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Via electronic submission to: *Mattie.Heith_sc@senate.texas.gov and Eiman.Siddiqui@house.texas.gov*

Joint Committee on Use of Prior Authorization & Utilization Review Processes
Senator Kelly Hancock, Chairman
Representative Tom Oliverson, Chairman

PUBLIC COMMENT LETTER

Re: Texas Hospital Association Response to the Joint Committee on Use of Prior Authorization & Utilization Review Processes

INTERIM STUDY REGARDING PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESSES. The joint interim committee created by Section 4.01 of this article shall study data and other information available from the Texas Department of Insurance, the office of public insurance counsel, or other sources the committee determines relevant to examine and analyze the transparency of and improving patient outcomes under the prior authorization and utilization review processes used by private health benefit plan issuers in this state. The joint interim committee shall propose reforms based on the study required under Subsection (a) of this section to improve the transparency of and patient outcomes under prior authorization and utilization review processes in this state. The joint interim committee shall prepare a report of the findings and proposed reforms.

Dear Honorable Members of the Joint Committee on Use of Prior Authorization & Utilization Review Processes:

On behalf of our more than 470 member hospitals and health systems, including rural, urban, children's, teaching and specialty hospitals, the Texas Hospital Association appreciates the opportunity to provide responses to the Joint Committee on Use of Prior Authorization & Utilization Review Processes' request for information. Hospitals and health plans are partners in ensuring that efficient, high quality care is delivered to Texans. Prior authorization is one of the more burdensome impediments to that partnership. Texas hospitals have seen an increase in requests for medical record reviews through a number of new policies, mandated in the middle of a plan year, forcing hospitals to choose between going out-of-network or simply accepting new administrative requirements. In addition, health plans around the country and in Texas have implemented policies that effectively require prior authorization for emergency care, a significant departure from the "prudent layperson standard," leaving hospitals with increased administrative burden and declining reimbursement.

Emergency Care. Federal law prohibits health insurance plans that cover emergency care from requiring prior authorization for care provided in an emergency department of a hospital, regardless of whether the care is provided in- or out-of-network.[1] In addition, the Emergency Medical Treatment & Labor Act (EMTALA)

[1] 29 CFR § 2590.715-2719A(b).

prohibits a hospital from seeking, or directing an individual to seek, insurer authorization for screening or stabilization services until after the hospital has provided a medical screening examination and initiated stabilizing treatment.[2] For Medicaid managed care, under Texas law, "A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists."[3] Despite a clear prohibition on using prior authorization for lifesaving emergency care, health plans nationwide—including in Texas—have implemented policies tantamount to prior authorization for emergency care. These policies utilize features such as automatic payment for certain diagnosis but full medical record requests for other diagnoses in order for hospitals to obtain payment after providing care in their emergency departments. Not only do these policies cause issues for prior authorization, they also condition payment on a patient's ultimate diagnosis, which runs contrary to the "prudent layperson standard." The prudent layperson standard defines emergency care subject to EMTALA and its treatment and reimbursement protections, defined under Texas law[4] below:

> "[E]mergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:
> (1) placing the person's health in serious jeopardy;
> (2) serious impairment to bodily functions;
> (3) serious dysfunction of a bodily organ or part;
> (4) serious disfigurement; or
> (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

In a January 7 letter[5] to the health plans of Texas, Texas Department of Insurance Commissioner Kent Sullivan wrote, "Claim denials based on a failure to meet the prudent layperson standard for emergency care must be based on a review of the patient's presenting symptoms, not on the later diagnosis code." Moreover, a recent federal case[6] from the Eleventh Circuit Court of Appeals found a patient's "ultimate diagnosis" to be "irrelevant" as to whether the patient presented with an emergent condition under the prudent layperson standard.

To ensure that emergency care is not improperly denied by a health plan, THA suggests changing the definition of "emergency care" under the prudent layperson standard to:

> "[E]mergency care" means health care services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable emergency facility to evaluate and stabilize a medical condition of a recent onset and severity, including severe pain, <u>regardless of the final diagnosis that is given,</u> that would lead a prudent layperson possessing an average

[2] 42 CFR 489.24(d)(4).
[3] 1 Tex. Admin. Code § 353.4(c)(2)(D).
[4] Tex. Ins. Code § 1301.155; Tex. Ins. Code § 843.002; Tex. Ins. Code § 4201.002.
[5] https://www.tdi.texas.gov/medical-billing/letter-to-health-plans.html
[6] Am. Coll. of Emergency Physicians v. Blue Cross & Blue Shield of Georgia, 20-11511, 2020 WL 6165852, at *1 (11th Cir. Oct. 22, 2020).

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Behavioral Health. Behavioral health care is historically subject to more utilization review than physical care, specifically more concurrent reviews[7]. However, more recently, one Texas health plan is transitioning its processes for all inpatient behavioral health from a prior authorization system to a retrospective review process and no longer accepting clinical information by phone[8]. This system of utilization review leaves providers at risk of additional uncompensated care, as they will have no guidance from the health plan during the patient's stay on what level of care will be compensated and what will not be, and will require the provider to submit the entire medical record, which is voluminous. Hospital estimate this proposed change will require additional staff to implement and will lead to most medical records needing to be faxed.

Specialty Pharmacy. Some Texas health plans have also implemented adverse policies related to specialty pharmacies, specifically through the emergence of a practice called "white bagging" and a related requirement restricting the availability of specialty pharmacies. "White bagging" requires a provider to write a prescription for a specialty drug (generally an injectable or infusible drug) and obtain the drug, premixed, for a specific patient from a specialty pharmacy. Oncology treatment is commonly subjected to these new white bagging requirements. White bagging is problematic because it removes the ability of a physician to control the preparation of drugs that often require adjustments in dosage or strength at the time of administration, because these drugs often require special handling and must be administered within a specified timeframe, because there is an inherent delay in obtaining the drugs and because, if a white-bagged medication cannot be used by the intended recipient, the provider is prohibited from using the drug on another patient. In addition to white bagging requirements, some health plans have implemented new mandates to obtain drugs from specific specialty pharmacies who have contracted with the health plan. This is especially harmful for hospitals who operate their own specialty pharmacies designed to efficiently deliver drugs from locations near the place of administration. Failure to obtain a specialty drug from a contracted pharmacy results in a denial of payment for the pharmacy and provider. Although these policies do not specifically require prior authorization, they set a limited path for providers tantamount to prior authorization.

Unilateral Contract Changes. The underlying cause of these and other detrimental policies impacting fairness in contracting and reasonable reimbursement are unilateral, "take it or leave it" mid-year contracting changes enacted by certain health plans. Hospitals and other providers are forced to choose between accepting the terms of the contract change, going out of network or receiving no or nominal reimbursement for care that is delivered. THA recommends exploring the impact of these contract changes imposed during the middle of a contract year that result in new prior authorizations or declining reimbursement.

[7] https://www.tdi.texas.gov/reports/documents/Final-draft-HB-10-report-8.31.18.pdf
[8] https://www.superiorhealthplan.com/newsroom/notice-in-patient-behavioral-health-admission-records.html

Thank you for the opportunity to provide comments on these important issues related to prior authorization and utilization review. Please do not hesitate to contact me with any questions.

Respectfully submitted,

D. Cameron Duncan III
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Texas Hospital Association