case, both a definition under HB 3459 and a prexisting inpatient inpatient preauthorization provision) to the contrary. And applying a rule on a different subject makes no sense in the context of HB 3459. This should be particularly evident when the TAHP cited mental health parity rule ***itself*** precludes its use in any other context by prefacing the limiting components of the rule definition with the phrase "[f]or purposes of this rule …".

[3] *Id.*

Further, TMA disagrees with the narrowed component of the mental health and substance use disorder parity definition rule cited by TAHP (which again applies in a different context and is not controlling in the instant case) which states that preauthorization does not include utilization review needed to reauthorize ongoing services or benefits. A preauthorization can be renewed while another prior preauthorization for the same services is in effect. This does not convert the preauthorization renewal request to a concurrent utilization review for purposes of HB 3459. And, it is not necessary for a preauthorization to lapse in order for a renewal to be approved. This is made clear by Sections 1222.0003 and 1222.0004 of the Texas Insurance Code, which provide, respectively, that: (1) a health benefit plan issuer must provide a preauthorization renewal process that permits renewal of an existing preauthorization at least 60 days before the date the preauthorization expires and (2) a health plan issuer that receives a preauthorization renewal request before an existing preauthorization expires must issue a determination, if practicable, before the existing preauthorization expires.

Again, for convenience, the full text of the relevant Insurance Code provisions is included, below:

> Sec. 1222.0003. PREAUTHORIZATION RENEWAL REQUEST. A health benefit plan issuer that requires preauthorization as a condition of payment for a medical or health care service shall provide a preauthorization renewal process that allows a renewal of an existing preauthorization to be requested by a physician or health care provider at least 60 days before the date the preauthorization expires.
>
> Sec. 1222.0004. DETERMINATION REQUIRED. If a health benefit plan issuer receives a preauthorization renewal request before the existing preauthorization expires, the health benefit plan issuer shall, if practicable, review the request and issue a determination indicating whether the medical or health care service is preauthorized before the existing preauthorization expires.

For all the foregoing reasons, we urge TDI to: (1) consider preauthorization renewals (including renewals prior to lapses in an existing preauthorization) to be preauthorizations (not concurrent reviews) for purposes of HB 3459; and (2) consider requests for approval of additional days for an inpatient to be preauthorizations for purposes of HB 3459. To do otherwise, would conflict with controlling statutory language and clear legislative intent.

**2b. How should approval rates be calculated for preauthorization request for a treatment regimen (such as three-drug regimen where some services within the request may be approved and others denied or approved with changes?**

**TMA Supplemental Comments on RFI No. 2b:**

Next, in RFI No.2b, TDI asks for clarification on how to calculate preauthorization approvals for a three-drug regimen. By posing this question, TDI is clearly implying that it has independently interpreted HB 3459's "gold carding" preauthorization exemption provisions as applying to prescription drugs. TMA agrees with this interpretation.

We note, however, that health plan stakeholders seek to severely narrow the Legislature's intended scope of HB 3459 by arguing that supplies and products (including medical equipment and prescription drugs) fall outside the scope of the bill. **Put simply, any narrowed interpretation of the statutory definition is contrary to the express language of the law.**

More specifically, 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 letter argues, however, that prescription drugs fall outside the definition of "health care services" because they differ from "pharmaceutical services" (i.e., an enumerated service under Paragraph (A)).[4]

TMA disagrees with this interpretation for multiple reasons. First, TAHP's argument seems 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

[4] *Id*. at p. 9.

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 cites 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, TMA contends that HB 2090's definition of health care services is inapposite in the context of HB 3459.

TAHP also cites 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 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 public policy rationale for limiting the plain language of the bill. 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 should apply to health care services, including prescriptions, supplies, products and procedures. We ask that TDI clarify the intended broad application of the bill, consistent with the plain language of the bill. It is important for TDI to avoid narrowing the Legislature's intended scope of the law. Anything less than an expansive application of the term "health care services," (inclusive of prescription drugs, x-rays, labs, products, supplies, etc.) would thwart the Legislature's goal of removing unnecessary barriers to patient access to care.

**Preauthorization exemptions**

**3. Under Insurance Code Sections 4201.655(a)(2) and 4201.656(d), the issuer must make a determination by evaluating a random sample of at least five claims from the most recent six-month evaluation period. Please provide input on how an exemption should be considered when there are four or fewer claims for the particular health care service in the most recent six-month evaluation period.**

**TMA Supplemental Comments on RFI No. 3**:

First, TMA notes that TAHP acknowledged in its September 20, 2021 letter that "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."[5] Although TAHP argues for a different result, this statement (along with the plain language of the bill) should lead TDI to reach the conclusion reached by TMA in our September 20, 2021 comments, which is that the initial preauthorization exemption for a particular health care service is not based upon a random sample of claims and there is no minimum claim number threshold for initially granting or denying a preauthorization exemption.

As stated previously in TMA's comments, for this question, it may be helpful to separate this issue by denials and recissions, because TMA believes this question is answered by the express language of the law. For denial of an exemption when there are four or fewer claims, Section 4201.655(c) states:

> (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.

In relevant part, Section 4201.653 states:

[5] *Id*. at p. 12.

> (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.

So in order to grant or deny an exemption for a particular health care service for which the physician has submitted four or fewer claims, the law states that the general 90 percent approval threshold from Section 4201.653(a), Texas Insurance Code would apply. To clarify further, the initial preauthorization exemption for a particular health care service is not based upon a random sample of claims. For example, if a physician had four claims and all were approved for that particular service, the physician would receive a preauthorization exemption for that service from the HMO or insurer, because the physician would have a 100 percent approval rate for those claims.

We reiterate that under the bill, the random sampling of claims comes into play when an HMO or insurer is attempting to rescind a preauthorization exemption that has already been granted. More specifically, Section 4201.654 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 are 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, 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."

As we stated previously, the bill's default status of a continuation of an exemption (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).

Finally, we also note that 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**.[6]

In response to this comment, we reiterate again that Section 4201.655(a)(2) 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.

**6. Under Insurance Code Section 4201.655, an issuer may rescind an exemption from preauthorization requirements only during January or June of each year. Under Section 6 of HB 3459, Subchapter N of Chapter 4201 applies only to a request for preauthorization of health care service made on or after January 1, 2022. Please provide input on TDI's consideration of rules that would require issuers to provide an initial notice of exemption or denial of exemption in June 2022, based on an evaluation of preauthorization requests that were submitted on or after January 1, 2022.**

**TMA Supplemental Comments on RFI No. 6:**

At the September 23, 2021 stakeholder meeting (as well as in written comments), health plan stakeholders asked for flexibility in the implementation of HB 3459. TMA urges TDI, both in terms of general implementation of the bill and, in particular with regard to the start time of implementation, to bear in mind the underlying goal of HB 3459, which is to remove unnecessary barriers to patient care.

HB 3459 was passed because the Legislature agreed that preauthorizations were being used excessively by insurers and HMOs. Rather than serving as a check on the health care system, preauthorizations were being applied to physicians and other health care providers performing common procedures who were having services approved the ***vast*** majority of the time.

This overapplication resulted in unnecessary burdens and expenses to physician practices (creating waste in the health care system). And, even more concerning, it resulted in unnecessary delays in patient access to medically necessary care. Treatment delays can seriously impact a patient's health. Thus, we greatly

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

appreciate the Legislature's efforts to streamline the preauthorization process through HB 3459. We encourage TDI to effectuate the Legislature's intent as expeditiously as possible.

As we stated at TDI's September 23, 2021 stakeholder meeting, it is important to note that HB 3459, in its final form, after compromise, was voted out of the Senate unanimously, 30 – 0. This is a strong indication of the Legislature's recognition of the pressing need for reform in this area. Throughout the nation, many medical associations attempted to worked with health plans to try to reduce preauthorization burdens. We are grateful that the Legislature stepped in to address this issue when needed change did not appear to be forthcoming outside of the legislative process and patient care was being negatively impacted. We ask that TDI not permit health plans to thwart or unnecessarily delay the Legislature's intent in passing this important legislation.

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. We ask that TDI do the same and require health plans to implement the law in a timely manner, consistent with the intent of the Legislature.

In our prior comments on the RFI, we noted that TMA is generally supportive of TDI's stated timeframe for implementation of the law. A conservative reading of the bill would be that the "Subchapter N of Chapter 4201 applies only to a request for preauthorization of health care service made on or after January 1, 2022" includes the claims being reviewed for eligibility for the preauthorization exemption. Under this approach, our assumption is that TDI would require insurers and HMOs to provide initial notices either granting or denying exemptions in June 2022 (based upon a review of claims from January 1, 2022 until the end of June). Any granted exemptions would go into effect immediately after qualifying for the exemption (as the law requires notice to be provided not later than five days after the physician qualifies for the exemption). And any exemption would not be subject to potential recission until completion of the next six-month evaluation period, consistent with the timeframe (i.e., January 2023) and other requirements set forth in the law. Any denied exemptions would be subject to appeal rights under the law. If TDI uses this implementation date approach, we do not believe that health plans would need additional time to evaluate claims beyond the initial six-month period (Jan. 1- end of June), because by that time they should have systems in place to track approvals and denials as they occur (since they can start preparing for the timeframe now).

We also disagree with health plan stakeholder arguments that this approach would entail a five-month evaluation period from January through June and a seven-month period for the next evaluation period, as under the express terms of the law, it would be considering claims from January 1-June 30, which is a six month evaluation period (i.e., January 1-January 31 (month 1), February 1- February 28 (month 2), March 1-March 31 (month 3), April 1-April 30 (month 4), May 1-May 31 (month 5), and June 1-June 30 (month 6). The next six-month evaluation period would be considering claims from July 1-July 31 (month 1), August 1- August 31 (month 2), September 1-30 (month 3), October 1-October 31 (month 4), November 1-30 (month 5) and December 1-December 31 (with recissions to occur in January).

To have a different reading of this timeframe would duplicate claims reviewed for the two six-month evaluation periods. A rational reading of the bill is that the timeframe for finalizing the recission (under Section 4201.654) and notice required to be given before a recission goes into effect (under Section 4201.655) is after the June and January notices of recission go out at the end of June and beginning of

January. Thus, the exemption continues under the law during that period while the appeal is pending. This makes sense as a default status because the physician or provider has already qualified for an exemption; thus, there is low risk for waste, fraud or abuse (and again, even with an exemption in place, the law has a separate provisions designed to address fraud – i.e., Section 4201.659)).

TMA disagrees that the health plans should be able to determine their own six-month evaluation period as it is clear that the law intends for recission notices to go out at uniform times in order to make it easier for physicians and providers to keep track of notices without having to be aware of each plan's individual requirements. To allow plans to choose their own evaluation period would conflict with the express terms of the law.

Alternatively, TMA notes that a more liberal reading of the bill's timing requirements (under SECTION 6 of the bill and Section 4201.655, Texas Insurance Code) would potentially permit plans to grant preauthorization exemptions based upon a review of requests submitted prior to January 1, 2022, since the status of any preauthorization request would not be impacted until the first exemption is granted. TMA previously stated that we would be supportive of this approach as well. Under this approach, health plans would not need additional time for implementation either because they could start evaluating the claims for the six-month evaluation period prior to January 1, 2021.

TMA reiterates that it would not be supportive of any further delay beyond that included in the TDI RFI question.

**Additional comments**

**9. Please provide any additional comments or points of clarification that the rule should address.**

In TAHP's comments they ask that the insurer or HMO's notice time period in Section 4201.659(d) be clarified to refer to business days. We ask that this be kept as calendar days to ensure physicians and health care providers receive prompt notice of being granted a preauthorization exemption.

Additionally, in TAHP's fifth point to RFI No. 9, TAHP states the following:

> TAHP recommends that the rules clarify that a PA exemption (and its corresponding prohibition on retrospective reviews and denials based on lack of medical necessity) is available only to physicians and providers **that order and submit PA requests and** direct the care of their patient. As noted above, 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 patients' particular circumstances; in other words, providers who excel at directing patient's 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 billing provider should not be.

TAHP recommends that TDI rules clarify that the prohibition on reducing payment based on medical necessity does not apply to the rendering provider based on the ordering provider's PA exemption. A PA exemption (and its corresponding prohibition on reducing payment based on medical necessity) should be available only to providers who are directing the patient's care (including determinations that a service is medically necessary and appropriate). Allowing one physician or provider's PA exemption to form the basis of a prohibition on reducing payment to another provider would invite manipulation of the process, allowing treating or dispensing providers to 'shop around' for providers with PA exemptions in order to inappropriately avoid health plan PA requirements.[7]

TMA disagrees with TAHP's comments and suggestions with regard to their claim of so-called "piggybacking" of exemptions. To illustrate, we ask that TDI consider a scenario where a surgeon orders an MRI for which the surgeon is exempt. TAHP is saying that the imaging provider does not receive the preauthorization exemption (and payment protections). If that is the case, then an additional preauthorization must be pursued by the imaging provider, doubling the burden and canceling out the efficiency the law strives for. This is not the intended result of the law. It is important that the preauthorization protections under the law apply to the service regardless of whether the physician billing for the service is the ordering or the rendering physician.

Further, it is important to note that, as TMA representatives stated the September 23, 2021 stakeholder meeting, diagnostic radiologists have restrictions on their ability to order studies, particularly when there is a financial interest (see Stark law). Only after a radiologist treats a patient, may they order studies. For example, after a spine injection, ordering an MRI. It makes no sense to require an additional preauthorization for the radiologist, who is not eligible to order the study themselves.

TMA thanks TDI for the opportunity to comment. If you have any questions, please do not hesitate to contact Kelly Walla, Associate Vice President and Deputy General Counsel, at kelly.walla@texmed.org

Respectfully,

E. Linda Villarreal, MD
President
Texas Medical Association

[7] See p. 18-19 of TAHP comments to TDI Re: Request for Information on Implementation on HB 3459, dated September 20, 2021