Kansas Hospital
ASSOCIATION

June 13, 2022

Ms. Sarah Fertig
Kansas Medicaid Director
1000 SW Jackson
Suite 340
Topeka, KS 66601

Re: KHA Recommendations to KDHE for Consideration of the KanCare 3.0 RFP

Dear Director Fertig,

On behalf of the 123 member hospitals, the Kansas Hospital Association offers the following recommendations to the Kansas Department of Health and Environment for consideration of the KanCare 3.0 Request for Proposal. Our Kansas hospitals are committed to working together with the Medicaid Managed Care Organizations to serve the most vulnerable population in our state, and we look forward to finding ways to improve the overall delivery systems that provides care to these Kansans.

Hospitals and providers have seen a significant increase in the number of denials related to prior authorization requests by the current Medicaid Managed Care Organizations. The Medicaid MCOs require prior authorization for many treatment options including prescriptions, tests, therapies, surgeries, acute inpatient stays and many others. Significant time is spent managing prior authorizations which requires navigation, inconsistent communication channels, variations in process and a host of other challenges associated with fulfilling the insurer requirements. The prior authorization process involves coordination across multiple communication channels including phone calls, faxes and electronic notifications. Multiple phone calls or lengthy conversations are required before approval or denial is received.

Fax transmissions are unreliable and problematic, yet remain one of the main communication channels between providers and payers for prior authorization. The time-intensive tasks involved in obtaining prior authorization with the Medicaid MCOs are among the foremost complaints of staff members who work on them. Peer-to-peer reviews required by the Medicaid MCOs present another set of challenges, sometimes leading to poor patient care, work-arounds, and even unnecessary tests and procedures. The burdens experienced with peer-to-peer review have driven some medical professionals to avoid them altogether, resulting in patients not receiving the proper health care they may need. These burdens include: providers expected to leave a patient appointment to speak to an insurance consultant on the payers' time schedule, repeat of information that was already given to the payer, documents lost by the payer, payer placing a busy provider on hold for a significant time period, lack of timely decisions by the payer, and speaking to an insurance consultant with no knowledge of the clinical skill level to make an informed decision.

Based on all these challenges, hospitals and providers are pressed to answer this difficult question each year, "Is it worth continuing as a Medicaid provider?"

KHA urges KDHE to require adoption of the following principles of utilization management by the Medicaid MCOs. We have identified four broad categories these suggestions fall under. They include Ensuring Timely Response, Closing Accountability Gaps, Instituting Standardization and Outlining Appeals Process:

ENSURING TIMELY RESPONSE

1) Utilization management programs should allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.
2) Utilization review entities should offer a minimum of a 60-day grace period for any step therapy or prior authorization protocols for patients who are already stabilized on a particular treatment upon enrollment in the plan. During this period, any medical treatment or drug regimen should not be interrupted while the utilization management requirements are addressed.
3) If a Medicaid MCO requires prior authorization for non-urgent care, the entity should make a determination and notify the provider within 48 hours of obtaining all necessary information. For urgent care, the determination should be made within 24 hours of obtaining all necessary information. Providers should have the authority to determine urgent-vs-non-urgent.
4) Medicaid MCOs should have set specific timeframes for approval of SNF transfers, rehabilitation, and inpatient authorization to 24 hours from start of approval process. Those timeframes should be made publicly available and easy to find online.

CLOSING ACCOUNTABILITY GAPS

1) A drug or medical service that is removed from a plan's formulary or is subject to new coverage restrictions after the beneficiary enrollment period has ended should be covered without restrictions for the duration of the benefit year.
2) A prior authorization approval should be valid for the duration of the prescribed/ordered course of treatment.
3) No Medicaid MCO should require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy.
4) Medicaid MCOs should provide, and vendors should display, accurate, patient-specific, and up-to-date formularies that include prior authorization and step therapy requirements in electronic health record systems for purposes that include e-prescribing.
5) Medicaid MCOs should publish statistics regarding prior authorization approval and denial rates available on their website (or another publicly available website) in a readily accessible format. The statistics should include but are not limited to the following:
    - Health care provider type/specialty;
    - Medication, diagnostic test or procedure, inpatient stay, SNF Transfer, etc.
    - Total annual prior authorization requests, approvals and denials;
    - Reasons for denial such as, but not limited to, medical necessity or incomplete prior authorization submissions; and
    - Denials overturned upon appeal.

    This data should inform efforts to refine and improve utilization management programs.

6) In order to allow sufficient time for care delivery, a Medicaid MCO should not revoke, limit, condition or restrict coverage for authorized care provided within 45 business days from the date authorization was received.
7) Prior authorization should never be required for emergency care.
8) The Medicaid MCOs should restrict utilization management programs to 'outlier' providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient mix and other relevant factors.
9) Health care is a 24/7/365 service. If Medicaid MCOs are going to require prior authorizations for services outside of their 8 to 4 workday, they must remain open 24/7/365 or have accountability to accept claims outside of their work hours.

INSTITUTING STANDARDIZATION

1) Any utilization management program applied to a service, device or drug should be based on accurate and up-to-date clinical criteria and never cost alone. This includes fair assessment of patients requiring an overnight stay that clinically meets inpatient status. The referenced clinical information should be readily available to the prescribing/ordering provider and public.
2) Medicaid MCOs should publicly disclose, in a searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information, applied to individual drugs and medical services. Such information should be accurate and current and include an effective date in order to be relied upon by providers and patients, including prospective patients. Additionally, the MCOs should clearly communicate to prescribing/ordering providers what supporting documentation is required to complete every prior authorization and step therapy override request.
3) A Medicaid MCO requiring health care providers to adhere to prior authorization protocols should accept and respond to prior authorization and step-therapy override requests exclusively through secure electronic transmissions using the standard electronic transactions for pharmacy and medical services benefits. Facsimile, payer web-based portals, telephone discussions and nonstandard electronic forms shall not be considered electronic transmissions.
4) Eligibility and all other medical policy coverage determinations should be performed as part of the prior authorization process. Patients and physicians should be able to rely on an authorization as a commitment to coverage and payment of the corresponding claim.
5) The Medicaid MCOs should be required to standardize criteria across the industry to promote uniformity and reduce administrative burdens.
6) The Medicaid MCOs should offer providers at least one physician-driven, clinically based alternative to prior authorization, such as but not limited to 'gold-card' or 'preferred provider' programs that reward providers that are demonstrating appropriate use criteria.

OUTLINING APPEALS PROCESS

1) The Medicaid MCO should offer an appeals system for their utilization management programs that allows a prescribing/ordering provider direct access, such as clearly defined contact information, to a provider in the same training and specialty/subspecialty for discussion of medical necessity issues. If the Medicaid MCO does not promptly return calls within four hours, the prior authorization is automatically reversed and approved.
2) Medicaid MCOs should provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All utilization review denials should include the clinical rationale for the adverse determination (e.g. national medical specialty

society guidelines, peer-reviewed clinical literature, etc.), provide the plan's covered alternative treatment and detail the provider's appeal rights.

3) Should a provider determine the need for an expedited appeal, a decision on such an appeal should be communicated by the Medicaid MCO to the provider and patient within 24 hours. Providers and patients should be notified of decisions on all other appeals within 10 calendar days. All appeal decisions should be made by a provider who is of the same specialty, and subspecialty, whenever possible, as the prescribing/ordering provider and was not involved in the initial adverse determination.

KHA is urging KDHE to require adoption by the Medicaid MCOs on these additional issues:

- *Other Utilization Management*
  - Elimination of prior authorization requirements on obstetrical services, critical conditions, burn unit, and serious trauma.
  - When approving a patient for observation versus inpatient stays, clinical criteria standards set by Interqual or MCG must be used as a guideline and not abused by the MCO as the authority. Clinical judgement by a clinician should always prevail.
  - Limit that no observation stay can surpass two midnights and must transition to inpatient status.
  - Set specific timeframes for approval and transfer of patients to long-term acute care or rehabilitation facility to 24 hours.

- *Workforce Issues*
  - Maintain a maximum of three Medicaid MCO contractors to ensure consistency in care delivery, quality and processes.

- *Care Coordination*
  - Require Medicaid MCOs to back-date approval of provider credentialing to the date the application was submitted by the provider.
  - Centralize credentialing at KDHE. One application for each provider is completed and approved at KDHE that all Medicaid MCO's must accept.
  - Limit Medicaid MCO recoupment timeline to 1 year. No recoupment can take place until the appeals process has been exhausted.
  - For providers that show good faith and consistent compliance, limit the number of external audits acceptable by a Medicaid MCO.

Thank you for the opportunity to comment on the KanCare 3.0 RFP process. Please contact me if you have questions at sflach@kha-net.org or (785)276-3132.

Sincerely,

Shannan Flach
Vice President Health Care Finance and Reimbursement