Survival Coalition
of Wisconsin Disability Organizations

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September 2013

To: Kitty Rhoades
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From: Survival Coalition
National Association of Social Workers-Wi (NASW)
Wisconsin Association of Family & Children's Agencies (WAFCA)

Subject: Medicaid Prior Authorization (PA) practices impact on accessing needed services for people with significant disabilities.

The Survival Coalition, NASW and WAFCA, groups long concerned about the Medicaid prior authorization process, convened a Medicaid prior authorization work group, representing recipients, advocates and providers who are experiencing similar and significant challenges accessing personal care services, outpatient psychotherapy, mental health, health check other services, therapies including augmentative and alternative communication therapies and devices, durable medical equipment and private duty nursing. We believe that the current application of the Medicaid Prior Authorization (PA) process whether intentional or inadvertent significantly reduces access to a set of services that are essential to people with disabilities. While the Wisconsin Medicaid state plan benefits are comprehensive, accessing those benefits remains challenging and is at times impossible. Families, people with disabilities, advocates and providers report the PA process is so difficult to navigate that critical services that help individuals with severe disabilities remain in the community become virtually unavailable. Recipients and providers continue to report their experience with PA as an arbitrary and capricious process that prevents continuity of service and discriminates against small providers and individuals without resources for advocacy. The chilling effect of the PA process has a cumulative impact on the quality of life for individuals with disabilities and the willingness of providers to serve this group of recipients.

This is not a new problem. The collective action of this coalition dates back to 1998. While limited in scope, a July 2001 Legislative Audit Bureau report was highly critical of the PA system for children's therapy services and found that children were disproportionately denied access to therapy services. The report found problems including long delays in processing PAs, multiple returns for inconsequential reasons, short approval periods and arbitrary denials. Sadly, children and adults with disabilities and providers continue to experience similar problems today despite repeated attempts by members of this workgroup to work with DHCAA and DHS to resolve problems.

There has been a cyclic pattern to this experience such that when advocacy by recipients, providers and advocates is undertaken, the issues related to individual situations and PA practices may change for a period of time, but inevitably access challenges return once scrutiny is turned elsewhere. All members of this coalition have had the experience of working with Medicaid staff to address issues related to PA, felt those issues were addressed only to have the same problems resurface later. While these discussions have sometimes resulted in short term changes in forms and reviewer practices, the problems persist. Challenges with PA have become even more problematic over the last two years. One reason for this could be the oversight for PA located in the Office of the Inspector General, an office whose focus on the prevention of fraud and abuse. The culture within the OIGs office, where this work is done may be inconsistent with the types of service requests and provision of services to people living outside of institutional and corporate settings.

Table 1 provides examples of the current experiences that are problematic. In summary

1. Denials or delays due to clerical errors.
2. The amount of documentation is excessive, unnecessary or unrelated to the service being requested.
3. Reviewers are using criteria that do not reflect standards of practice.
4. PAs returned for more information, often information that was included in the original request resulting in delays of authorization for treatment.
5. The professional expertise and supporting documentation of providers is discounted or ignored
6. Health Check Other Services is not available – cost shifting to Waivers
7. Internal inconsistency with reviewing of PAs
8. Arbitrary criteria for denial or modification
9. Coordination of benefits with School-Based Services
10. PAs approved on appeal are denied for same reason that was overturned.

To further understand the extent of this problem we think Medicaid data will be very helpful. Attached are a set of questions submitted to DHS by the Council's on Long-Term Care/Support for children and adults to help us better understand the extent of the problem. No response has been forthcoming to date.

We believe that a fundamental change in the PA process is needed for people who have met level of care for WI long-term care and mental health programs. One way to approach this might be to view people who have had a level of care established in a way similar to the way Birth-3 eligibility affects prior authorization. In a review of the federal guidance to states (42 C.F.R. 440.230c), it appears that there is a degree of flexibility and latitude that WI could take advantage of to reduce the administrative burden on providers and on the Medicaid program for these services.

We request a meeting with you to further explore the current process and options for improvement that would benefit providers and recipients while meeting DHS's obligation to the Medicaid program.

Please respond to Kit Kerschensteiner at DRW (267-0214) to set up a time to meet in September. In the mean time we would like to have a response to the data questions attached.

Survival Coalition Co-Chair

Kit Kerschensteiner, Disability Rights Wisconsin
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Table 1. Survival Coalition-Medicaid Prior Authorization Workgroup. Experiences in Common with Medicaid Prior Authorization Process

Issues	Specific examples
Denials or delay due to clerical errors.	• A pharmacy submitting a PA for life sustaining daily cardiac medication for a child was denied the medication because the physician had used an old form to justify medical necessity although this information was not included in the rejection letter to the pharmacy. After 3 resubmissions the pharmacy was then told they needed to include the rejection letter with the new submission to speed up the process. The medication was finally approved after 7 weeks. • New forms developed for requesting mental health services are denied upon submission as the wrong form.
The amount of documentation excessive, unnecessary or unrelated to the service being requested.	• Outpatient Psychotherapy Therapists being asked to answer questions related to medication – This is outside the therapist scope of practice. • Suggestions are made for medical treatments and interventions beyond the scope of the MA-PC.
Reviewers are using criteria that do not reflect standards of practice.	• IQ scores for an individual needing augmentative communication. There is no evidence in the literature to suggest IQ has an impact of ability to use AC. • Diminishing respect for credibility of FFS specialist documentation information for PA. • Suggesting that non-verbal communication is adequate and negates need for AAC.
PAs returned for more information, often information that was included in the original request resulting in delays of authorization for treatment.	• Requests are made for additional information that has already been sent to the reviewers or are not appropriate for the requested service. • The time frame to receive PA approvals has changed from days to months for personal care approval. WPSA reports that it is not uncommon to get requests for additional information at the 30 day which then allows another 20 working days before a response is required". This results in significant delays in approval for services, sometimes when there is a level of urgency for the service. • Often PAs will be returned for additional information even though providers have submitted all the documentation required for personal care. • "Every time my child needs services we have to have them authorized even though a doctor has already stated the medical necessity. One example is my son's wheelchair wheel fell off and we needed a new one. It took 3 months for the authorization to go through". • "Instead of a denial they would return to the pharmacist asking for more information and wanting a specific study for a specific diagnosis. The pharmacist had done a recent PA with 50+ pages of information sent to MA and they came back requesting more information".
The professional expertise and	• Reviewers are requesting significant medical documentation of

supporting documentation of providers is discounted or ignored	the need and level of support an individual needs ie., medical notes and information personal care providers typically do not have access to in order to document the medical necessity for support for ADLs. Even when this is available and provided, the reviewer will modify the request with little justification. • RN and MD clinic notes are routinely being requested making the assumption that the Physician Plan of Care signed by the MD is no longer adequate to determine need for personal care services.
Health Check Other Services is not available – cost shifting to Waivers	• Pharmacist would not do the paperwork for Tom since he had done a recent PA with 50+ pages of information which came back requesting more information for another child looking for the same medication. The family is paying for this expensive supplement at about 2/3 dose because they cannot afford any more (approx. $500). • HMOs are denying services and not using HCOS. Requiring family to appeal, when done, DHS instructs HMO to use HCOS. When requested again, HMO again denies. • Private insurance HMO G-tube supplies denied. Medicaid denied rather than accessing Health Check Other Services. • Medicaid denying services that are medically necessary and could be covered by HCOS-mouth wash to treat a fungal infection denied. How much effort and time should county put into appeal before using waiver dollars? • A child cared for by his grandmother was at imminent risk of out of home placement without a lift that would operate in the limited space of a mobile home. Medicaid denied as not meeting cost criteria for medical necessity. Denied by HCOS for same reason.
Internal inconsistency with reviewing of PAs	• A PCST was done on a 2-year-old with multiple health issues. The child needs frequent respiratory attention, including a cough assist machine, multiple feedings (now via G-Tube), occasional Bi-Pap, even during the day, and has growth/developmental delays and issues. An addendum was written to add more time to the screening tool for nurse delegated tasks and when personal cares take longer to provide then the designated time assigned through the PCST. After weeks of waiting to receive the PA back, the hours were only increased to 4 hours per day. The agency has had similar cases and received 6 to 8 hours per day for personal cares.
Arbitrary criteria for denial or modification	• Denials of SED services for children who do not have autism. Told to go to waiver. • Reviewer modification to personal care hours made even though there was no change in child's cares or needs. Seemed to coincide with change in interpretation of rare condition.
Coordination of benefits with School-Based Services	• The current definition of duplication of services that DHS is using has been overturned in court yet still being applied to PA requests. • Denials that have been overturned on appeal and resubmitted are again denied.
PAs approved on appeal are denied for same reason that was overturned.	Pharmacy and AAC.

Data Request from WI Long-Term Care Councils

Disability and provider organizations are trying to better understand the experience with prior authorization of Medicaid recipients who are eligible for long-term supports and providers who request reimbursement for services.

Council on Children with Long Term Support Needs - June 2013

We would like the following information for people 18 and under who are receiving FFS/ Card MA Services and living in the community for 2011 and 2012.

For OT, PT, Speech Therapy, DME, Personal Care, Private Duty Nursing, and Health Check Other Services:

1. Data on the number of requests, approvals and denials for 2011 and 2012 for OT, PT, Speech Therapy, DME, Personal care, Private Duty Nursing, Health Check Other Services
2. The % of PAs where there were modifications. For PAs modified provide the top 5 types of modifications such as changes in duration or frequency.
3. The % of PA denials for OT, PT, Speech Therapy, DME, Personal care, Private Duty Nursing, Health Check Other Services.
4. The # of PAs returned for additional information and the length of time before final disposition.
5. The # of lapsed PAs following a request for additional information.
6. The average time from initial submission to approval within 10, 15, 30, 45, 60 days as a percentage of total PAs submitted.

Please provide a flow chart of the PA process including the role of subcontracted agencies and DHS reviewers and the timeline for review.

Adult Long-Term Care Council - June 2013

We would like the following info for people 18 and over who are receiving FFS/ Card MA Services and living in the community (in other words people with disabilities and the aging receiving LTC):

1. Data on requests, approvals and denials for 2011 and 2012 for OT, PT, Speech Therapy, DME, Personal care, Private Duty Nursing, Health Check Other Services
2. The % for PA modifications requested including changes in duration or frequency of the original request for time period 2011 and 2012.
3. The % of PA denials for OT, PT, Speech Therapy, DME, Personal care, Private Duty Nursing, Health Check Other Services

Please provide a flow chart of the PA process including the role of subcontracted agencies and DHS reviewers and the timeline for review