Chair Nosse and Committee Members,

While HB 3134 seems good in theory, there are equity and operational hurdles to be considered and at least one portion of the bill that appears to contradict federal law.

Many health plans currently have programs in place that allow high-quality providers to skip prior-authorization (PA) requirements for certain (or all) treatments normally requiring prior-authorization (commonly called "gold carding"). Recently, those programs have come under scrutiny because they can be seen as steering members to certain providers and have been shown to create equity issues within a health plan. For example, providers with sophisticated electronic medical records (EMR) may have better success in getting PA requests approved and could end up in the 80% exemption pool, while lower-volume or rural providers who cannot afford such systems may not meet the 80% threshold so easily. In effect, this means members living in rural areas or in low-income areas (where we already know access disparities exist) are more likely to have to endure PA processes and resulting delays in care. Similarly, large medical group practices with sophisticated EMR systems and which are able to meet the 80% threshold may be perceived by members as "better" practices because the members experience fewer barriers and by implementing this program the health plan has now been forced into a position of seeming to be steering members to these practices. Medicare also requires that members receive the same services and benefits regardless of where they seek the services, so there could be legal concerns with this rule as it applies to Dual-Special Needs Medicare Advantage plans that serve people with both Medicare and Medicaid benefits.

Operationally, this regulation will be very difficult to implement and will require extra investment in staff to handle manual processes. Most claims processing systems do not even have the ability to require PAs for some providers and not for others. Their claims processing rules are built based at the code level and if a particular code requires a PA, then it requires PA for all providers. Instituting this program could require manual (human) adjudication of claims against some master list of providers in the 80% pool. This will require health plans to hire additional staff for this manual processing when they have spent years trying to format their systems for automatic adjudication to meet provider demands for prompt payment. It will also require providers to undergo additional chart-review activities to administer the program and review their charts each year to see if they still qualify for the program. This means health plans will have to hire more nurses to review the charts, and some providers will have to hire staff or contracted vendors to copy/submit charts for review by the plan.

There are a multitude of coding rules, regulations, and guidance that determines when a claim is complete, accurate, and appropriate for payment. These are called "clean claims". One of the requirements that all states have to abide by is the Medicaid National Correct Coding Initiative (NCCI) and section 2.8 of the proposed rule seems to violate this requirement by requiring payment of all claims submitted under this program, regardless of coding rules, incomplete data, or other errors/omissions to be paid. This can put health plans in violation of other federal and state claims coding rules. This section could be updated to only apply to "clean" claims, or could specify that the reason for denying a claim cannot be related to lack of authorization.

An alternative way to approach this would be to require health plans to justify the items/services that require PA based on overall patterns of requests/denials over time. Plans could analyze each service for which they currently require PA and for any items/services that enjoy an overall approval rate of a specific percentage (probably higher than the 80% threshold), the plan would be required to drop their PA requirements for all providers. The rule could require the plans to re-visit their PA list and claims denials on a specific periodicity to adjust their list of services that require PA. This would account for patterns of care by providers in a given community or within a specific practice area and would be much easier and cheaper to administer.

While I support the rule in theory, I think it needs more stakeholder feedback to understand implementation (including feedback from rural providers and health plans of varying sizes), and it needs legal review to ensure it does not contradict federal requirements for processing of claims by health plans.

Thank you for your consideration,

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