

State of New Hampshire



Department of Health and Human Services

**New Hampshire
Prior Authorization Focus Study
SFY 2014–2015**

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Overview

In December 2013, the New Hampshire Department of Health and Human Services (DHHS) began enrolling Medicaid members in the statewide Medicaid Care Management Program. Originally there were three managed care organizations (MCOs) providing services to enrollees. In July of 2014, one of the MCOs exited the State. The remaining two MCOs, New Hampshire Healthy Families (NHHF) and Well Sense Health Plan (WS), continue to administrate the services provided through the Medicaid Care Management Program. In addition to the two MCOs, New Hampshire has Medicaid recipients in the State's fee-for-service (FFS) program.

Both the managed care and FFS programs have established prior authorization requirements for medical services, medications, and equipment. Because each entity individually established procedures and guidelines for their prior authorization process, there are different requirements to follow when requesting prior authorizations from the two MCOs and FFS. In an attempt to minimize the disparities between the MCOs' prior authorization processes, DHHS established a requirement in the state fiscal year (SFY) 2015 New Hampshire Medicaid Care Management Contract (Section 22.1.8) that "the MCOs shall work in good faith with DHHS to develop prior authorization forms with consistent information and documentation requirements for providers, wherever feasible."¹

Background

The federal Balanced Budget Act of 1997 (BBA), Public Law 105-33², requires State Medicaid agencies that contract with Medicaid MCOs to use an external quality review organization (EQRO) to review the quality, timeliness of, and access to, care and services provided to Medicaid members by Medicaid MCOs. Health Services Advisory Group, Inc. (HSAG) is the EQRO for the State of New Hampshire, and HSAG began working in the New Hampshire Medicaid Care Management Program in August 2013. The contract between DHHS and HSAG requires HSAG to conduct focused areas of study on topics identified by DHHS.

In September 2014, DHHS requested assistance from HSAG to conduct a focused study to determine the current prior authorization process used by the two MCOs and the New Hampshire FFS system. DHHS and HSAG met to discuss the study and to determine the methodology that would be used to elicit the information needed to assess the prior authorization processes. DHHS and HSAG decided to structure the study with two distinct phases.

Phase I of the study involved contacting Medicaid providers to request feedback concerning their experiences using the three prior authorization systems (i.e., NHHF, WS, and FFS). Telephone interviews were conducted with 40 providers' offices who served members in both MCOs. Information obtained during the interviews defined the topics that HSAG investigated during the next phase of the study. During Phase II, the areas of concern expressed during the interviews were grouped together to form four key elements of the prior authorization process: prior authorization requests, documentation

¹ State of New Hampshire Department of Health and Human Services. (2014). *Amendment #5 to the Medicaid Care Management Contract*. Retrieved from <http://www.dhhs.nh.gov/ombp/caremgmt/documents/mco-amendment-072014.pdf>. Accessed on: July 22, 2015.

² United States Government Printing Office. (1997). *Public Law 105-33*. Retrieved from <http://www.gpo.gov/fdsys/pkg/PLAW-105publ33/pdf/PLAW-105publ33.pdf>. Accessed on: April 22, 2015.

requirements, determinations, and resolution. This report explores the four areas and evaluates the similarities and differences in the way NHHF, WS, and FFS implement their prior authorization procedures and processes.

Methodology

The External Quality Review Protocols established by the Centers for Medicare & Medicaid Services (CMS) defined the process that EQROs use to conduct focus studies.³ The protocol for conducting focus studies lists eight activities that must be completed. These activities are discussed below.

Activity One involves selecting the study topic that could benefit from process improvement. DHHS received provider feedback concerning the difficulty in navigating the prior authorization requirements, both prior authorizations processes and clinical content, and decided that studying the prior authorization programs may assist the State in developing quality improvement strategies to improve the existing systems.

Activity Two in the focus study protocols involves defining the study questions. The study question developed for this project is as follows: How can the New Hampshire Medicaid program (managed care and fee for service) prior authorization process be made more efficient and effective?

The question was initially explored during Phase I which included provider interviews. Study participants were asked the following question: What feedback do New Hampshire Medicaid providers have concerning their experiences with the FFS and MCOs' prior authorization systems?

Specific information about the MCOs' and FFS prior authorization processes was obtained during provider telephone interviews. That information was used to determine the actual areas of concern which in turn generated the study questions for the second phase of the study. Focused areas that were considered in the review of prior authorization processes during the second phase of the study included physical, occupational, and speech therapy; hospice; home health; personal care services; private duty nursing; home visiting services; and pharmacy. These areas were chosen by the State as being high volume and potentially amenable to more efficient prior authorization approaches, or being more problem-prone services related to the prior authorization process.

During the second phase of the study, the MCOs provided documentation describing and demonstrating their prior authorization process for each of the services being investigated. HSAG worked with DHHS to define the current FFS prior authorization processes.

Activity Three in the focus study protocols concerns the development of the study variables which included the prior authorization processes established by FFS and each of the two MCOs.

Activities Four and Five in the focus study protocols require the identification of the sample (e.g., the provider population) that will be contacted to obtain feedback about the three prior authorization systems. Information from providers or their office staff was elicited by calling 40–50 provider offices

³Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 8: Conducting Focused Studies of Health Care Quality, Version 2.0, September 2012*. Retrieved from <http://www.medicare.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/eqr-protocol-8.pdf>. Accessed on: April 22, 2015.

and talking to the person who initiated the requests for prior authorizations. Based on the services studied, the following specialties were sampled for the telephone interviews: primary care providers (i.e., general medicine, internal medicine, family practitioners, pediatricians, and advance practice registered nurses), speech and/or occupational therapists, and psychiatrists (focusing on prior authorizations for medications).

The sampling methodology for the provider calls was developed in collaboration with DHHS. To ensure that HSAG received meaningful information from the providers, DHHS furnished the names of providers who have submitted comments in the past about the prior authorization systems. In order to gain the perspective of providers who have used the two MCO and FFS prior authorization systems, HSAG generated a sample that included providers who were on the network of both MCOs. If a provider’s office had not used the prior authorization process, that provider was eliminated from the study. The remaining interview questions were developed in collaboration with DHHS.

Activities Six, Seven, and Eight of the focus study protocols require reliability in the collection of data, the analysis of data and the interpretation of the study results, and the reporting of results to the State. To compare the prior authorization processes, key activities were defined in the individual services’ prior authorization procedure for each MCO and FFS. Comparisons were made to show where the processes are similar and where they differ for each entity. The study was designed to ensure validity and reliability in the results of both phases of the project.

Phase I of the Focused Study

In January 2015, Horn Research published a report (Attachment A) summarizing findings from the provider interviews regarding their experience with the prior authorization process within the Medicaid Care Management Program. Horn Research surveyed 40 health care providers via telephone interviews during November and December 2014. Table 1 displays the specialties of the providers who were surveyed.

Table 1—Respondents to Telephone Survey by Provider Specialty

Provider Specialty	Number of Respondents	Percentage of Respondents
Pediatrics	11	27.5%
Family practice	9	22.5%
Medical Center/Hospital	7	17.5%
Obstetrics/Gynecology	3	7.5%
Psychiatry/Behavioral Health*	4	10.0%
Oncology/Hematology	2	5.0%
Cardiology	1	2.5%
Home care	1	2.5%
Neurology	1	2.5%
Pain management	1	2.5%
Total	40	100%
*This specialty includes providers associated with the New Hampshire Community Mental Health Centers		

Areas of Concern Categorized

HSAG reviewed the survey responses given by providers and noted that providers listed 27 separate concerns with the prior authorization processes, which are presented in Tables 2, 3, 4, and 5. The 27 concerns noted by providers were categorized into four key elements of a prior authorization process, which included:

1. Request and access
2. Documentation requirements
3. Determination
4. Appeals and resolution

Table 2 displays the six concerns expressed by providers during the telephone interviews that related to prior authorization request and access process.

Table 2—Prior Authorization Request and Access Process

Concerns Noted for Request and Access	
1	Telephone option for submitting requests needs to be improved by the MCOs
2	Restrictive formularies; more user friendly
3	NHHF’s forms easier to complete; providers experience higher denial rate from that MCO
4	Needing to verify patient eligibility prior to submitting FFS prior authorizations is cumbersome*
5	Different forms to complete for each MCO and FFS; would be helpful if they were standardized or a centralized process; consistent requirements
6	Explore the option of online submissions
*This item is listed in Table 2 and Table 3.	

Table 3 displays the five concerns expressed by providers during the telephone interviews that related to prior authorization documentation requirements.

Table 3—Prior Authorization Documentation Requirements

Concerns Noted for Documentation Requirements	
1	Amount of time it takes the office staff to complete the prior authorization paperwork; cost burden to office
2	MCOs request too much information
3	Well Sense requires more information and require patients to “fail first” for off-formulary medications; providers receive faster responses from that MCO; helpful website
4	Needing to verify patient eligibility prior to submitting FFS prior authorizations is cumbersome*
5	Elimination of some prior authorizations**
*This item is listed in Table 2 and Table 3.	
**This item is listed in Table 3 and Table 4.	

Table 4 displays the 15 concerns expressed by providers during the telephone interviews that related to prior authorization determinations process.

Table 4—Prior Authorization Determination Process

Concerns Noted for Determinations	
1	Inflexible medical policies at MCOs; medical policy variations; unable to determine decision criteria
2	Frequency (high number) of denials
3	MCO staff training for employees working in the prior authorization department needs to be improved; staff lacks clinical knowledge which increases denials; staff not friendly
4	Clinical follow-up requested by MCOs
5	Timing of responses or lack of response from MCOs; delays in treatment; unnecessary risks to patients; real-time responses needed
6	Authorizations required too frequently; approvals need to be given for longer periods of time; denials for ongoing medications for no valid reason
7	Requiring unnecessary tests before authorizing the most effective test
8	Medical policies related to pain medications
9	Inflexible dosing criteria for medications
10	Requiring step therapy when the provider has already tried other medications that failed
11	Receiving prior authorization for urgent and emergent needs for medications or procedures; refusing to give prior authorizations over the telephone
12	Confusion concerning MCOs' formularies and policies
13	Denial of generic medications (due to rebate system?); perception of miscommunication between MCO and pharmacy resulting in denials
14	Inconsistent results from prior authorization requests; understanding why requests are denied; need to have more information concerning protocols, formularies, and procedure codes
15	Elimination of some prior authorizations*
*This item is listed in Table 3 and Table 4.	

Table 5 displays the three concerns expressed by providers during the telephone interviews that related to prior authorization appeals and resolution.

Table 5—Prior Authorization Appeals and Resolution Process

Concerns Noted for Appeals and Resolution	
1	Burden of peer-to-peer reviews; and two-layer processes where a specialist must first consult with the medical director prior to discussing prior authorization requests with a clinician of the same specialty
2	Length of time for prior authorization problem resolution (amount of time to prepare and time for resolution with an unfavorable results; process confusing)
3	Providers would like a specific person to call to resolve prior authorization issues

Phase II of the Focused Study

Prior authorizations provide a challenge to providers and health plans. The goal of prior authorization is to have an efficient process in place for the providers and health plans to make medically appropriate and cost effective decisions. To accomplish this, the prior authorization activities should be a collaborative effort between providers and the authorizing entity.

Phase II of the study was designed to identify prior authorization activities that each MCO and FFS use in making prior authorization determinations. HSAG requested flowcharts and documentation from the MCOs to demonstrate the key activities conducted for each element of the prior authorization process.

The health plans were asked to submit documentation and provide the Internet addresses for health plan or vendor websites that would demonstrate processes used within its prior authorization programs (*MCO Document Request List*, Attachment B). The requested items were placed on the HSAG secure website in 24 folders that described the MCO's prior authorization process. For FFS, State staff members provided information, and HSAG obtained a copy of the contract signed in 2013 between DHHS and its medical services prior authorization vendor, KePRO. HSAG also reviewed all prior authorization information available on KePRO's New Hampshire Medicaid website. Magellan Medicaid Administration (Magellan) is the pharmacy benefit manager (PBM) for New Hampshire Medicaid. Additional information was captured from the DHHS pharmacy benefits management website. The results of the documentation review were aligned to the four key elements of the prior authorization process—request and access, documentation requirements, determinations, and appeals and resolution.

Although the two MCOs submitted documentation that addressed most of the 24 components listed on the *MCO Document Request List* (Attachment B), the types and content of documents submitted varied between the two MCOs. In some instances this resulted in an inability to compare the results of both MCOs and FFS. For example, NHHF provided the number of non-clinical referral specialist staff, number of prior authorization nurses, medical directors, and pharmacy staff to make respond to prior authorization requests. WS only provided the number of internal prior authorization staff used for pharmacy. As a result, a comparison of the number of staff used in each MCO's prior authorization program to total membership could not be made.

The information presented in the sections that follow (i.e., Tables 6, 7, 8, and 9) was derived from documentation submitted by the MCOs, a review of each health plan's website, and a review of documentation that described the FFS program's prior authorization process.

Prior Authorization Request and Access

The first activity associated with a prior authorization is submitting the request for service. Before the prior authorization can be submitted, however, a provider must obtain information concerning the process each entity uses to receive prior authorization requests.

Table 6 displays the similarities and differences for 13 key prior authorization components found during the review of each payer's prior authorization request and access process.

Table 6—Prior Authorization Request and Access

Prior Authorization Request and Access	NHHF	Well Sense	FFS
Provider communication of prior authorization requirements	Yes	Yes	Yes
Provider portal to verify member eligibility	Yes	Yes	Yes
Medical policies accessible to providers	Yes	Yes	Yes
Prior authorization forms used for urgent and standard requests	Yes	Yes	Yes
Provider online training	Yes	Yes	(Medical/Pharmacy) Yes/No
Comprehensive online matrix for services with medical policy imbedded that is used for medical determination	*	Yes	Yes
Pharmacy step-therapy program	No ¹	Yes	Yes
Staffing numbers for medical approvals provided by MCO	Yes	No	Yes
Staffing numbers for pharmacy approvals provided by MCO	Yes	Yes	Yes
Notices to providers about updates to the prior authorization process	Yes	Yes	Yes
More than one clinical pharmacy websites	No	No	Yes
Prior authorization forms include check-box for urgent requests	Yes	Yes	No
Non-clinical staff handles initial prior authorization request	Yes	Yes	(Medical/Pharmacy) Yes/No

*Unable to determine from the website and the information submitted for the study.
¹ While NHHF confirmed they do not have a pharmacy program specifically titled step therapy, the study could not confirm if the health plan has a program that requires a recipient to fail preferred medications before having access to the requested medication.

Similarities

NHHF has a Medical Reference Guide which furnishes a two page resource for providers to use to assist in understanding and submitting prior authorizations. WS communicates requirements to providers through a variety of mechanisms, including online posting of internal medical policies and a Prior Authorization Matrix or quick reference guide. Pharmacy requests are submitted by fax to either of two numbers depending on the drug. Each individual prior authorization form directs the provider to the appropriate fax number. FFS also communicates prior authorization requirements to providers via the website and mailed provider notices.

Both MCOs and FFS have a provider portal for use in verifying member eligibility. Providers can submit prior authorization requests online or by fax for both MCOs. FFS allows prior authorization requests to be submitted by telephone, fax, or email.

According to the FFS contract with KePRO, FFS uses a call center as the single point of contact for the providers to obtain information, authorization for Medicaid benefits, and other medical services and procedures.

NHHF and WS both have non-clinical, prior authorization staff members who respond to telephone calls for prior authorization questions. Both MCOs specify a set of services that can be approved by non-clinical prior authorization staff if the criteria established for the services are met. Service authorization requests that do not meet the established criteria are forwarded to clinical staff (registered nurses) for

review. FFS also uses non-clinical staff to review medical service prior authorization forms for completeness prior to routing the prior authorization request to clinical personnel for review. FFS pharmacy requests use only clinical staff to review forms. The clinical staff used in FFS included a certified pharmacy technician and a registered pharmacist for pharmacy requests, and a nurse for medical requests.

Both MCOs ensure that appropriate clinical credentials and licensing requirements are met for the staff positions performing prior authorizations. In addition, the MCOs offer training and mentoring programs that enhance the job skills of its staff. The MCOs and FFS (KePRO) provide online training presentations for the providers covering prior authorization topics.

Both MCOs and FFS send regular (weekly and annually) notices to providers about updates to the prior authorization process.

Differences

It could not be determined if NHHF included a comprehensive matrix that listed the covered services and associated medical policies used for medical determination. WS has one website location in which the provider can check services, drug prior authorization criteria, medical policies, and the appeal process. In addition, WS has a comprehensive online Prior Authorization/Notification Requirements matrix that provides the covered service, types of services, vendor and contact information (including telephone number, fax number, and website). The matrix has the clinical policy for the service and the timeframe requirements for submission. The provider needs only to click on the clinical policy to find a resource that is used for the medical determination. For the FFS system, providers may access the administrative rules for clinical decisions at the New Hampshire DHHS website.

NHHF did not provide information and did not provide confirmation concerning step-therapy details for its pharmacy prior authorizations. WS and FFS use a pharmacy step-therapy approach to care that requires the use of a recognized preferred/first-line medication before approval for a non-preferred/second-line medication is granted. If the required therapeutic benefit is not achieved using the preferred/first-line medication, the prescriber may request the use of a non-preferred/second-line medication.

Concerning the number of staff devoted to the prior authorization process, NHHF reported there were 6.5 non-clinical referral specialists; 6 prior authorization nurses; 2 medical directors; and 8 pharmacy staff devoted to prior authorization. The only staffing numbers reported by WS for its prior authorization program included 6 pharmacy staff. For FFS, staffing numbers were provided for medical prior authorizations (1 full-time equivalent), but the information concerning the credentials of the staff member was not provided. For FFS pharmacy prior authorizations, 1 certified pharmacy technician and 1 registered pharmacist were noted.

Both MCO prior authorization forms include a check box to indicate if the request is urgent and needs to be expedited. This status ensures the provider's request is handled expeditiously, if needed. The FFS forms do not include a check box to indicate if the request is urgent but providers are instructed to mark "urgent" on the top of the form and include the reason for the urgent request. The FFS pharmacy provides a response for all prior authorization requests for FFS pharmacy services within 24 hours.

The FFS pharmacy program has a pharmacy website in addition to the pharmacy vendor, Magellan. The information on the FFS website is repeated on the Magellan website. Providers and members may find it confusing as to which of the locations should be used for obtaining pharmacy information.

Prior Authorization Documentation Requirement Process

An important component to the prior authorization process is whether all the required documentation has been submitted by the provider in order for the health plan to make a determination based on medical necessity. Clinical documentation must support the rationale for the request for the medical and pharmacy services.

Table 7 displays the similarities and differences for six prior authorization components found during the review of each entity’s prior authorization documentation requirement process.

Table 7—Prior Authorization Documentation Requirements

Prior Authorization Documentation Requirements	NHHF	Well Sense	FFS
Prior authorization forms clearly state requirements for clinical information	Yes	Yes	Yes
Provider notified of delay in processing if documentation not complete	Yes	Yes	Yes
Prior authorizations submitted by fax or web	Yes	Yes	Yes
Prior authorizations submitted by mail	Yes	No	Yes
Prior authorizations submitted by telephone	(Medical/Pharmacy) Yes/No	No	(Medical/Pharmacy) No/Yes
Prior authorizations mailed to out-of-state locations	Yes	No	Yes

Similarities

Both MCOs and FFS instruct providers to include supporting clinical information with the prior authorization request and the instruction is clearly marked on the prior authorization request form. The forms also instruct the provider that incomplete information might delay the processing of the response. Further, providers are instructed to submit prior authorization request forms to MCOs and FFS by fax or email.

Differences

For NHHF, medical prior authorizations can be sent by web portal, fax, or telephone; and pharmacy requests can be faxed or mailed, but not submitted via telephone. The mailing address is a location in Fresno, California. If by telephone, documentation supporting medical necessity is required. For WS, prior authorizations can be faxed or submitted online through the Clear Coverage system, accessible with a login. For FFS, requests for prior authorization completed forms can be faxed or mailed. To mail, the address is located in Henrico, Virginia. KePRO does not accept FFS prior authorization request by telephone, however, Magellan will accept pharmacy prior authorization requests by telephone.

Prior Authorization Determination Process

Once the prior authorization forms and documents have been submitted by the providers, the health plan point of contact (i.e., the non-clinical staff) determines if specific criteria have been met. If the specific criteria have been met, a decision can be made immediately. If not, clinical staff needs to review the request. Both MCOs utilize nationally established clinical criteria developed by experts, as well as internal medical policies approved by clinical committees. FFS uses nationally established clinical criteria as well as New Hampshire administrative rules. KePRO also uses nationally established criteria and Medicare rules for durable medical equipment.

Table 8 displays the similarities and differences of 22 prior authorization components found during the review of each entity’s prior authorization determination process.

Table 8—Prior Authorization Determination Process

Prior Authorization Determinations	NHHF	Well Sense	FFS
National Criteria used to make determinations	Yes	Yes	Yes
Internally developed criteria for medical decisions	Yes	Yes	Yes
Utilizes additional external prior authorization criteria	*	Yes	(Medical/Pharmacy) No/Yes
Pharmacy offers 72-hour emergency supply	Yes	Yes	Yes
Access after normal business hours to clinical staff	Yes	Yes	(Medical/Pharmacy) No/Yes
Viewing by provider of processed prior authorization requests online	Yes	*	Yes
Drug formulary online	Yes	Yes	Yes
Non-clinical staff can approve prior authorizations, with specific criteria	Yes	Yes	No
Only medical directors can make adverse decisions	Yes	Yes	Yes
Annual review of medical policies	Yes	Yes	Yes
Denial letter components include rationale for determinations	Yes	Yes	Yes
Denial letter includes opportunity to request criterion used to make decision	Yes	Yes	No ¹
Denial letter includes appeals rights	Yes	Yes	Yes
Denial letters faxed, posted to secure website, and mailed	Yes	Yes	Yes
Provider notified of delay in processing, if documentation not complete	Yes	Yes	Yes
Inter-rater reliability threshold of <80%	Yes	Yes	No ²
Inter-rater reliability applies to individuals and departments	Yes	*	Yes ²
Corporately developed policy for prior authorization	Yes	*	No ³
Utilizes medical management system for prior authorizations	Yes	Yes	Yes
Authorizations and denials internally audited	*	Yes	Yes
Requests for therapies, durable medical equipment (DME), orthotics, and prosthetics referred to board certified consultants	Yes	*	No
Immediate response to urgent prior authorization requests by telephone	No	No	(Medical/Pharmacy) No/Yes
*Unable to determine from the website and the information submitted for the study.			

Prior Authorization Determinations	NHHF	Well Sense	FFS
<p>¹Denial letter includes criteria used to make decisions in plain language, but offer to request criteria used to make prior authorization decision is not included in the letter.</p> <p>²Inter-rater reliability (IRR) testing is performed on a quarterly basis for medical prior authorization requests to determine if problems exist. There was no IRR threshold provided. IRR for pharmacy prior authorization was not reported.</p> <p>³For the FFS program, policies for prior authorization of medical and pharmacy services were developed by the New Hampshire DHHS.</p>			

Similarities

Both health plans utilize InterQual^{®4} Level of Care Criteria (InterQual) and internal medical policies to make clinical decisions regarding medical necessity. FFS uses New Hampshire administrative rules, Milliman Moderate Care Guidelines^{®5}, nationally recognized guidelines for durable medical equipment, and Medicare guidelines.

After normal business hours and holidays, NHHF prior authorization calls are directed to NurseWise, their nurse advice line. If NurseWise staff members are unable to approve an urgent request, the case is forwarded to NHHF on-call clinical staff for immediate resolution. FFS offers after hours assistance for pharmacy-related requests.

For WS, medical determinations for urgent care are issued within 72 hours of receiving the request for service. After normal business hours and holidays, calls are directed to the Nurse Advice Line. If they are unable to approve an urgent request, the case is forwarded to their on-call clinical staff for immediate resolution. Both MCOs and FFS offer a 72-hour emergency supply when there is a delay in the pharmacy review process.

For NHHF, the non-clinical referral specialist performs the non-clinical review of prior authorization requests that are received by telephone. For both MCOs and FFS, the non-licensed staff members do not conduct any activities that require evaluation or interpretation of clinical information, and they do not make adverse decisions. For both MCOs and FFS, nurse reviewers forward authorization requests that do not meet criteria to the medical director and/or a board certified currently licensed physician, and only medical directors and/or designated licensed clinical review staff can make adverse determination decisions. Both MCOs have non-licensed staff who can make prior authorization approval meeting specific criteria. FFS medical review also uses non-clinical staff to review medical service prior authorization forms for completeness before routing the prior authorization request to clinical personnel for review. For FFS pharmacy reviews, only clinical staff members are used.

Both MCOs and FFS review medical policies at least annually. All three entities make their medical policies and drug formularies available online.

When criteria are not met, both MCOs and FFS fax a written denial notice to the provider, post the notice to the secure portal, and mail the denial letter to the beneficiary. MCO and FFS adverse decision letters include:

⁴ InterQual[®] Level of Care Criteria. Copyright © 2014 McKesson Corporation and/or one of its subsidiaries. All Rights Reserved.

⁵ Copyright © 1990–2015, MCG Health, LLC. All Rights Reserved.

- ◆ The rationale for determinations.
- ◆ The criteria used to make the decision to deny the service.
- ◆ The appeal rights of members to appeal the decision.

Differences

NHHF has a secure provider website and a provider instructional guide can be located under provider resources. The guide provides instructions on how to view processed prior authorizations and how to submit new prior authorizations to NHHF for review. FFS also offers providers the ability to view processed prior authorization requests online. It could not be determined, however, if WS offers the same processed prior authorization viewing capability.

Both MCOs and FFS use non-clinical staff to review medical service prior authorization forms for completeness. The MCOs, however, allow non-clinical staff to approve prior authorization requests when specific criteria are met. For FFS, only clinical staff members are allowed to approve prior authorization requests for medical and pharmacy.

Both MCOs administer annual inter-rater reliability testing with a failing threshold of less than 80%. FFS does not specify an 80% threshold for inter-rater reliability testing, but it does perform internal audits on authorization and denials and conduct inter-rater reliability testing. FFS submits outcomes of staff audits to the DHHS on a bi-annual basis for medical services.

For NHHF, inter-rater reliability applies to individuals, as well as, departments. Individual and departmental corrective action plans are initiated for scores less than 80%, and the corrective action may include precepting individuals or departmental retraining. For NHHF, retesting occurs within 30 days. For NHHF, the Corporate and Health Plan Pharmacy and Therapeutics Committees make the final decisions regarding which medications are included in the NHHF formulary and of these, which require prior authorization for approval. NHHF corporate staff members consider and incorporate New Hampshire Medicaid Care Management contract and New Hampshire regulations into the NHHF Medicaid Care Management formulary.

It could not be determined if NHHF performs internal audits of authorizations and denials, but NHHF does conduct an annual review of medical policies. WS reviews pharmacy policies at least annually for updates that include the addition of new drugs, removal of authorization requirements, generic substitution, and/or changes in treatment recommendations per nationally accepted guidelines. On an annual basis, WS audits authorization or denial determinations against level of care criteria to assess the decision making consistency of clinicians. WS initiates a corrective action plan and provides education in identified areas needing improvement. The corrective action plan information also becomes part of the individual's performance evaluation. No retesting timeframes were provided in the policy. FFS updates clinical criteria at least annually.

According to the Provider Manual, NHHF makes an urgent decision within 72 hours. WS makes an urgent decision within 24 hours based on information provided in the Provider Manual. For urgent pharmacy prior authorization requests by telephone, FFS provides an immediate response. FFS does not allow medical prior authorization requests to be submitted by telephone.

Prior Authorization Appeals and Resolution Process

A final step in the prior authorization process may occur if there is an adverse determination for a prior authorization request. The health plans have processes and timelines in place that allow the provider to appeal an adverse decision. An appeal may include the submission of additional clinical information impacting the adverse decision, or the provider has an opportunity to discuss the decision peer-to-peer.

Table 9 displays the similarities and differences for eight prior authorization components found during the review of each entity’s prior authorization appeals and resolution process. Based on the appeal and grievance reports submitted to DHHS and individual reports submitted by the MCOs, Table 9 also displays prior authorization measures reported for the first three quarters of 2014.

Table 9—Prior Authorization Appeals and Resolution Process^{6,7,8}

Prior Authorization Appeals and Resolution	NHHF	Well Sense	FFS
Contract Standard for resolution of expedited appeals within three days (first three quarters in 2014)	Yes N=134 100%	Yes N=18 100%	N/A ¹
Reversed greater percentage of total appeals than upheld (first three quarters in 2014)	Yes Total Reversed (349)=47.9% Total Upheld (230)=31.6%	Yes Total Reversed (88)=37.8% Total Upheld (57)=24.5%	N/A ¹
Pharmacy has the highest number of denials (2014 Q3)	Yes Highest denials: Pharmacy (45.02%) Second highest: Outpatient surgeries all settings (18.32%)	Yes Highest denials: Pharmacy (30.93%) Second highest: Outpatient surgery all settings (17.31%)	*
High number of appeals that were reported as “abandoned”	Yes (149)=20.5%	Yes (88)=37.8%	N/A ¹
Peer-to-peer process	Yes	Yes	Yes
Higher proportion of expedited appeals (three quarters in 2014)	Yes	No	N/A
Annual pharmacy policy updates	*	Yes	Yes
Initial appeal is submitted to DHHS fair hearing	No	No	Yes
*Unable to determine from the website and the information submitted for the study.			
¹ There is no internal appeals process in FFS for providers. Recipients may file through State administrative hearing process.			

The data displayed in 9 shows:

⁶ New Hampshire Department of Health and Human Services. (March 2015). *New Hampshire Medicaid Care Management Quality Performance Report*.

⁷ Well Sense Health Plan. (Third Quarter 2014 Information). SERVICEAUTH.05 Report.

⁸ New Hampshire Healthy Families. (Third Quarters 2014 Information). SERVICEAUTH.05 Report.

- ◆ For three quarters of data in 2014, both health plans reversed a greater percentage of the total appeals than they upheld.
- ◆ For three quarters of data in 2014, NHHF and WS had a high number of appeals that were abandoned: 20.5% and 37.8%, respectively. No information was provided concerning the reason for the abandoned appeals.
- ◆ For three quarters of data in 2014, both health plans exceeded the 98% contract standard by achieving 100% for resolution of expedited appeals within three days.
- ◆ For the third quarter of 2014, the highest number of denials for the MCOs was for pharmacy, followed by outpatient surgery in all settings.

Similarities

As with both MCOs and FFS, providers may request peer-to-peer discussions in the event of an adverse decision. For NHHF, all requesting physicians must be notified verbally of his/her peer-to-peer rights within 24 hours of the NHHF medical director's initial review. A request for a peer-to-peer must be submitted by the provider within forty-eight hours from the verbal notice of denial. According to the NHHF peer-to-peer policy, the non-clinical referral specialist, who is the first point of contact with the health plan, creates a peer-to-peer task in TruCare (internal care management system). The non-clinical referral specialist then sends an e-mail containing the peer-to-peer request details and contact information to the medical director responsible for responding to the request. The peer-to-peer must occur within one business day after receiving the request from the provider. Once the peer-to-peer is completed, the medical director updates and submits the advisor review and completes a structured peer-to-peer note to document the call and outcomes in the TruCare system.

For WS, there are two options for conducting appeals: re-review and peer-to-peer request. A re-review occurs when additional clinical information is received from a provider by fax. The peer-to-peer request (also known as Doc-to-Doc) typically starts with a physician calling prior authorization or the provider services department and requesting to speak with a medical director. The MCO sends the request to the medical director who made the original decision, if the medical director is available. If the medical director who made the initial decision is not available, another medical director handles the review. Neither process is an option that can be used for an administrative or benefit denial. Providers are not permitted to speak to a medical director regarding an administrative or benefit denial.

Recipients in the FFS program have the right to file an appeal via the fair hearing process; thus, several of the components related to prior authorization appeals and resolution are not applicable to the FFS program.

Differences

NHHF had a higher proportion of expedited appeals than WS in 2014. The total number of expedited appeals was 134 versus 18 expedited appeals for WS during the first three quarters of 2014. For FFS, providers and beneficiaries are notified of appeals and expedited appeals, and must submit a request within 10 calendar days of the date of the denial notification. The FFS appeal decision goes to DHHS within 30 calendar days of its notice. The estimated number of FFS fair hearing requests was 15–17 per year.

For NHHF pharmacy requests, the prior authorization and medical necessity criteria were developed to promote the most appropriate utilization of selected high risk and/or high cost medications. Decisions concerning prior authorizations and medical necessity criteria content were coordinated with input from pharmacy and medical practitioners, health plan representatives, and review of current available medical literature and professional standards of practice.

It was unclear if NHHF updated its pharmacy policies annually. For WS pharmacy, policies were reviewed at least annually for updates that include addition of new drugs, removal of authorization requirements, generic substitution, and/or changes in treatment recommendations per nationally accepted guidelines. FFS updated pharmacy policies at least annually.

Both MCOs and FFS offer peer-to-peer discussions to providers upon request. NHHF, however, maintains a two-layer process for peer-to-peer discussion such that a specialist must first speak with the medical director prior to discussing a prior authorization request with a clinician of the same specialty, such as a psychiatrist.

Vendor Oversight

Both MCOs delegate some portions of their prior authorization processes for medical services or pharmacy services to vendors. NHHF currently delegates pharmacy services to Pharmacy-US Scripts. WS currently delegates prior authorizations to Northwood, Inc. for durable medical equipment and MedSolutions, Inc. for outpatient radiology. WS delegates pharmacy to Envision.

The FFS program contracts with KePRO for medical service prior authorizations and Magellan for pharmacy prior authorization. KePRO, however, is responsible for responding to prior authorization requests for medications that are administered in the physician's office or outpatient setting and Magellan is responsible for responding to prior authorization requests for medications that are dispensed from a pharmacy.

Similarities

Both MCOs have mechanisms in place to provide oversight for its vendor operations and take full responsibility for monitoring the vendor activities and processes. No information was available for the oversight of delegated entities for the FFS program.

Differences

No significant differences were noted in the review of the vendor oversight materials.

Conclusions and Areas for Consideration

Prior authorization is a complex and challenging process, as evidenced by the feedback providers gave during the telephonic interviews. In general, prior authorization requests, documentation requirements, determination processes, and the appeals and resolution process are currently viewed by the providers as inconsistent and cumbersome. Continuation of the collaboration that has already occurred among DHHS, the MCOs, and FFS vendors will be vital to build and sustain a collaborative infrastructure that

supports effective and efficient health care resource utilization and ensures timely decision making for medical and pharmacy service authorization requests.

After reviewing provider responses from the telephone survey, studying each MCO's website, and reviewing the prior authorization documents provided by each MCO and FFS, HSAG identified several key areas that DHHS, the MCOs, and FFS vendors should consider as they work to make improvements to the Medicaid prior authorization processes. Those areas for consideration are organized by the key elements of the prior authorization process—request and access, documentation requirements, determinations, and appeals and resolution.

Request and Access

Regarding request and access of prior authorizations, providers expressed concerns with restrictive formularies, not having the capability of submitting requests online, verifying patient eligibility prior to submitting a FFS prior authorization request, and the need to complete different prior authorization forms for each MCO and FFS. Through a review of the documentation and websites provided for the MCOs and FFS, HSAG observed that there were inconsistencies in the amount of information provided by each entity, such as a comprehensive matrix of services and medical policies, and where information could be located by providers. As DHHS and the MCOs refine the standardized prior authorization template that is already under development, DHHS and the MCOs should consider:

- ◆ Determining if additional opportunities to streamline the current prior authorization process exist. One way to streamline would be to offer providers a single location for submitting prior authorizations online in a web-enabled form that allowed providers to verify eligibility and track the progress of the request.
- ◆ Websites should be easy to navigate so that providers are able to get to needed information and/or prior authorization forms within “3 clicks.”

Documentation Requirements

Through its review of MCO and FFS documents related to documentation requirements, HSAG observed that there were inconsistencies among the payers as to how prior authorization requests were to be submitted (i.e., by telephone, mail, email, or fax). Providers shared their concerns regarding the amount of time it takes for provider office staff to complete prior authorization paperwork and the amount of information needed for prior authorization approvals. Providers also expressed concerns with one MCO's “fail first” approach for off-formulary medications. Providers recommended that prior authorization for some services be eliminated. To address these concerns, DHHS and the MCOs should consider:

- ◆ Gathering provider input into the development and roll-out of the standardized template that is currently being evaluated by DHHS and the MCOs. While a standard prior authorization form template cannot address the clinical detail needed for each medical or pharmacy services request, it could help to gather demographic information in a consistent manner and improve the prior authorization process. Vetting the standardized document in this way has the potential to ease the

transition to the new template and process for many providers and demonstrate to providers that their input is valued by DHHS and the MCOs.

- ◆ Developing a centralized location that includes links to all three payers' prior authorization request submission guidelines, medical policies, clinical criteria, and the standardized prior authorization request form. DHHS could also consider allowing online submissions of prior authorization request as another vehicle of submission by providers.

Determinations

Providers expressed many concerns about the prior authorization determination process including the requirement to perform unnecessary tests before authorizing the most effective test; the high number of denials and inconsistent results from prior authorization requests, which was confusing when providers tried to understand the reasons for the denials; delays in responding to requests; and the level of training MCO prior authorization staff members receive due to a perceived lack of clinical knowledge. Additionally, HSAG observed that there were inconsistencies among the payers regarding allowing providers to view previous prior authorization requests online; using inter-rater reliability thresholds to determine consistency of staff's responses; and conducting internal audits of denials to identify opportunities for improvement. To address these concerns, MCOs should consider:

- ◆ Reviewing the high proportion of denials to determine if there is a pattern in the type of service that is denied. Consider using process mapping to illustrate the sequence of actions that comprise the prior authorization process. The process map will help to highlight areas of complexity and repetitive tasks that may complicate the prior authorization process. To better understand experiences of the provider and member, the process map should be illustrated from the perspective of the provider and Medicaid recipient. Use the results from the process mapping to conduct a failure mode and effects analysis to determine where in the process a failure does occur (or might occur in the future). This will be useful to pinpoint and select impactful activities that will most positively affect the overall prior authorization process so that denials can be reduced. Impactful activities might include but not be limited to, targeted training for MCO prior authorization staff, targeted training for providers, centralized repository of information and links to each payers prior authorization criteria and medical policies, or web-enabled prior authorization request tracking that allows providers to track the progress of a request.
- ◆ Using the results from the failure mode effects analysis, develop updated training materials that providers may access online. The materials should inform providers about drug formularies, pharmacy prior authorization criteria, and step therapy programs mandated by the MCO so that providers may be more familiar with, "the path to yes" when they request authorizations for services.
- ◆ Using provider focus groups to obtain insight into what changes should be included in the prior authorization process, and the most effective way to communicate those changes to providers. Focus groups may be an effective way to determine modifications to the current procedures and methods of communication that would be beneficial to the provider community.

- ◆ Determining the level of consistency of medical determinations made by MCO, FFS, and delegated vendor staff. An increase in the inter-rater reliability threshold from 80% to 90% may ensure a greater consistency for those making prior authorization decisions within the same entity. By increasing the inter-rater reliability threshold, the MCO may more readily discover when prior authorization staff members require additional training so that they obtain the appropriate clinical knowledge to make consistent decisions about medical and pharmacy services.
- ◆ Expanding the use of “auto-PA” wherein web based prior authorization requests are able to query data, typically administrative data, to determine, for example, if a trial of step therapy medication or a required diagnosis is present. Auto-PA can shorten the prior authorization decision turn-around time and lessen provider burden for prior authorization requirement documentation.
- ◆ A single set of clinical prior authorization criteria and a single prior authorization process across the MCOs and FFS could also be considered. While this would have the greatest positive impact on providers, it is understood that each payer would abdicate oversight of their individual program’s utilization management.

Appeals and Resolution

Regarding appeals and resolution, providers shared their concerns regarding the burden of peer-to-peer reviews where a two-layer process was enacted at one MCO such that a psychiatrist must speak to the medical director prior to speaking with a peer in the same specialty; length of time it takes to resolve prior authorization problems or denials; and not being able to define a single point of contact to resolve prior authorization issues. To address these concerns, the MCOs should consider:

- ◆ Allowing prescribers quick and clear access to physician peers for peer-to-peer discussions regarding prior authorization decisions.
- ◆ Determining if a pattern exists in the types of reversed appeals. If there is a pattern, determine if the reversal could be eliminated by clarifying the first-level decision criteria in order to decrease the time and effort expended on the prior authorization process.
- ◆ Conducting focus groups or interviews with members and providers to determine the reasons for the high numbers of both pharmacy denials (45.0% for NHHF and 30.9% for WS) and abandoned appeals (20.5% for NHHS and 37.8% for WS) and determine if the number of appeals can be reduced overall. For example, if appeals are abandoned after the Medicaid member and provider are educated on the rationale for the denial, then it is possible that more initial education is needed to inform providers of the prior authorization requirements.

The DHHS and MCOs have already recognized that opportunities for improvement exist throughout the prior authorization process. Although the concerns expressed by providers were many, the major themes expressed were: lack of standardization among the payers, the amount of provider staff time devoted to prior authorization requests, and the lack of consistency in the application of medical and pharmacy policies. The work already underway by DHHS and MCO staff to develop a standardized prior

authorization template will address some of the concerns expressed by providers. Further, a clearer understanding of the clinical criteria and a consistent application of clinical criteria among payers has the potential to reduce administrative burden at the provider level due to mastering a single process for all payers. By collecting input from providers as changes to the prior authorization processes are considered, DHHS and the MCOs have the potential to get early buy-in from the providers and reduce the amount of confusion that surrounds each set of processes.

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New Hampshire Medicaid Care Management Prior Authorization Study Summary Report

A report detailing the results of qualitative interviews held with health care providers to explore their experience with the prior authorization process within the Medicaid Care Management Program.

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January 15, 2015

**State of New Hampshire
Department of Health and Human Services
Office of Medicaid Business and Policy
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INTRODUCTION

In support of the New Hampshire Department of Health and Human Service Medicaid Care Management Program, Horn Research was subcontracted by HSAG, the State's external quality review organization, to gather qualitative data from health care providers regarding their experience with the prior authorization process within the Medicaid Care Management Program. Horn Research conducted 40 telephone interviews with targeted health care providers during November and December 2014.

Five Key Points of Inquiry were developed based on material provided by DHHS to frame the information to be gathered from participants during the interviews. The Key Points of Inquiry were as follows:

1. Positive Experiences

- The key areas participants considered to be working well within the prior authorization process and any positive experiences they have had

2. Primary Challenges & Negative Impacts

- Participants' challenging experiences with the prior authorization process including the most difficult aspects of the process and the negative impacts of the problems they have encountered

3. Understanding of the Process

- Participants' assessment of their understanding of the prior authorization process and the availability of needed information to successfully interact with the system

4. Problem Resolution

- Participants' experience with the review and appeals process within the prior authorization system and whether they feel that their problems are resolved easily

5. Improvements

- Participants' suggestions for improvements to the prior authorization process

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METHODOLOGY

To complete the goals set forth by DHHS to qualitatively gather information from health care providers regarding their experience with the prior authorization process within the Medicaid Care Management Program, Horn Research engaged a standard qualitative data gathering process as detailed below. A total of 40 individuals participated in a telephone interview.

Sample Size and Composition

The DHHS provided Horn Research a purposefully sampled list of 96 health care providers in New Hampshire representing a range of provider specialties. The sample list included seven providers who had called DHHS to discuss the prior authorization process. The information provided by DHHS included the provider name and contact information, provider type and specialty, and service location.

Participant Recruitment

Each provider on the list was contacted by email and/or telephone to explain the project and to identify the target respondent within their practice. The target respondent was the person who is most responsible for working with the prior authorization systems to submit requests and receive authorizations for Medicaid services: Well Sense, New Hampshire Healthy Families (NHHF), and the NH traditional Medicaid fee-for-service system (FFS).

Multiple contacts were attempted throughout the recruitment period. Initial email and telephone contacts were implemented on November 20, 2014 with interviews commencing immediately. Each provider in the sample was contacted a minimum of five times via email and/or telephone. A total of 40 individuals completed interviews for the project.

Provider Specialty

Table 1 details the number of actual respondents and the full sample list by provider specialty. Overall, the distribution of respondents' specialty type was consistent with the overall sample with a slight under representation of medical centers/hospitals and over representation of psychiatry/behavioral health providers. Each of the provider specialty types in the sample were represented by at least one respondent. The greatest percentage of respondents represented pediatric, family practice, and larger medical centers.

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Table 1. Number of Respondents and Full Sample List by Provider Specialty

	Full Sample	Percentage of Full Sample	Respondents	Percentage of Respondents
Pediatrics	28	29.2%	11	27.5%
Family practice	18	18.8%	9	22.5%
Medical Center/Hospital	27	28.1%	7	17.5%
Obstetrics/Gynecology	5	5.2%	3	7.5%
Psychiatry/Behavioral Health	10	1.4%	4	10.0%
Oncology/Hematology	2	2.1%	2	5.0%
Cardiology	1	1.0%	1	2.5%
Home care	1	1.0%	1	2.5%
Neurology	3	3.1%	1	2.5%
Pain management	1	1.0%	1	2.5%
<i>Total</i>	96	100%	40	99.9%*

*Due to rounding, this column is 0.1% less than 100%.

Data Collection Process

The telephone interviews were led by an experienced facilitator with responses captured in real-time and were directed by an Interview Guide (Appendix 1) developed to address the Key Points of Inquiry. The interviews lasted approximately 10-15 minutes. All participants received a summary of the purpose of the project prior to the interview and were read a statement verifying the confidentiality of the information collected during the interview.

Data Analysis and Validity

When all telephone interviews were completed, the information was analyzed by identifying, coding, and categorizing primary patterns in the data. The consistent patterns found in the analysis of the data and the representative sample supports the validity of the information gathered, but should not be assumed to be *statistically* representative of the whole population. The information provided in this report should be used to identify salient issues relevant to the population, provide contextual information for the larger assessment, and identify avenues for further research.

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ENGAGEMENT WITH THE PRIOR AUTHORIZATION PROCESS

To understand each provider's level of engagement with the prior authorization process, respondents were asked to explain who is responsible for submitting prior authorization requests, how often they submit requests, and the manner in which they submit their requests for each of the MCO plans and for the traditional FFS plan. Organizations interact daily with the prior authorization process and use a variety of personnel to manage the process and submit requests via fax.

Personnel Responsible for Prior Authorization

Interview data suggests that organizations use a variety of personnel to interact with the prior authorization process. Some organizations have administrative staff whose primary role is to manage the prior authorizations whereas others add the process to the duties of their clinical staff. Some organizations use a combination approach of administrative staff and clinical staff. One respondent described their process as follows, *“When we get a request for a prior authorization, the first thing we do is ask if the provider wants to look for a medication within the formulary. If the provider says no, we proceed with the prior authorization. Hopefully we can get the right form on the website, print it out, and we fill out as much of the form as we can. It takes time, it’s not pre-filled out. And then it goes to the provider and they will finish the form to do the clinical questions. Then it comes back to the medical assistants and we fax it to the pharmacy. It’s a little bit of a process, but it’s all we have time for. We have never had staff for this type of administrative process. We don’t have it now and I can’t imagine hiring someone to just do prior authorizations. It takes a lot of time.”*

Frequency of Submission

The vast majority of respondents indicated that their office submitted prior authorization requests daily. A handful said they submit weekly or less often. Nearly all work with all three prior authorization systems, but most noted that they have had decreasing numbers of FFS patients. One respondent said her organization had never submitted a prior authorization request. She suggested that the time engaging with the system was not worth the amount of reimbursement they would receive.

Methods of Submission

Most respondents said they primarily submit their requests via fax. Two organizations said they submit requests through an online portal and two said they submit over the telephone. Of those who submit by fax, about one third said they use the MCOs’ websites to determine if prior authorization is required and to download the proper form. One respondent reported, *“We try to use the forms, and to get the form, we access their website. If it’s a good website, they have a list of medications, and you click on that medication and it will print out the prior authorization form that goes with that medication. For those sites that have that, that’s good. Well Sense has a site like that and it expedites the process to some respect. We like that.”*

Several respondents indicated that while they would prefer to submit requests by telephone, it was usually a fruitless and frustrating experience. A respondent said, *“The one or two times I tried to call, I got blocked. I was told that even if it’s an emergency, I’m unable to complete it verbally by phone. That’s very frustrating. I fax because I’m forced to.”* A provider at a medical center shared, *“Calling is a waste of time. You spend 20 minutes on the phone, and they say fax a form.”* One respondent noted that the FFS allowed authorization requests over the telephone. She said, *“With the straight New Hampshire Medicaid we can call and they’re always very helpful. The MCOs require us to fax a form with the clinical information. We don’t usually call them unless we are checking in.”*

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Many respondents indicated they preferred using the fax option because it offers them the opportunity to keep track of hard-copy files of the submissions. A respondent from an oncology center said, *“I have to send a lot of records, and I want to have my own copy of what I’ve sent in so if there is a problem, I can say this is what I’ve done. It’s easier for me to have the paper copy.”*

A couple of respondents indicated that their organization had limited technical capability to access the MCO websites. One respondent remarked, *“The websites are difficult because we are still antiquated. It’s more of a pain to get on the Internet than getting on the phone.”*

POSITIVE EXPERIENCES

Respondents were asked to describe the aspects of the prior authorization process that were working well. Many respondents said they could not think of anything that was working well with the prior authorization process. The respondents who did note positive experiences mentioned the quick response time from the MCOs, the online tools, the option for submitting requests via telephone for FFS, and specific examples of procedures and services that did not require authorization any longer. A number of respondents also acknowledged that the MCOs are trying to improve.

Timeliness of Response

The most frequently mentioned positive experience was that the MCO typically responded to authorization requests for medications in a timely manner. One respondent reported, *“Eight times out ten, we will get a fax back within twenty-four hours.”* A pediatric provider agreed, *“The response usually comes back within 24 hours.”* Other respondents noted that for some imaging requests the response time was also prompt. A referral specialist at a medical center said, *“With Med Solutions and NIA, I can usually get an answer within a day.”*

Online Tools

Respondents also frequently mentioned the online lookup tool for medications and procedures as a positive aspect of the prior authorization process. In particular, respondents noted that Well Sense’s online tool is clear and helpful. One respondent described, *“Well Sense has a great website where you can type in a name of a medication and it will tell you if it’s covered or not and if it requires authorization. Their website is really great and their forms are really clear and drug specific. It’s helpful.”*

FFS Telephone Option

A handful of respondents noted the option for submitting authorizations by telephone through the FFS system as something they liked. One respondent said, *“The only one that’s working well is the straight Medicaid. You can talk to a real person who helps you on the phone. If they don’t cover it, they let you know what to go back to doctor with to change it. It works very efficiently.”* Another respondent agreed saying, *“Basically the only positive is the straight Medicaid. Usually I can call there and it’s done in five minutes and I have my decision. That’s so unusual.”*

Improved Coverage

A few respondents indicated that there were some procedures or medications which no longer require prior authorization. An OB/GYN provider said, *“They finally agreed to pay for IUDs. Of course we want all our young ladies to get birth control if they want it. They’re a good \$1,000, and for a while we were having to get prior authorization. This is a good thing!”* A pediatrician said, *“Well Sense wants*

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documentation, but they work with you more. They give the patient a month's worth if they have already been on the drug to have time to look into the prior authorization." In addition, a home care provider noted that they now have more leeway to provide services prior to authorization. She shared, "I'd say the new guidelines from NHHF giving six visits upfront is at least cutting down what we have to do on the front end. We still have to send a completed authorization form, but we don't have to worry about denial."

MCOs Improving

A handful of respondents also noted they felt that the MCOs were trying to improve and work with providers. One respondent said, *"Everyone's been very friendly."* Another mentioned, *"It's certainly working better than it did."* Another provider said they noticed that recently there had been fewer prior authorizations required which they appreciated. A family practice respondent shared the MCOs are providing better information and feedback. She said, *"When they deny it now, they send a form that says 'this patient needs to have tried these medications'."* Another respondent mentioned that they had recently received a helpful preferred medication list. She said, *"NHHF provided us a formulary effective October 14 which is a really good 275 page formulary list. It's helping guide us on what we need to do for prior authorization."*

PRIMARY CHALLENGES

Respondents were asked to describe the primary challenges they faced when working with the prior authorization process. Respondents most frequently said the amount of time the prior authorization process took was a burden for staff and patients. Inflexible medical policies which do not take into account medical necessity and expose patients to undue risk were also high on respondents' list of challenges. Respondents expressed frustration with the frequency of denials and restrictive formularies as well as dissatisfaction with the MCOs' staff training.

Too Much Time, Too Often

By far, the most frequently noted challenge was related to the amount of time the providers' staff spends on the prior authorization process. One provider lamented, *"It just takes so much time out of our schedule with the back and forth all the time."* A family practice nurse described, *"It's just time consuming. I'm on triage all day long. I actually stay on my own time and do these. We're not getting reimbursed for all this time I'm spending on this. That's another drawback. I already have a full load and one patient takes me twenty minutes or more to gather all the information. If I have three to do that day, it's an extra hour."* Respondents noted it is not just providing the initial information that takes time: Peer-to-peer reviews also add a significant burden on staff time. An administrator in a medical center explained, *"Our medical assistants are spending more time on the phone with the clinical follow-up for the authorizations. And then we have to take our doctors time to do peer to peer review."*

Others mentioned that they frequently had to follow-up with the MCOs for responses to requests as well. One respondent said, *"You get no response. It takes a long time to hear back. I've never actually gotten anything saying it's approved. I have to follow-up."* Another remarked, *"Sometimes I'll call them, and they'll say that it's been approved, but they didn't send it to me."*

Respondents said that overall the MCOs require too much information which takes too much time to collect and provide. A pediatric provider said, *"NHHF's paperwork requires us to research the whole chart and find documentation supporting why the patient is on the medication, consultation notes, and*

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all the other visits they've had here, what they've tried, when they've tried it, why it didn't work. It takes twenty to twenty-five minutes just to research, not even filling out form. I've faxed over twenty pages before on a patient. It's extremely time consuming." Another respondent shared that the burden is heavier with Medicaid than other plans. She said, *"We find that they ask more information than even Medicare does. We don't have any other insurance company that require as much as they do."*

Respondents also said that the MCOs require authorization too often. A pediatric provider summed it up as, *"Too many things require requests."* Other respondents said that having to submit prior authorization requests for ongoing needs was an unnecessary burden. A provider in a medical center said, *"I've had birth control approved for one month. It's ridiculous. I've had an inhaler approved for three days use – what am I supposed to do?"*

Inflexible Medical Policies

The second most frequently noted challenge respondents shared about their experience with the prior authorization process was related to the criteria the MCOs use for deciding which medications and procedures require prior authorization and whether the requests will be approved. Several respondents commented on the lack of flexibility based on medical necessity. One respondent said, *"When we've tried to work with medical necessity criteria or speak with peer reviewers about what we might need, they will not bend. There's not been much flexibility."* A respondent expressed concern over the medical policy related to pain medications. She said, *"They have a policy that repeated injections extending past 12 months are considered experimental and investigational. Basically they are saying NHHF is going to be rejecting all authorizations for our patients we've seen for the previous year."*

Respondents reported the MCOs sometimes required unnecessary tests before authorizing the most effective test. One respondent described an issue with the MCOs requirement for an ultrasound prior to allowing a CT scan. She said, *"It drives me crazy. Hernias don't show up on ultrasound. When we tried to pre-certify a CT scan based on a clinical assessment suggesting a hernia, they required the ultrasound first. Of course it didn't show up. It was a waste of patient time and staff time. Not to mention the cost."*

Respondents also described challenges with inflexible dosing criteria for medications. One provider described, *"I had a person on a generic, four dollar a month medication. I put the person on one and a half pills at twenty milligrams because the person didn't do well on twenty milligrams and wasn't comfortable with forty milligrams. But because it was forty-five pills a month, it had to go through prior authorization. The person was nice on phone, but it still took twenty minutes. Anyone with a medical background would see the dosing was within norm. To me, there's no reason to waste my time with that."* This was reiterated by other providers describing challenges with the process finding the right dose of medications for attention deficit/hyperactivity disorder (ADHD). A respondent said, *"We have trouble with Well Sense with ADHD medications. Some kids will start with one [pill], and if it doesn't work, we go up to two. And you call back because the kid did better with two and the MCO will say 'you just got it two weeks ago.' The prior authorization didn't cover the option of increasing or figuring out the dose. A lot of times they won't approve it without a lot of hassle."*

Stable Regimen/Fail First

Many respondents indicated requiring patients to "fail first" with other medications or denying a stable regimen because the medication is not on the formulary was very problematic for patients. A provider expressed, *"When patients are stable on a medication regimen and they deny it, it's hard on the families and the patients because they know they need their medications for their conditions."* A respondent from a neurology center said, *"Denial of ongoing medications for no valid reason is a problem. We have*

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patients that have been on the same seizure medications for ten years and all of a sudden they say no. After ten years, I don't care what's on their formulary." A psychiatrist agreed saying, "There are requests for authorization for a medication that's generic that a person has been on and stable with for a long time. The medication itself isn't outside the recommended dose, is being used for the proper reason, and is quite conventional. It's like you're having to authorize why you're eating. If you do something unusual, it makes sense they'd want to know more about that." Another psychiatrist described the challenges with requiring patients to fail other medications first, "Oftentimes, the person has already done that. I've had one situation where they wanted the child to try a different medication first. He had already tried it two years before, but we couldn't get records for various reasons. So this child had to go back and do the same medicine again for a month. He completely decompensated and had a lot of trouble in school which was predictable because he had already tried it."

Urgent Needs

Several respondents said they had difficulties with urgent needs for medications or procedures during the prior authorization process. A medical center provider said, "I currently have one that's rather urgent and I couldn't get anywhere and the nurse couldn't get anywhere. I submitted it to the MCO, but PET scans are only done one day a week. We have to order the test by 1:30 today, or the patient will have to wait another whole week before finding out how bad her cancer is. But our hands are tied. The nurse is going to nag them all day – sometimes that's what you have to do. This isn't typical, but we do run into urgent situations and it's sad we can't get a nurse on the phone to get an authorization. In some of the private insurance companies, I can do that no problem as long as I have the information in front of me to answer their questions." A provider in an oncology/hematology clinic shared, "We don't always have the notice of a change in the moment. Sometimes with a patient all of sudden their white count is low, but not all the time can the doctor stop and send me an email saying they had to do this or that. And there is no leeway so claims are denied." A neurology center agreed saying, "They refuse to do the prior authorization over phone. There's no real time answer even in an emergency."

Denials

Many respondents noted frustration with the high number of denials for their prior authorization requests. A provider said, "I honestly don't think I've ever gotten a prior authorization on the first try without having it to go review. It all goes to review, no matter what it's for, whether I provide a lot of information or a little. It always goes to review. I don't think honestly of all the ones I've done, I've gotten one. It just always does. I don't know why. It's always those two [Well Sense and NHHF]. I can get authorization for Harvard Pilgrim usually no problem." Another respondent said, "I will tell you honestly as soon as I look at the requisition and I see Medicaid, I cringe because nine out of ten times they deny it." A provider commented, "NHHF has the easiest form, but we get the highest amount of rejections from them. They are consistently asking for follow-up, more specific clinical. They have very difficult and in-depth clinical policies."

Formulary Confusion

Some respondents said they were confused by the MCOs' formularies and policies. One respondent said she did not understand why they still had to submit for prior authorization for a preferred drug. She described, "One hard part with NHHF is that I'll do paperwork and documentation and they'll deny it saying 'we'd like you to use our preferred drug', but if you read the fine print, it also requires a prior authorization. They cover it, but it still requires prior authorization." Another said, "I'm trying to figure out before the provider even prescribes it what the right prescription is so you don't have to do prior authorization, but I'm not sure how to do that."

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Several respondents said they did not understand why generic medications were denied. A psychiatrist said, *"I've had a lot of difficulties with things that don't make sense. I can't understand having to justify cheap, generic, appropriate use medications."* Another illustrated his frustration with the formularies with the example of ADHD medications. He said, *"The state has a preferred drug list that Well Sense and NHHF follows. Their preferred drugs for ADHD meds are higher cost brand name because they do a rebate system. Our providers are accustomed to ordering generic meds and we were running into problems where our patients couldn't get meds and we couldn't figure out why. It was because we were ordering generic. They said we have to order brand names, but it's not cost effective. These are policy based problems."*

MCO Staff

Several respondents noted that they had difficulties with a lack of clinical knowledge by the MCOs' front line staff and peer reviewers. One respondent said, *"The people on the front lines of authorization have no clinical experience. They directly read the policy and if the clinical notes do not meet the exact wording specifically, they just reject it."* Another agreed saying, *"When they get the assessment from doctors, if it's not in their specific medical wording, they automatically reject it. Where we might use a different name for a test, they'll reject it because they want to see their medical policy."* A physician commented, *"Sometimes when I'm doing a telephone peer to peer review, the person I'm talking to isn't really a peer. I want to talk to someone else that can understand the particulars of the situation."* Another provider described, *"My biggest complaint is being denied by people who don't know what they're doing. Some are excellent, but some of them haven't had enough clinical training. For example, people with a history of breast cancer and have pelvic pain and the doctor might want a CT scan. The MCO says we don't have a good enough reason. A history of breast cancer is a good enough reason."* Some respondents also noted that the MCO staff is also not very friendly.

Inconsistent Results

Respondents also suggested that insufficient training and resources for MCO staff lead to inconsistent results for prior authorization requests. One respondent said, *"At Well Sense, staff is their biggest problem out of everything. Nobody is trained, or trained completely differently. By the sound of it, they're reading straight from a handbook, but each handbook sounds completely different. Just last week I had somebody deny a referral to a nutritionist, but the very next day I got an approval for a different patient. What's the difference? It was the same thing, same diagnosis, same age – one person [at the MCO] saying no, other saying yes. And it is the same thing for the medication – same exact problem."* A pediatric provider said with NHHF, *"Sometimes the medication is covered for one child and not another, even at the same dose. I think it depends on who's on the other end."* A medical center respondent mentioned, *"We're finding that training is very inadequate for customer service for prior authorization for both companies. They are having to educate and re-educate their staff."* Some respondents said that errors on the MCOs' end can result in denials. One respondent said, *"Their formulary will say a medication is covered and but then kick it back for prior authorization. Usually it's a miscommunication of date or a code they didn't put in right. It's usually an error between the pharmacy and Well Sense."*

Length of Time for Response

Respondents noted that the time they have to wait for prior authorization for procedures was problematic for their practice. A provider said, *"They take forever for answers. Sometimes the doctor will book something as soon as possible and I'm getting a denial or approval two days after the test. She's the type of doctor whether or not it's approved, she's doing the test. She eats a lot of cost. I pre-certify it and fingers crossed it will be approved. I can call or go online for Anthem, and I get told yes or no right*

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then. With Medicaid, you never get an automatic approval.” Another respondent explained that the delays in response from the MCO will delay scheduling procedures and make the process even longer for patients. She said, “For neuropsych testing or imaging, even if the radiologist says the patient really needs it, the process is long. The hospital won’t schedule until we know it will be covered.”

NEGATIVE IMPACTS OF CHALLENGES

Respondents were asked to describe the impact of the prior authorization challenges on their practice and patients. Providers said the primary consequences of problems with the prior authorization process internally were the increased burdens on staff time which negatively impact patient care and financial losses. Respondents also said patients frequently experienced delays in treatment and medications as well as experienced unnecessary side effects and risks.

Impact on Providers

By far, respondents said the biggest impact of problems with prior authorization is the amount of time they have to commit to the process and how that affects their office. Several respondents indicated that the amount of time spent on prior authorization negatively affects their ability to effectively serve patients. A family practice respondent said, *“To call and track it down, we don’t have time to do that. We just don’t have the staff. It has affected our ability to care for patients the way that we want to.”* A medical center respondent said, *“It has really increased staff time. I work as nurse manager. My job should not be doing prior authorizations for seven hours a day. I average at least forty hours a week for prior authorization time. They’re saving time on their end, we’re spending it on ours. Sometimes when I work over an hour on a prior authorization, I think that I should just give the patient the money to go buy the medication.”* A family practice respondent said, *“It takes a lot more staff time. We have to take the doctor to do this peer to peer thing. It’s tough because they see patients all day long and they have to interrupt that process.”* Another provider said, *“We need authorization for every single patient. It might be 20-25 people at a time that we now have to get paperwork for, get notes, forms, orders, and it needs to be faxed and we need to follow-up on it. We don’t have any more staff, just more work.”* A provider from a hospital noted, *“I spend more time on NHHF and Well Sense than all our other plans combined.”*

Some respondents say they have suffered financial losses as a result of prior authorization. An OB/GYN respondent said they have experienced reimbursement losses. She said, *“We just decide if we can’t get it authorized, we go ahead. The patient care is worthwhile to us. We’re not going to compromise patient care.”* Another respondent commented on the increased administrative costs because of the prior authorization. She said, *“We went from a FFS Medicaid system with no loss to a managed care where everything now requires authorization. We were told this wouldn’t be the case and that it would be like going into an HMO. NHHF and Well Sense caused ten times more work. And we don’t get paid nearly half as what we do for Anthem. We have always graciously welcomed Medicaid patients when others have limited their Medicaid numbers. But when I say there are burdensome administrative costs, we are finding that Medicaid is now 80% of our costs but 60% of our patient population.”*

Impact on Patients

The primary impact on patients reported by respondents was the delay in treatment caused by the wait for both procedures and medications. Providers suggested that these delays have an adverse effect on patient care. A provider recounted, *“If I have to send a patient for an MRI outside of the office, the consequence of not getting an immediate approval is that I can’t book it – so the patient waits. For Medicaid, it could be fourteen days. And a lot of times this is a person with a severe headache and*

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fourteen days means a lot.” A family practice provider noted, “It’s absolutely a delay for patients. Just imagine it, a patient sees a provider and they get prescribed a medication. The provider intends them to get it right away and the patient tries to go to fill it. The next day we might get an authorization request, but we’re a fairly busy office and a prior authorization takes about twenty-four to forty-eight hours to get processed, then the insurance company could take two to three days. That’s a delay of up to five days and that’s never good. It’s a medication they need, but they’re not getting it in a timely manner. It has thrown a real wrench in our ability to prescribe medications that patients need right away. It’s definitely affecting care – we don’t know of anybody who’s had dire consequences, but we’re not really tracking it either.”

Respondents said that patients sometimes have to face unnecessary risks as a result of the prior authorization process. A respondent in a clinic said, *“We can’t get these injections approved. We’re dealing with chronic pain patients, if they can’t get their injections that is more time they are lying on a bed, not able to work, and it’s forcing us to up their medications and put them on opiates. We’re trying to pull patients off opiates, that’s why we do the injections. It’s counter intuitive that they’re making us jump through these hoops. It’s underhandedly telling us to put all our patients on opiates.”* A psychiatrist shared another example, *“A woman who was on a dose of medicine of three hundred milligrams at bedtime and wanted to be able to take a little during the day if she got really agitated and that was refused – but I don’t know why. I think it was because of two strengths of same medicine so I decided to write them all in fifty milligrams so she could take several. That got refused because the quantity limit said she couldn’t have eight pills in a day, even though it was a modest dose of medicine. So we went back to 300 mg at bedtime and had to switch to another medication for during the day. This meant she has to take two anti-psychotics in the same family when she only needed one. This is relatively frowned on, it’s not medically streamlined or smart. If any other doctor saw that they would think I’m stupid for prescribing that. She has a high risk for side effects and it was not necessary for her to have that exposure.”* An OB/GYN provider said, *“There have been patients that we need to determine if they have an IUD, but the guidelines for an ultrasound say it won’t be approved for that purpose. If you can’t get an ultrasound, what are you supposed to do? If they have a copper coil IUD, the last thing you want to do is put them in MRI. It’s ignorance on the pre-certifying agent’s part. That’s really dangerous not to have that approved.”* Some providers also noted that patients decompensate during the time it takes to get approval. A family practice provider said, *“During the wait time for the answers to be approved or denied, the patient can get worse. Particularly if it’s a medication for a serious health problem such as heart disease or diabetes.”* A pediatric provider said, *“We have teenage boys who have been on ADHD medication for years, but because the dosing was above FDA guidelines because the boys were big, they had to come off that medication and onto another. It happened in June at end of school year. We had teenage boys in tears trying to take exams who couldn’t get their medications.”*

UNDERSTANDING OF THE PROCESS

Respondents were asked whether they felt they understood the prior authorization process and if they had the information they needed to effectively submit requests. About half of respondents said they know what they need to do to submit requests, but did not necessarily understand why their requests are denied. A medical assistant in a pediatric office said, *“The forms are very simple and really easy for me to do my part. And the doctor does his part. I give them to the doctor when they have a break and I get them right back. It’s really an easy process.”* However, a provider noted, *“I wish I knew what they want. I don’t know why things are denied.”* Another respondent agreed saying, *“I feel like we do, but we*

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seem to get a different answer from what we're told, or what our handbook says. It's contradictory." Some respondents said they end up providing extensive documentation. A family practice respondent said, *"What I do now is err on the side of giving too much information. I don't want them coming back to me."* Others noted this did not necessarily ensure authorization however. A pediatric provider commented, *"Sometimes we'll send the whole chart to prove the case. For example, a child who is now fifteen and on his ADHD medication since he was five, and it still is not approved. We will call and they say they need more information, but are still not approving. It's more work for us and doesn't seem to make a difference. It's very frustrating."*

Some respondent said they wish they had more information available to them for the prior authorization process such as protocols, formularies, and procedure codes. A psychiatrist said, *"I just learned where one of the formularies is for one of the companies. I would like to have that at my fingertips – guidelines, doses, algorithms. Sometimes I want to prescribe something for off-label use because in my experience it works, even though it's not a first line agent. I would like to know what would be the requirements for that sort of thing."* A family practice provider said, *"I have an old list of the procedure codes that need preauthorization. That's a huge help, but it came out in 2008. It would be nice if it was updated and I could look and see. Some places require a pre-certification for bone scans, others don't. Some places will cover it if you change it to something with contrast. If I had a list that says you don't need a pre-certification, then I don't have to bother them, or the provider, and that patient is seen quickly."* A family practice provider commented, *"For the most part, because I've been doing it a long time, I know what to do. But it would be nice if we had the protocols for ordering all these tests. If you go online, there are ten pages of protocols for just a CT scan for the abdomen. It would be nice to have an abbreviated form of the protocols, so the provider could refer to it. These guys don't do it all day, all the time. We're family practice, but we don't always order the right tests. And sometimes an insurance company will approve a CT, but not an MRI, but we don't know in advance. A comparable thing as a formulary. Something to look into for any office."* Another respondent said they now had the medical policy information, but that it was not necessarily helpful. She said, *"We didn't have access to any of medical policies for NHHF or Well Sense at first. We were able to get around that and get them. But the decisions are still a mystery."*

DIFFERENCES BETWEEN PLANS

Respondents were asked to describe the differences between Well Sense, NHHF, and the traditional Medicaid FFS prior authorization systems. For the most part, respondents indicated that they felt the systems are pretty much the same in terms of challenges and process.

A handful of respondents did indicate they had different experiences with the three systems. The main distinction respondents noted was that NHHF's forms are much simpler to fill out, but that they experienced a higher denial rate, more extensive requests for follow-up clinical information, and a slower response time. Respondents suggested that Well Sense required much more time to submit requests because they ask for more information up front and require patients to "fail first" for off-formulary medications. Well Sense has a more transparent and helpful website and responds more quickly. Respondents also said that prior authorization requests through FFS was more likely to result in immediate approval over the telephone and patients being able to go to a wider range of providers, but the need to verify patient eligibility immediately prior to service was cumbersome. One respondent remarked on what he defined as a cultural difference between the MCOs. He said, *"I feel they just have different philosophies. Well Sense is a bit more polished. They're more of a traditional carrier and NHHF*

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has a bit more of a home spun feel. There's nothing I can put my finger on to tell you why. They have more of a personal touch rather than the Harvard Pilgrim large scale feel you get with Well Sense. Each way has its own benefits and downsides. NHHF might be slower to respond to me on getting a policy because it might not have it. But they will call me right back. Well Sense always has a policy, but might have 156 layers of red tape."

PROBLEM RESOLUTION

Respondents were asked to describe their experiences with the prior authorization problem resolution process including whether they experienced any difficulties or whether they felt their problems were resolved easily. The majority of respondents said that problem resolution takes too much time both in terms of the amount of time they must dedicate to it and also the length of time until a resolution is achieved. One respondent said, *"It's a long drawn out thing. We have on a rare occasion appealed, but we wait forever and the patient is calling. They won't approve ancillary tests. We had a patient who needed a cardiac MRI done. It was a good reason, but it was denied. We appealed, it was denied again, so the patient got a sub-optimal test just because she has Medicaid."* A pediatric provider said, *"Problems are not resolved easily. The nurses get very frustrated. It takes a long time for them to do it."* Another said, *"It's time-consuming. We have been trying to get a prescription for a lady that's been on it for years. We've been trying since the end of October. We appealed and still no word."*

Some respondents reported that the problem resolution process frequently did not result in favorable results even after the time and effort. A respondent from a neurology clinic described a very challenging case, *"After making several phone calls and leaving several messages for requests for peer-to-peer reviews, it still resulted in a denial because of formulary. The patient had been on a medication for 15 years, but they denied it. We had three requests for peer-to-peer, but were still denied based on formulary. There was no consideration for the patient needs. As a result, the patient's parents are paying out of pocket. It was too much of a risk to change the medication."*

About a third of respondents said they did not have any trouble with the problem resolution process. One respondent said, *"I don't really have denials. I've honed my process to the point by doing it over the phone where I can hear it's going south and I can look up more information. I've made a form here that I give my providers to complete before I pick up the phone. I have all the questions I'm going to be asked before I even pick up the phone."* A few respondents said they had made connections with specific personnel at the MCOs they could contact to resolve problems. One respondent said, *"I've tried to make contacts with different people on the clinical side so I have a name and phone number my clinician can call."* Another noted, *"When something is denied, the appeal process is challenging. But with NHHF, if something is denied, they have a representative working with appeals and grievances. She's easily accessible for questions so that's good."*

A few respondents said the problem resolution process is confusing. One respondent said, *"The appeal process isn't clear. When it's denied, it's not clear on what we do first. What is the first step to a denial? Do I arrange a peer-to-peer review or submit a letter of medical necessity or provide more clinical information? Also it requires written consent from patient to appeal on their behalf which is an obstacle."*

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SUGGESTED IMPROVEMENTS

Respondents offered a wide range of suggested improvements to the prior authorization process for Medicaid Care Management. Respondents noted several process suggestions as well as some overarching policy recommendations.

Standardized and Centralized Process

Some respondents suggested it would be easier if the forms and process were standardized across plans. One respondent said, *“In a perfect world, I would love to see standardized authorization forms across FFS, Well Sense, and NHHF. They don’t have to standardize what they’re authorizing, but if they could have similar forms it would be extremely helpful.”* A respondent suggested this could be accomplished through the pharmacies. He said, *“I would like the pharmacy to fax us the right form with all the information included. The pharmacy has all the information. That would be great.”* Another respondent remarked, *“I would like everything centralized so I had the same person to talk to. And once an issue was settled with a patient and medications, the same questions wouldn’t have to be answered again and again with other patients in the same situation. Make it more user-friendly and structured so it informs itself.”*

Access to Formularies and Decision Standards

Other respondents said they would like access to clearer, more user-friendly formularies and decision-making rationales. One respondent said, *“I would like their formularies and how they base their decisions. For example, for an MRI for low back pain, what are the things that we need to show proof of so it’s going to go through. You just never know if it’s going through, even if you make a good argument. I know we’re all supposed to be in it for the patient, but it feels adversarial especially when the information isn’t easily accessed as to what their standards are that they’re judging by.”* Another simply requested that the preferred list for medications be accurate. She said, *“It would save us time and having to do all the paperwork, plus avoid having the patients go to the pharmacy and not getting it filled because it needs a prior authorization.”* Another respondent requested, *“Make it clearer for us to know the quickest and easiest steps for the patient.”*

Better Response from MCOs

A number of respondents said they would like the process to move more quickly. A respondent commented, *“I would like to get a response back more quickly; either a fax/phone call. I always have to call and follow-up.”* Others agreed with wanting better feedback from the MCOs. A provider said, *“I would like more contact from the MCOs. I don’t know where it stands. I never receive any feedback at all.”* Another respondent noted, *“Sometimes we don’t get the faxes they send. They say they sent it, but we never get it. Sometimes it gets a little exasperating. The only way I track it is in a file, I know if it’s been there a while I call find out.”*

Better Training for MCO Staff

Respondents also said they would like the MCOs to train their front-line staff better. One respondent said, *“It’s usually a denial, and I’ll look back at form we submitted, and I’ll see that I filled out the forms correctly, but they’re not reading what I send them.”*

More Submission Options

Several respondents would like to be able to submit requests over the telephone and receive real-time answers. A respondent said, *“I would like to be able to do it over the phone. Then there wouldn’t be a*

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delay in medication.” Others respondents noted they would prefer more online options. One respondent said, “If they could do the PAs online that would make my girls a lot happier instead of filling out forms and faxing them. An online portal would be easier.” Another mentioned she would like an easier way to submit clinical information online.

Improved Medical Policies

Respondents requested improved medical policies which take into account urgent needs and continuity of therapy concerns. One respondent said, *“I would like a number we could call when something is urgent and not to be told we have to send paperwork in. We have fairly good judgment. We’re not going to call with a sprained ankle. We are pretty sure a patient has cancer, but we need to know the extent so we know where to refer her. If we could do the prior authorization on the phone, we’d could have her scheduled for tomorrow [for the PET scan], but we can’t. I would like a telephone number that could be used for emergencies.”* Another respondent said, *“I would have consideration for non-formulary requests for patient specific needs. We refer to it continuation of therapy. If the patient has been on the same medication and it’s been working, don’t change it. Continuation of therapy needs to be a consideration.”* Another respondent agreed, *“The MCOs should not require authorization for standard treatment that someone’s stable on.”*

Expanded Authorization Periods

Respondents said they would like the authorization period for medications to be longer. One respondent remarked, *“I have 90-day periods or 30-day periods for medications, that’s ridiculous. If it’s authorized, it’s authorized. To have to call or re-fax every 90 days is really ridiculous.”* Another respondent suggested, *“I would allow you to prior authorize multiple non-stress tests and OB ultrasounds in advance, instead of one by one. For example with gestational diabetes, I know we’re going to need two of them, but we can’t anticipate any other ones. We might authorize those two we know of, but the unscheduled ones kill us.”* Another respondent said she would like some flexibility on submission dates, *“It would help out if we had two or three days for backdating. That would be the biggest thing. Especially if something’s done on a Friday and we don’t find out ‘til Monday or Tuesday.”*

Eliminate Prior Authorizations

Several respondents said they would like the entire prior authorization process eliminated entirely. They suggested that the MCOs should trust the doctors’ judgment instead. One respondent said, *“I wish they just trusted the doctors to know what they’re doing when they ask for the test.”* Another shared, *“If I had my way, it would be nice to give these patients what they need. Which is more expensive: The MRI or the pre-certifying staff? And then what if the patient has to go the emergency room? If a doctor calls with legitimate claims, maybe they shouldn’t have to do it every single time. It seems like everybody is being punished for a few bad apples. And it doesn’t move the patient along. When you’re in pain and somebody says your doctor can’t give the medication or services to you – it gets silly and very frustrating.”* A physician summed it up as, *“Really the problem is you feel like you’re being babysat. I know what my patient needs. I’ve been seeing this patient for six years.”*

Do Not Make it Worse

A respondent cautioned that she hoped that they do not make it worse with any new changes. She said, *“Before making a change think about how easy it will be for someone to deal with it on the other end. I know they are probably responding to agencies’ requests, but don’t wait until it’s going smoothly and bring out a harder process.”*

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ADDITIONAL COMMENTS

Respondents were uniformly appreciative of the opportunity to share their experiences about the Medicaid prior authorization process. Several respondents shared they felt the process had already gotten somewhat better, but were glad that DHHS is looking into the issues. They were hopeful that more improvements are on the horizon.

Some respondents mentioned other issues they wanted DHHS to be aware of that were not captured in the context of the interview questions. A handful of respondents said they have had difficulties with getting their providers credentialed or having problems providing referrals to patients due to an insufficient pool of credentialed providers. A respondent said, *“NHHF’s process for mental health is atrocious. I’ve got one therapist that started with us in May. She is still not credentialed. She is one of three seasoned clinicians we need credentialed. They are licensed in the state of New Hampshire. It shouldn’t be rocket science to get them on the panel. They are bringing clients they can’t see. We have claims going back to July and August and we can’t get paid.”* Another respondent said, *“I know we’re just talking about prior authorization, but if anything should ever come up about referrals, in the past patients could go to Maine medical partners or Boston Children’s. With the new MCOs those doctors aren’t participating and you can’t get approval for a referral. I’d like them to try to get credentialed with these other places.”*

A few respondents also noted challenges with payment rates from the MCOs and third party liability. A psychiatrist said, *“When this all came about, we were all told our rates would remain the same, but now they’ve instituted something else under third party liability. When one of the parents had another insurance policy as the primary, and Medicaid came in as secondary, if what the primary paid was less than the rate, Medicaid paid us the difference. Now all of a sudden they’re stopping paying the extra. It really hurts us. United Behavioral Health is telling us we can’t use our one hour therapy. They only let us do the 41-45 minutes and pay accordingly (\$61) and Medicaid is not paying secondary. People can’t live on the \$61 rate.”* Another said, *“We are the PCP office and we should get the higher rate until the end of year. But NHHF converted back to all the old rates and I’ve been trying to get somebody to help me with this since. And I haven’t had any luck with it.”* An oncology center respondent said, *“There are still outstanding charges that we’re waiting for because they didn’t have their act together.”*

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CONCLUSION

The telephone interviews held with health care providers in November and December of 2014 provided valuable insight into providers' experiences and challenges with the prior authorization process within the State of New Hampshire's Medicaid Care Management Program that commenced in December 2013. Due to the sample size, the information presented in this report should not be assumed to be statistically representative of the entire provider population in the Medicaid Care Management Program in New Hampshire. The data generated during the interviews can be used to identify issues and concerns that may warrant further exploration.

Respondents detailed several challenges they face with the prior authorization process. Overall respondents expressed that the prior authorization process placed a significant time and cost burden on their offices due to the staff time required to engage with the process. They also described several areas where medical policies, poor MCO staff training, and frequent denials negatively impacted patient care and well-being by causing delays in treatment and patient exposure to unnecessary risks. Respondents noted a preference for having a more streamlined process, clearer information on formularies and decision criteria from the MCOs, improved medical policies which address medical necessity and continuity of therapy, and better training for MCO staff.

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APPENDIX 1. INTERVIEW GUIDE

Identification of Target Respondent

My name is ____, and I am working with NH Medicaid to explore the prior authorization process for NH Medicaid, with a focus on the Medicaid managed care programs, NHHF and Well Sense, but also the current fee-for-service. Could I please speak to the person who is responsible for obtaining prior authorizations for your practice?

Introduction

I'm working with the NH Department of Health and Human Services to explore your experience working with the prior authorization process for NH Medicaid, with a focus on the Medicaid managed care programs, NHHF and Well Sense, but also the current FFS. We hope to identify the main strengths and weaknesses of the process in order to improve the process in the future. I want to assure you that all the information you provide will be kept completely confidential. The information gathered through these interviews will only be presented in aggregate – no personal information or provider information will be released in any way.

Verification of Target Respondent

1. Are you the person who is most responsible for working with the prior authorization systems to submitting requests and receiving authorizations from the Medicaid managed care organizations (Well Sense and NHHF) and the NH Medicaid FFS system (traditional Medicaid)? *(If no, Can you please direct me to that person?)*

Level of Experience with Pre-Authorization Process

2. How often do you submit pre-authorization requests? Have you worked with all three of the pre-authorization systems (Well Sense, NHHF, FFS)?

For the next series of questions, I'd like you to tell me about your experience with EACH of the pre-authorization systems you work with.

3. What method(s) do you typically use to submit prior authorization requests or to interact with MCO information and staff? Do you call, fax, or use the website(s)? Let's start with NHHF. How about Well Sense? And FFS?

Attachment A

Satisfaction with Pre-Authorization Process

4. Can you please describe any positive experiences you've had working with the prior authorization systems? What are the best parts of the process? What is working well?
5. What have been the most difficult aspects of working with the prior authorization process? What are the challenges?
6. Have there been any negative consequences on the office due to any problems you've encountered? (probe: too much staff time, etc. Have there been any negative consequences for patients due to any problems you've encountered? (probe: delays in patients receiving medications/services)
7. Are you able to find all the information you need to submit a prior authorization request? Do you have a good understanding of what information (clinical or otherwise) is needed for the prior authorization request to be processed?
8. What would you say are the main differences between the three systems (Well Sense, NHHF, and FFS)? Are there any aspects of each that works better than others? Any that are harder?
9. If you have problems with any of the systems, do you feel like you can get them resolved easily? Can you describe that process? If not, what would be needed to resolve a problem?
10. If you were going to make one improvement to the prior authorization system, what would it be?
11. Do you have any other comments?

Thank you so much for your insight and help with this project. Do you have any questions for me?

Attachment B
State of New Hampshire
Department of Health and Human Services (DHHS)
Prior Authorization Process Focused Study
Document Request

Phase II of the Prior Authorization Study requires documentation from the managed care organizations (MCOs). The documentation will be reviewed by Health Services Advisory Group, Inc. (HSAG) to determine similarities and differences in each of the prior authorization processes. The following are the MCO documents to be uploaded to the HSAG FTP site **no later than March 4, 2015**.

1. Utilization Review Program documentation
2. Policies, procedures, and flowcharts concerning prior authorizations, denials, and appeals
3. Letter templates used to notify providers of approvals and denials of prior authorization requests
4. Forms used to request prior authorization for medical services and pharmacy
5. Documentation concerning what services and medications require prior authorization
6. Access to the MCO's formulary
7. Location of formulary information (e.g., hard copy, web-site address, etc.)
8. Training material and provider resources/communications concerning the prior authorization process (hard copy and web-based)
9. Staff credentials, training, and retraining requirements for employees processing prior authorization requests
10. Job descriptions of staff processing prior authorization requests
11. Number and title of FTEs devoted to prior authorization processing
12. Name of the criteria used to determine approval/denial of prior authorizations, an explanation of any modifications made to the criteria, and frequency of updating the criteria
13. Process and frequency of peer-to-peer discussions concerning prior authorization requests
14. Process used to disseminate prior authorization criteria to providers
15. Location(s) of forms to request prior authorizations and method(s) for submitting the requests for completing prior authorizations
16. Methods available to submit prior authorizations (e.g., fax, web, telephone, etc.)
17. Method to process urgent prior authorizations including after-hours requests
18. Inter-rater reliability procedure for prior authorizations
19. Process to monitor turnaround times for prior authorization requests
20. Procedure used to notify providers of denied requests for prior authorizations include staff responsible to notify providers and the monitoring of that activity
21. Appeals process used when requesting reconsideration of a denied request
22. Vendors providing prior authorizations for medical services and pharmacy

Attachment B
State of New Hampshire
Department of Health and Human Services (DHHS)
Prior Authorization Process Focused Study
Document Request

23. Vendor policies, procedures, and flowcharts concerning prior authorizations, denials, and appeals
24. Oversight provided by the MCO for the vendor's prior authorization processes and procedures

HSAG will create folders under a link called **Prior Authorization Study**. The folders will be numbered 1–24, and each MCO can place the appropriate information requested in the corresponding folder. You do not need to upload all the documents at once. If you have a group of documents ready to upload, please put them in the corresponding folders. Then notify Jenny Montano (jmontano@hsag.com) or Debbie Chotkevys (dchotkevys@hsag.com) of the upload.

If you have any questions regarding posting the information or to obtain FTP account login, please contact Jenny Montano.

Jenny Montano, Project Coordinator
Health Services Advisory Group, Inc.
Email: jmontano@hsag.com

If you have any questions regarding the document request list, please contact Debbie Chotkevys.

Debbie Chotkevys, Director Professional Services
Health Services Advisory Group, Inc.

Phone: 614-477-1563
Email: dchotkevys@hsag.com