

STATEMENT OF CONSIDERATION RELATING TO
907 KAR 17:025

Department for Medicaid Services
Not Amended After Comments

(1) A public hearing regarding 907 KAR 17:025 was not requested and; therefore, not held.

(2) The following individuals submitted written comments regarding 907 KAR 17:025:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Kathy Adams, Director of Public Policy Nancy C. Galvagni, Senior Vice President	The Children’s Alliance; Frankfort, KY Kentucky Hospital Association; Louisville, KY
Carolyn E. Kurtz, JD, General Counsel & Vice President, Government/Public Affairs	Accreditation Association for Ambulatory Health Care, Inc.; Skokie, IL

(3) The following individuals from the promulgating agency responded to comments received regarding 907 KAR 17:025:

<u>Name and Title</u>	<u>Organization/Agency/Other Entity</u>
Christina Heavrin, General Counsel Dr. Michael Cornwall, Behavioral Health Director	Cabinet for Health and Family Services Department for Medicaid Services
Stuart Owen, Regulation Coordinator	Department for Medicaid Services

SUMMARY OF COMMENTS AND AGENCY’S RESPONSES

(1) Subject: Section 1: Utilization Management

(a) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association, stated the following:

“Section 1 of this rule sets out requirements for MCO utilization review. Of concern is language contained in subsection (1) which states that MCOs are to use ‘nationally-recognized’ standards. KHA and hospitals strongly urge the Department to delete the reference to ‘nationally-recognized’ standards and insert instead a requirement that the MCOs follow the standard established in the Department's regulation 907 KAR 3:130

which specifies the use of Interqual criteria for determining medical necessity. Interqual criteria is developed by national experts and is an industry standard for providers and payers. In fact, all of the MCOs use Interqual but one behavioral health vendor which continues to use its own proprietary criteria which is not a national standard since it is only used by them. Requiring all MCOs to follow Interqual criteria, which is also the standard applicable to recipients in the fee-for-service system, will assure that **all** Medicaid recipients will be treated the same in terms of having access to medical services, regardless of which plan they are enrolled with. It will also assure that all recipients are having their clinical conditions reviewed in accordance with a true national standard, and one that is used in the Medicare program.”

(b) Response: One of the major differences between “fee-for-service” Medicaid and managed care Medicaid is that managed care limits enrollees’ choices for physicians, pharmacies, and hospitals. Those limits are recognized and endorsed by the federal agency (the Centers for Medicare and Medicaid Services) which oversees and provides federal funds to states’ Medicaid programs. Each managed care organization operates differently. If a given enrollee believes that treatment available via another managed care organization is better than what they are receiving through their managed care organization the enrollee can change managed care organizations during the annual open enrollment period.

Additionally, Milliman (rather than InterQual) is currently viewed as the industry standard for utilization management of behavioral health services.

(c) Comment: Kathy Adams, Director of Public Policy of the Children’s Alliance, stated the following:

“Comment: Section 1. (1)(g) requires **written** confirmation from the MCO of approval of a ‘referral for service’ within 2 days. Children’s Alliance members report that one MCO does not provide “written” confirmation of approval of a referral for service. The Children’s Alliance requests that provisions to provide oversight and address non-compliance be added to the regulation.”

(d) Response: The managed care organizations have an internal grievance process to address these types of complaints.

The Department for Medicaid Services (DMS) has the authority to determine whether a managed care organization is complying with this authorization requirement. DMS has a contract with each managed care organization (MCO) and among the terms and conditions of the contracts are requirements regarding utilization management/prior authorizations. The contracts also state DMS’s remedies for addressing MCO failure to comply with contractual requirements. The contracts possess the necessary authority for DMS to police this issue.

DMS welcomes any specific information that can be provided so that it can investigate the matter.

(e) Comment: Kathy Adams, Director of Public Policy of the Children’s Alliance, stated

the following:

“Comment regarding: Section 1. (3), which states:

‘(3) Only a physician with clinical expertise in treating an enrollee’s medical condition or disease shall be authorized to make a decision to deny a service authorization request or authorize a service in an amount, duration, or scope that is less than requested by the enrollee or the enrollee’s treating physician.’

Children’s Alliance members report that not all MCOs consistently comply with this requirement. One member reports that there are still cases of adult psychiatrists reviewing on children and adolescents. Children’s Alliance requests that provisions to provide oversight and address non-compliance be added to the regulation. Examples of problems experienced by Children’s Alliance members include:

We have had residential clients admitted to a psychiatric hospital in need of a medication change due to an exacerbation of mental health symptoms. During the hospitalization the client is stabilized with a specific medication/s. The client is then discharged back to residential care with a prescription/s. The MCO then requires a PA (which is very difficult if not impossible to obtain as most hospital discharges occur late in the day and the prescribing physician is not accessible) or denies payment of that medication/s and indicates the client should be tried on another medication/s first (in most cases the other drug indicated was tried first). This results in missed doses of psychotropic medication and disrupts the continuity of care and overall stability and safety of the client.”

(f) Response: Instead of asking for more medication, why not find out if the program the child is attending is providing adequate care? Children are not expected to be stabilized on psychotropic medication. They are expected to be exposed to medication for a reason related to their inability to participate in therapy. Children are expected to be tapered and removed from mood-altering medications as therapy progresses and skills are enhanced as a result of therapy. DMS is uncomfortable with this agency depending on medication as a primary source of treatment.

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DMS welcomes any specific information that can be provided so that it can investigate the matter.

(g) Comment: Kathy Adams, Director of Public Policy of The Children’s Alliance, stated the following:

“A client has been stable taking Vyvanse since admission. We now have a prior authorization stating that he cannot be on Vyvanse and needs to be on Methylphenidate or Adderall instead. There are no provisions that would allow continuation of the Vyvanse until the doctor can change the prescription, which may not be in the best interest of the client.”

(h) Response: Again it appears that some are “stabilizing” children on medication, ostensibly as a primary source of treatment. In any event, if the physician who is prescribing Vyvanse believes that the child would be harmed if she or he were to change medications, the physician can request an override accompanied by a medical necessity statement.

(i) Comment: Kathy Adams, Director of Public Policy of The Children’s Alliance, stated the following:

“A client is prescribed Zoloft, Abilify and Adderall. All three medications require a prior authorization. The MCO will not approve the dosing of Zoloft and Abilify and wants the client prescribed Vyvanse instead of Adderall. This client’s medication dosing has been closely monitored and titrated by the psychiatrist, in order for the client to reach and maintain stability.”

(j) Response: Is this individual a child? If so, is this child taking three (3) psychotropic medications? If so, there is a clear and present danger to this child’s health and development. If the individual is a child is the notion that the child is “stabilized” by being placed on these chemicals?

With what type of talking therapy is the individual being treated? Is there no other way of helping this individual other than with medications? DMS believes that the managed care organization should investigate and monitor this issue more closely.

(2) Subject: Section 2: Service Authorization and Notice

(a) Comment: Kathy Adams, Director of Public Policy of the Children’s Alliance, stated the following:

“Comment: Section 2. (4) establishes notice requirements if an MCO denies a service authorization or authorizes a service in an amount, duration or scope that is less than requested. Children’s Alliance members report that some MCOs are not consistently complying with these requirements. The Children’s Alliance requests that provisions to provide oversight and address non-compliance be added to the regulation.”

(b) Response: The Department for Medicaid Services (DMS) has the authority to determine whether a managed care organization is not complying with this authorization requirement. DMS has a contract with each managed care organization (MCO) and among the terms and conditions of the contracts are requirements regarding utilization

management/prior authorizations. The contracts also state DMS's remedies for addressing MCO failure to comply with contractual requirements. The contracts possess the necessary authority for DMS to police this issue.

DMS welcomes any specific information that can be provided so that it can investigate the matter.

(c) Comment: Nancy Galvagni, Senior Vice President of the Kentucky Hospital Association, stated the following:

“Section 2 of this rule contains requirements for MCOs to provide a written notice if they deny a service or authorize it an amount less than requested. Subsection (4) requires that the notice state the ‘reason for the action.’ We encourage the Department to strengthen this language to prevent an MCO from simply stating in the denial notice that the service ‘was not medically necessary.’ Requiring more specific reasons of a denial is also required of the MCOs under the private utilization review law. That law requires the content of denial notices to state the specific medical and scientific reasons that coverage or care is being denied. In order to assure this is followed, we request that subsection (4) of this rule adopt that same language to require that the MCOs state the specific clinical basis that an enrollee's condition does not meet the medical necessity criteria. Without this specific information, it is impossible for enrollees and providers to know if the MCO has appropriately applied the criteria and to have sufficient information on which to file an appeal.”

(d) Response: The enrollee and provider will receive the managed care organization's records after an appeal has been filed. The records will contain the information used to deny the request and the enrollee will have the opportunity to demonstrate that the service is medically necessary.

(3) Subject: Accrediting Organization

(a) Comment: Carolyn E. Kurtz, JD, General Counsel & Vice President, Government/Public Affairs, of the Accreditation Association for Ambulatory Health Care, Inc., requested that DMS expand the organizations authorized to accredit an MCO from only the National Committee for Quality Assurance (NCQA) to “any accrediting organization with CMS deemed status.” Ms. Kurtz stated the following:

“The Accreditation Association for Ambulatory Health Care (AAAHC) supports the State of Kentucky in establishing requirements for the state Medicaid managed care program. However, in regard to Section 5, requiring each Medicaid MCO to acquire NCQA accreditation, we request that this section be amended to require accreditation of ‘*any accrediting organization with CMS deemed status.*’ The barrier to competition in the accreditation services market that is created by including only NCQA can be effectively removed by including our recommended language.

Because Medicaid health care organizations provide health care services to

underserved individuals, accreditors with experience surveying these types of organizations should have the opportunity to compete in the accreditation services market. This would not only reduce the cost of accreditation but also provide each MCO the opportunity to choose an accrediting body that best understands its particular business model and culture. The AAAHC, in fact, has extensive experience accrediting health care organizations that serve the underserved. We currently accredit close to 20 Medicaid health plans in Florida, and accredit Indian Health Centers and community health centers across the United States, including several in Kentucky. We are also deemed by CMS to accredit Medicare Advantage managed care plans. Following please find further information about the extensive experience of the AAAHC.

AAAHC OVERVIEW

The AAAHC is a private, independent, not-for-profit corporation with over 30 years dedicated exclusively to quality improvement in ambulatory care. With over 5,000 organizations currently accredited worldwide, including community health centers and ambulatory surgery centers in Kentucky, AAAHC accredits more ambulatory health care organizations than any other accrediting body in the country.

The AAAHC is also recognized by several government entities. As previously mentioned, AAAHC holds deeming authority, first received in 2002, for Medicare Advantage managed health care organizations. AAAHC recently received notice of renewal of its deeming authority from the Centers for Medicare & Medicaid Services (CMS) for an additional six years.

The Centers for Medicare and Medicaid Services also recognize AAAHC as the largest non-hospital (ambulatory) deeming organization for Medicare in the country. In addition, both the United States Air Force and the United States Coast Guard selected the AAAHC to accredit their ambulatory care facilities. AAAHC also holds a contract with the Health Resources and Services Administration Bureau of Primary Health Care to accredit Federally Qualified Health Centers and community health centers.

HEALTH PLAN ACCREDITATION

The AAAHC began accrediting health plans in 1983. Our review encompasses all types of health plans that conduct utilization reviews including staff, group and IPA models. In 1996, the AAAHC became the first organization to conduct an accreditation survey of a pure independent physician association. The AAAHC also conducted HMO surveys on behalf of the Arizona Health Cost Containment System and the Hawaii Medicaid program, and was selected to survey and accredit all of CIGNA's staff and medical group/IPA model health plans in the United States.

AAAHC health plan accreditation is further recognized by nine other states (*please see enclosure for more information on state recognition*). In 1992, the AAAHC was approved by the Florida Agency for Health Care Administration (AHCA) to provide accreditation reviews of health maintenance organizations and prepaid health clinics in

Florida. This designation led to the AAAHC's current position as the largest accreditor of managed care organizations in Florida. AHCA recently notified AAAHC that it will retain the status of an approved accrediting organization for the state of Florida. The approval is valid for a period of three additional years.

In addition to these specific areas of health plan involvement, many AAAHC accredited organizations have their own prepaid health plan, or participate as a provider in a prepaid plan and specifically in managed health care.

AAAHC SURVEYORS & STANDARDS

Surveyors

AAAHC accreditation surveys are conducted by surveyors who are physicians, registered nurses, and administrators who are actively involved in health plans. Only experienced professionals who meet stringent recruitment qualifications are selected as health plan surveyors. These individuals are screened by the Surveyor Training and Education Committee, approved by the Board of Directors, and trained by the AAAHC. Surveyors must attend re-training every two years.

Standards

AAAHC standards, published annually, are developed by professionals representing the highest levels of achievement in clinical practice and health care management. The standards are designed to be dynamic in order to reflect evolving trends in ambulatory health care. Enclosed with this letter is a copy of the *2013 AAAHC Accreditation Handbook for Health Plans*.

Clearly, the AAAHC's expertise in accrediting managed care organizations qualifies us as an accreditor of Medicaid MCOs in the State of Kentucky."

(b) Response: NCQA accreditation is the requirement established in the contracts between the Department for Medicaid Services and the managed care organizations and DMS does not wish to create a discrepancy between the contract and administrative regulation regarding this subject. DMS will consider expanding the authorized accrediting bodies in the future when the current contracts expire.

SUMMARY OF STATEMENT OF CONSIDERATION AND ACTION TAKEN BY PROMULGATING ADMINISTRATIVE BODY

The Department for Medicaid Services (DMS) has considered the comments received regarding 907 KAR 17:025 and is not amending the administrative regulation.