Office of Kansas Attorney General

Kris W. Kobach

Integrity * Accountability * Oversight

Audit Report

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MCO Prior Authorization

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Office of Inspector General

25-002

October 02, 2025

Table of Contents

Letter from the Inspector General

October 2, 2025

To: Attorney General Kris W. Kobach
Kansas Department of Health and Environment, Janet Stanek, Secretary
Members of the Robert G. (Bob) Bethell Joint Committee on Home and Community Based Services and KanCare Oversight:

Representative Will Carpenter, Vice-Chair	Senator Beverly Gossage, Chair
Representative Barbara Ballard	Senator Renee Erickson
Representative Ron Bryce	Senator Stephen Owens
Representative David Buehler	Senator Vigil Peck
Representative Susan Ruiz	Senator Pat Pettey
Representative William Sutton	

This report contains observations and findings from our performance audit of the Kansas Department of Health and Environment's (KDHE) management of the Kansas Medicaid Managed Care Organizations' (MCO) utilization management (UM) processes and its impact on the hospital reimbursements received from the MCOs.

This audit was completed in accordance with the *Association of Inspectors General Principles and Standards for Offices of Inspector General: Quality Standards for Inspections, Evaluations, and Reviews*, July 2024 Revision.

We greatly appreciate the cooperation and candor of KDHE and Kansas Medicaid Managed Care staff throughout this audit. We welcome any comments or questions you may have regarding this report or our operations.

Respectfully submitted,

Steven D. Anderson
Inspector General

Executive Summary

The scope of our audit included an assessment of the complaints by Kansas hospital providers regarding the administrative burdens of UM processes and their impact on Medicaid MCO reimbursements from January 1, 2021, to December 31, 2023.

The objectives of this audit were to determine the following:

1. **Are there delays in the peer-to-peer (P2P) review process under each MCO?**
   Yes. P2P reviews can take up to 7 business days, depending on the MCO, which may result in delays to critical care. High rates of prior authorization (PA) denials result in additional P2P reviews, placing an administrative burden on hospitals and physicians and causing further delays. One MCO reported over **50%** of PA requests result in denials.

2. **Are Medicaid beneficiaries being placed in observation status when they should be classified as an inpatient?**
   Yes. Patients are defaulted to observation status when they are admitted to the hospital. MCOs appear to be misusing commercially sold InterQual or Milliman Care Guidelines (MCG) criteria to deny inpatient status and keep patients in observation status despite them meeting the medical standard for inpatient criteria.

3. **Is there consistency in how each MCO determines the level-of-care (LOC) for post-acute care (PAC)?**
   No. There is no universal standard or federal requirement for how MCOs determine LOC for PAC. The MCOs' individual determination processes are not available to hospitals and PAC claims are often denied without explanation.

MCO Conflict of Interest

It was discovered that one of the MCOs owns a clinical criteria screening tool for PAs. As a KanCare MCO, using its own clinical criteria screening tool creates a potential conflict of interest. Having control of the design, logic, or algorithms associated with these criteria provides the MCO the opportunity to abuse the cost containment strategies for the purpose of maximizing profits and to boost performance metrics. Additionally, hospitals indicated they employ claim review services provided by either Optum or Change Healthcare. These services apply Correct Coding Initiative (CCI) edits to verify that claim coding aligns with Kansas Medical Assistance Program (KMAP) requirements. Both Optum and Change Healthcare, the review vendors utilized by Kansas hospitals, are subsidiaries of UnitedHealthcare.

Delay and Denial of Medically Necessary LOC and PAC

Hospitals reported that MCOs delay responses for PAC PA requests, sometimes resulting in patients being discharged without the needed PAC. Hospitals often wait up to 14 days for PAC

PA responses, causing extended stays and delayed discharges. Hospitals frequently change PA requests to observation status to increase the likelihood of approval. The delays in PAC PAs also reduce hospital bed availability, leading to longer wait times for ER patients and hospital transfers.

MCOs Frequent Denial of Hospital Readmissions within 30 Days, even if the New Admission is Unrelated

MCOs issue readmission denials when patients with similar diagnoses are readmitted within 30 days, citing administrative denials for readmission. These denials occur even when patients' conditions necessitate readmission.

Hospitals report that MCOs frequently deny requests for long-term acute-care hospital (LTACH) placements, steering patients toward lower-cost PAC options instead. These denials often lead to preventable hospital readmissions, which the MCOs then refuse to cover. Additionally, MCOs frequently reject readmission claims within 30 days of discharge, even if the subsequent admission is unrelated. This results in the hospital losing money when claims associated with readmissions are denied.

Trends for Hospital Claims from the KanCare Claims Adjudication Statistics

An analysis of claims found a steady increase of Hospital denied claim values across all three MCOs over a three-year period.

In 2021: The ***number*** of denied claims for Hospital services averaged only 7% of all denied claims. However, the ***value*** of denied Hospital claims disproportionately averaged 64% of all denials.

- MCO 1: The value of all services denied was $1,427,654,908. Hospital claim denials accounted for $921,732,748 (65%).
- MCO 2: The value of all services denied was $876,443,203. Hospital claim denials accounted for $633,157,066 (72%).
- MCO 3: The value of all services denied was $1,258,015,913. Hospital claim denials accounted for $696,988,584 (55%).

In 2022: The ***number*** of denied claims for Hospital services averaged only 7% of all denied claims. However, the ***value*** of denied Hospital claims disproportionately averaged 65% of all denials.

- MCO 1: The value of all services denied was $1,658,564,120. Hospital claim denials accounted for $1,022,239,851 (62%).
- MCO 2: The value of all services denied was $926,806,509. Hospital claim denials accounted for $659,333,189 (71%).
- MCO 3: The value of all services denied was $1,477,490,969. Hospital claim denials accounted for $899,546,297 (61%).

In 2023: The ***number*** of denied claims for Hospital services averaged only 6% of all denied claims. However, the ***value*** of denied Hospital claims disproportionately averaged 67% of all denials.

- MCO 1: The value of all services denied was $1,833,302,065. Hospital claim denials accounted for $1,276,162,988 (70%).
- MCO 2: The value of all services denied was $1,019,967,786. Hospital claim denials accounted for $707,664,730 (69%).
- MCO 3: The value of all services denied was $1,838,971,701. Hospital claim denials accounted for $1,135,230,556 (62%).

Introduction

Kansas Medicaid, known as KanCare, is the state's managed care program that provides healthcare coverage to Medicaid beneficiaries. KanCare is administered by KDHE and includes three MCOs: Sunflower Health Plan, United Healthcare Community Plan of Kansas, and Aetna Better Health (contract ended December 31, 2024), replaced by Healthy Blue in January 2025.

Kansas Hospital Providers' Complaints

Kansas hospital providers have raised concerns about the administrative burdens associated with utilization management (UM) – the policies and procedures aimed at promoting cost-effective, high-quality care – and utilization review (UR), which involves case-by-case assessments of medical necessity. These concerns include delays in the peer-to-peer (P2P) review process, which may hinder timely clinical decisions, as well as inconsistencies in how MCOs determine the level of care (LOC) for admission status and post-acute care (PAC), potentially leading to misclassifications and inappropriate service authorizations.

Insurer Strategies for Controlling Costs and Regulating Care Access

Rising healthcare costs have led Medicaid MCOs to adopt strategies to control expenses while ensuring access to quality care. In the United States healthcare system, wasteful spending (spending that can be avoided without affecting care quality) is estimated to be between $600 billion and $1.9 trillion annually[1]. Public and private insurers use various strategies to reduce unnecessary care and manage rising costs. KanCare MCOs have adopted UM and UR processes to control their expenses and ensure their patient have access to quality care.

Advantages and Disadvantages of Utilization Management and Utilization Review

Prior authorization (PA) requires KanCare medical providers to get approval from MCOs before administering certain services, items, or medications. This process aims to ensure care is necessary, cost-effective, and meets clinical standards. Although it can help reduce healthcare costs, it may also delay or deny needed services, burdening patients and providers. Concurrent reviews, which also assess the necessity and efficiency of healthcare services, can cause delays and denials, adding to the burden on patients and providers.

Reimbursement Regulations

KanCare has rules in place to ensure healthcare providers are paid fairly and that costs are managed effectively. Providers need to keep track of their expenses and revenues, submit detailed reports, and provide financial data to KDHE for review. This process helps determine the right payment rates and ensures providers follow Medicaid rules efficiently.

[1] Speer, M., J. McCullough, J. Fielding, et al. 2020. Excess medical care spending: The categories, magnitude, and opportunity costs of wasteful spending in the MCO 1 States. *American Journal of Public Health* 110, no. 12.
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7661971/pdf/AJPH.2020.305865.pdf

Impact on Medicaid Managed Care Reimbursements

Hospital reimbursements from Kansas MCOs are closely tied to UR and PA processes administered by the MCOs. Delays, inconsistencies, and administrative complexity within these UR processes can result in delayed or denied payments for services rendered to Medicaid beneficiaries. This, in turn, can affect hospital cash flow, operational stability, and potentially the continuity of patient care. Additionally, providers are entitled to pursue internal appeals and independent third-party reviews under Kansas Statutes Annotated (K.S.A.) 39-709i. However, hospitals reported that the burden of navigating these appeal processes– often involving legal or administrative costs– may result in unreimbursed care for services provided in good faith, particularly when denials are upheld or go unresolved.

Audit Scope and Objectives

Our objectives were to obtain sufficient evidence to answer the following questions:

1. Are there delays in the P2P review process under each MCO?

2. Are Medicaid beneficiaries being placed in observation status when they should be classified as inpatient?

3. Is there consistency in how each MCO determines the LOC for PAC?

The scope of our audit included an assessment of the complaints expressed by hospital providers regarding administrative burdens associated with the UM processes and its impact on the reimbursements received from MCOs from January 1, 2021, to December 31, 2023.

The Office of Inspector General (OIG) conducted a review of the laws and regulations governing reimbursements to hospitals from MCOs to assess the efficiency and effectiveness of the process. Additionally, the OIG examined concerns raised by hospital providers regarding the administrative burden associated with MCOs' UM processes and the impact of these processes on reimbursement outcomes. Noncompliance with applicable UM regulations can adversely affect clinical patient care and impose financial strain on Medicaid providers.

Background

The Medicaid Program

Medicaid is an entitlement program that was authorized by Title XIX of the Social Security Act (SSA) in 1965. It provides healthcare coverage for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. The Centers for Medicare and Medicaid Services (CMS) is responsible for the overall administration of the program at the federal level. Although the federal government establishes certain parameters for all states to follow, each state administers its own Medicaid program differently, resulting in different variations of coverage throughout the U.S.

The Medicaid program is funded by a combination of state and federal dollars. The federal government pays states for a specified percentage of program expenditures, known as the Federal Medical Assistance Percentage (FMAP). In exchange, states must fund their share of Medicaid expenditures in accordance with a CMS approved state plan. States then establish their own Medicaid provider payment rates within federal requirements, and generally pay for services on behalf of Medicaid beneficiaries through a managed care method or a fee-for-service (FFS) method.

KanCare

Most of Kansas' Medicaid beneficiaries are covered by KanCare, the state's Medicaid managed care program. KanCare became effective on January 1, 2013, after the state submitted and received federal approval for a Section §1115 waiver. This waiver authority allowed Kansas to move most Medicaid beneficiaries to managed care, with services provided through MCOs. During our audit period, KDHE contracted with the following MCOs:

- Aetna Better Health of Kansas (contract with KDHE ended December 31, 2024)
- Sunflower State Health Plan (a subsidiary of Centene)
- United Healthcare Community Plan of Kansas

Medicaid MCOs

An MCO is an insurance company that contracts with state Medicaid agencies to provide healthcare services to Medicaid recipients. Under these contracts, the state pays MCOs a fixed monthly fee–known as a capitation payment–for each member, referred to as "per member per month" (PMPM), regardless of how much the member utilizes services. Payment rates vary based on the member's characteristics, such as age, since expected costs differ for children and older adults. In exchange for these payments, MCOs are responsible for managing care and provider reimbursements while also absorbing the financial risk if costs exceed their payments.

MCOs are incentivized to lower healthcare costs by improving health outcomes. Their contracts may include financial rewards for achieving these outcomes or penalties for failing to do so. MCOs also establish a provider network to deliver covered services, pay providers fixed amounts, and prevent any additional charges to enrollees for covered services. The capitation

payment model encourages MCOs to minimize service utilization while enhancing care quality and overall health.

Responsibilities of the State and MCOs

States partner with MCOs to ensure budget predictability and reduce administrative effort by shifting financial risks and tasks, such as provider network management, case coordination, payment, and authorization. States design Medicaid programs in accordance with federal CMS rules, covering both mandatory and optional services, and set healthcare goals and capitation payments for MCOs with CMS approval. External quality review organizations (EQROs) are engaged to assess MCO performance, increasing accountability. MCOs manage member care, maintain provider networks, and may offer extra services to improve outcomes and attract members.

As of November 2023, Kansas contracted with three MCOs under KanCare, which are required to obtain accreditation from the National Committee for Quality Assurance (NCQA). This non-profit organization evaluates health plans on quality management, UM, provider credentialing, and consumer rights. Accreditation ensures Medicaid consumers receive high-quality care. NCQA assesses organizations on key aspects like internal quality improvement, confidentiality, medical necessity decisions, and handling appeals. Kansas also requires health plans to obtain NCQA's Long-Term Support Services (LTSS) Distinction, aligning with federal, state, and Medicaid requirements.

MCO Oversight, EQROs

Per 42 Code of Federal Regulation (CFR) § 438.66 and 438.310 - 438.370, state Medicaid agencies oversee MCOs by contracting with EQROs for regular reviews. These reviews must encompass MCOs' compliance with the standards outlined in subpart D of 42 CFR § 438.66, including service authorization standards in 42 CFR § 438.210 (CMS 2023, 42 CFR § 438.358(b)(1)(iii)). Although the EQRO review guidance does not mandate the collection of specific data elements related to UM or assessing the clinical appropriateness of PA denials, CMS provides optional guidelines for interviewing UM staff and evaluating UM policies and procedures.

Kansas Foundation for Medical Care (KFMC) Health Improvement Partners, under contract with the KDHE, Division of Health Care Finance (KDHE-DHCF), serves as the EQRO for KanCare. As the EQRO, KFMC provides external quality review (EQR) services to ensure access, quality, and timeliness of care for KanCare members. Using the federally mandated CMS EQR Protocols, KFMC conducts a review of the MCOs and aggregate level information and validates MCO collected and submitted performance measures and performance improvement projects.

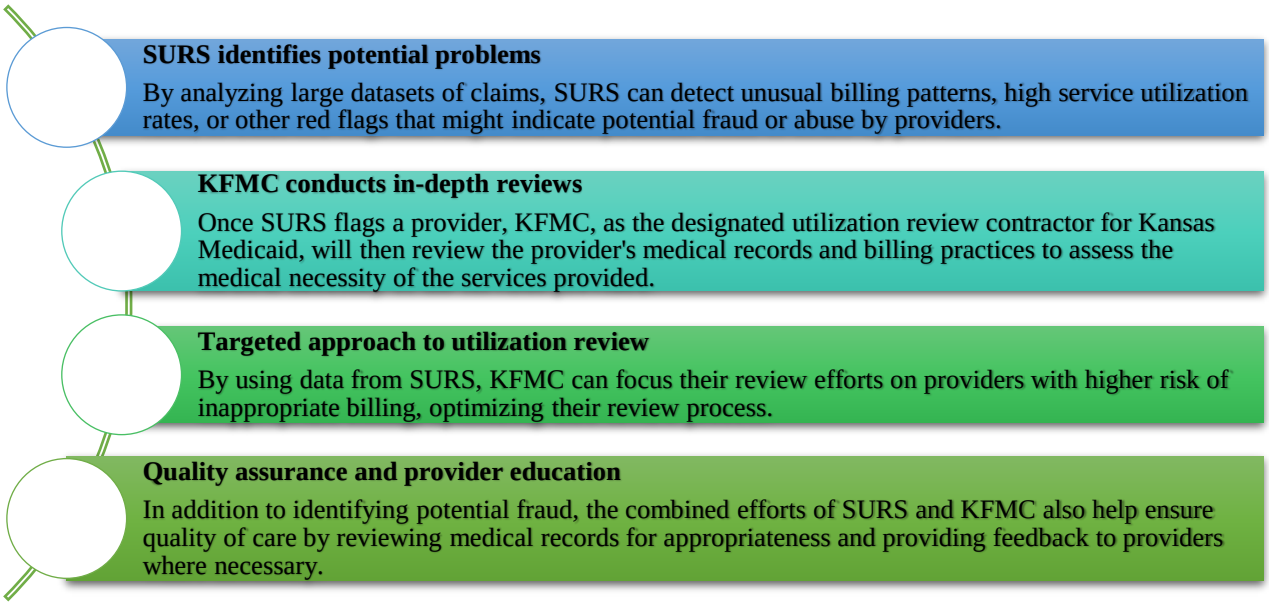
KDHE Surveillance and Utilization Review Subsystem (SURS) Process

KDHE utilizes SURS to safeguard the integrity of the Medicaid program. This system leverages data analysis to identify potential instances of fraud, waste, and abuse. Extensive Medicaid claims data, encompassing provider billing information, beneficiary utilization patterns, and other relevant data points, are collected and analyzed. Sophisticated algorithms and data mining techniques are utilized to detect anomalies, including excessive utilization, billing inconsistencies, and provider-specific patterns. Based on this analysis, cases with the highest risk are prioritized for further investigation, which may involve in-depth medical record reviews and contact with providers. For unintentional errors or minor discrepancies, KDHE may provide education on proper billing and documentation procedures. In cases of overpayments, recovery efforts are initiated. For suspected fraud or abuse, matters are referred to law enforcement agencies. The SURS is designed to improve continuously using data analysis and program evaluation to enhance its accuracy, efficiency, and effectiveness in identifying and addressing program integrity (PI) issues.

Under the State's predominantly managed care delivery system, there is not sufficient FFS claims volume to attract a Recovery Audit Contractor (RAC). Per KanCare State Plan Amendments (SPA) 21-0001 and 23-0001, KanCare contracted with Gainwell Technologies to utilize their SURS for FFS provider reviews, expanding the scope of fraud detection and recovery efforts. This amendment addresses mitigating the need for a RAC by incorporating the Gainwell Technologies SURS for FFS provider reviews. The amendments were approved with an effective date of January 1, 2021, through December 31, 2022, and January 1, 2023, through December 31, 2024.

Collaboration of SURS and KFMC

For KanCare, the SURS acts as a data analysis tool to identify potential issues with provider billing practices by flagging suspicious patterns. KFMC then uses this information to conduct detailed utilization reviews on those flagged providers, ultimately determining the medical



necessity and appropriateness of the services billed, ensuring quality of care and preventing unnecessary utilization of Medicaid funds. An overview of the collaboration process is below:

In addition to identifying potential fraud, the combined efforts of SURS and KFMC also help ensure quality of care by reviewing medical records for appropriateness and providing feedback.

UM and UR – Purpose, Strategies, and Goals

UM and UR are often used interchangeably; however, they serve distinct purposes. UM is a proactive approach to ensuring quality healthcare while controlling costs. It includes several techniques, such as PA, which requires pre-approval for certain services, and concurrent review, which monitors patient care during treatment to ensure its necessity and appropriateness. Additionally, retrospective review assesses past care for compliance and areas of improvement, while case management coordinates care for patients with complex needs. The goal of UM is to improve care quality, reduce unnecessary expenses, and ensure patients receive the proper treatment at the right time.

UR is a more specific process focused on evaluating the medical necessity and appropriateness of individual treatments or services. The UR goal is to ensure that care is provided efficiently, cost-effectively, and in the most suitable setting for the patient's condition. Typically, the UR process involves reviewing a medical record to determine whether a hospital admission is necessary or if a less costly alternative treatment would be more appropriate.

The primary strategy is PA (also referred to as preauthorization, prior approval, precertification, prospective review, preadmission certification, admission certification, PA preservice review, or preprocedural review).

PA analyzes a patient's case and proposes treatment to eliminate unneeded, ineffective, or duplicate therapies. It is used for routine and urgent referrals, but not for emergency room (ER) admissions. The review occurs before treatment begins, either before or after admission to a facility. Sometimes, a doctor's orders may be overridden, potentially causing resentment among medical staff and patients.

Other common strategies include:

- **P2P Review**: An optional step in some PA cases where the requesting provider discusses the medical necessity of care with an insurer-affiliated provider. There are no federal guidelines for these reviews, and they are not available for all providers or requests. MCOs may use them when a PA denial is likely, helping to determine if the denial is clinically appropriate. These reviews may also be requested for additional clinical insight or triggered by insurer guidelines, especially for costly or high-risk treatments.

For Medicaid MCOs, P2P review is an extra step beyond the requirement to consult providers when needed for PA decisions. A study found that denied radiotherapy requests were always

referred for P2P review, suggesting that some insurers automatically include this step.[2] However, this process can lead to delays due to back-and-forth communication and may involve a reviewer from a different specialty with limited knowledge of the requested care.

- **Concurrent Review**: This review monitors a patient's progress and resource consumption, which may lead to the modification or cessation of ongoing care procedures. A concurrent review takes place during treatment, usually starting within 24 to 72 hours of hospital admission. The review focuses on tracking resource utilization and the patient's progress, with the goal of reducing coverage denials after treatment.

During a concurrent review, an ongoing service or treatment may be stopped, reviewers may seek alternatives to ongoing inpatient care, or they may initiate discharge planning sooner than the doctor prefers. These actions can cause conflicts among the insurer, treating physician, and patient. Concurrent reviews may also be referred to as continued stay reviews or admission reviews.

- **Retrospective Review Denial**: Performed after treatment has concluded, this review assesses the appropriateness and effectiveness of the treatment to provide insights for future patients. PA approvals are not final and typically include language stating that approval does not guarantee payment. This allows MCOs to review services or products after they have been provided and potentially deny payment.

The goal of a retrospective review is to identify effective treatments for future patients, find problems and successes, and provide data back to caregivers. This data can also be used in education and contract negotiations between insurers and hospitals. If proven treatments are not used and a claim is denied, the financial burden falls on the caregiver. The process ensures reimbursements are accurate or determines if a claim should be denied. The review can be redone if a denial is challenged or to respond to grievances.

A retrospective review can also be conducted at a key juncture of treatment rather than at the end, resulting in the patient's treatment reverting to an earlier point if the patient has not responded, the diagnosis changes, or if different UM criteria apply (e.g., if the patient's insurance coverage changes).

Although healthcare providers submit clinical and administrative information for PA, the MCOs must decide whether the PA is approved or denied within a set time, especially for urgent cases. Some studies show that PA can reduce costs without impacting care quality.[3] However, concerns exist about unintended consequences, including delays or denials of necessary care.

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[2] Koffler, D., B. Chitti, D. Ma, et al. 2022. Futility of the third-party peer-to-peer review process and entailed delays to cancer-directed therapy. *International Journal of Radiation Oncology – Biology – Physics* 114, no. 3. https://www.redjournal.org/article/S0360-3016(22)01230-5/fulltext.

[3] Asher, A., K. Contreary, J. Coopersmith, et al. 2019. *Evaluation of the Medicare Prior Authorization Model for Non-emergent Hyperbaric Oxygen (HBO): Final Report.* Washington, DC: Mathematica. https://www.cms.gov/priorities/innovation/Files/reports/mpa-hbo-fnlevalrpt.pdf. Asher, A., K. Contreary, and J. Coopersmith. 2020. *Evaluation of the Medicare Prior Authorization Model for Repetitive Scheduled Non-Emergent Ambulance Transport: Second Interim Evaluation Report*. Washington, DC: Mathematica. https://www.cms.gov/priorities/innovation/data-and-reports/2020/rsnat-secondintevalrpt.

A recent report from the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (HHS/OIG) highlighted issues with PA, including reduced access to care due to delays or denials of needed services.[4]

A 2023 survey found that 16% of insured adults experienced problems with PA, leading to delayed or denied care and health declines.[5] Additionally, provider groups have emphasized that the PA process is administratively burdensome and costly.

Medicaid PA Process for Hospitalizations

Healthcare providers submit both clinical and administrative information for PA requests, which the MCO reviews to issue a decision. MCOs are required to make these decisions within a specific timeframe and must expedite requests if the beneficiary requires urgent medical care. States have the option to impose shorter decision times than those specified by federal regulations. The current PA process for medical items and services is as follows:

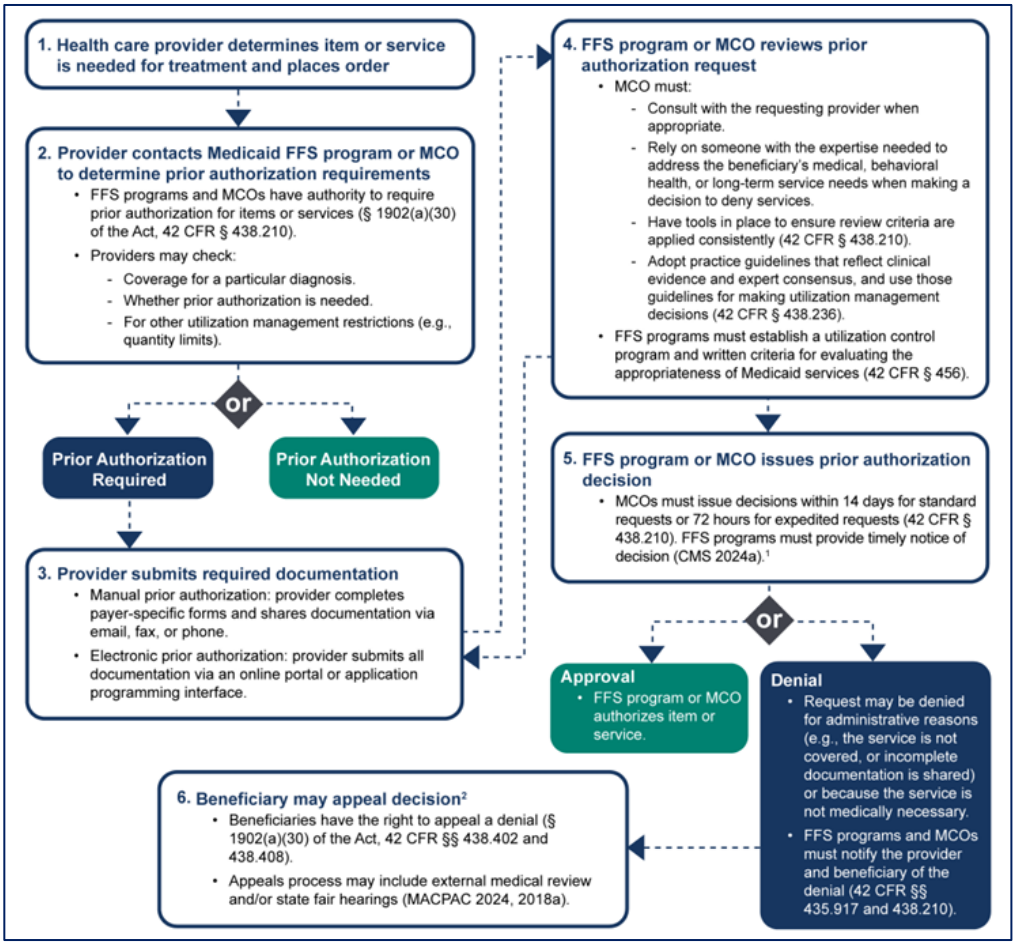
1. A healthcare provider determines an item or service is needed and places an order.
2. The provider contacts the MCO to confirm PA requirements.
3. The provider submits the required documentation:
    - Manual: Completed forms and documentation shared via email, fax, or phone.
    - Electronic: Documentation submitted via an online portal or Application Programming Interface (API).
4. The MCO reviews the PA request:
    - Consults with the requesting provider when necessary.
    - Uses experts to address medical, behavioral health, or long-term service needs for denials.
    - Ensures review criteria are applied consistently.
    - When the PA does not meet the InterQual and Milliman Care Guidelines (MCG), expert consensus is requested.[6]
    - Clinical evidence, InterQual, and MCG are applied:
        a. Initial screening: When a provider submits a PA request, the payer's UM team often uses either InterQual or MCG criteria to perform an initial assessment of medical necessity.
        b. Clinical review: If the initial review flags potential concerns based on the guidelines, a clinical reviewer may conduct a more detailed evaluation, considering the patient's specific case and potentially requesting additional information from the provider.

[4] Office of the Inspector General (OIG), U.S. Department of Health and Human Services. 2023. *High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns about Access to Care in Medicaid Managed Care.* Washington, DC: OIG. https://www.oig.hhs.gov/oei/reports/OEI-09-19-00350.pdf.
[5] Pollitz, K., K. Pestaina, L. Lopes, et al. 2023. Consumer Problems with Prior Authorization: Evidence from KFF Survey. Washington, DC: KFF. https://www.kff.org/affordable-care-act/issue-brief/consumer-problems-with-prior-authorization-evidence-from-kff-survey/.
[6] The InterQual and MCG criteria are created and sold by commercial companies, and hospitals buy these products, paying for a license, to have access to these commercial clinical criteria.

c. Decision making: Based on the clinical review and the criteria applied, the payer decides whether to approve or deny the PA request.

5. The MCO issues a decision:
    - Standard Requests: Decision is required within 14 days.
    - Expedited Requests: Decision is required within 72 hours.
        - If Approved: The item or service is authorized.
        - If Denied: The provider and beneficiary are notified.
            - Denial Reasons:
                1. Administrative issues (patient is not covered or the provider sent incomplete documentation).
                2. Lack of medical necessity.
6. The beneficiary or provider may appeal a denial decision:
    - Beneficiaries and providers have the right to appeal. The appeals process may include external medical review and/or state fair hearings.

In straightforward cases, providers submit documentation to demonstrate the necessity of care, which the insurer reviews and approves, allowing the service or item to be provided. The infographic below is a reiteration of the steps above:



Infographic rom MACPAC.gov: *This process diagram does not apply to prescription drugs. FFS is fee-for-service. MCO is managed care organization.*
1 Upcoming changes required by the Interoperability and Prior Authorization final rule (i.e., adding a time frame for decisions for Medicaid FFS programs and updating the existing time frame for MCOs for standard requests from 14 days to 7 days) are not reflected in this figure (CMS 2024a).
2 MACPAC has conducted separate work on appeals in Medicaid managed care, as described in Step 6 (MACPAC 2024).
Sources: *§§ 1902(a)(3) and 1902(a)(30) of the Act; 42 CFR §§ 435.917, 438.210, 438.236, 438.402, 438.408, and 456; CMS 2024a; MACPAC 2024, 2018a.*

Kansas Medical Assistance Program (KMAP) Provider Payment Resolution Process Overview

Definitions

- Action – Full or partial denial of payment for a service.
- Appeal – Request for review of an action by the MCO.
- Reconsideration – Request for the MCO to review a denial before filing a formal appeal.
- State Fair Hearing – A legal hearing to present evidence and arguments about an action.

Optional Reconsideration (Before Filing an Appeal)

Providers can dispute claim denials by requesting reconsideration from the MCO. This step is optional and not required before filing an appeal. Providers can stop the reconsideration process and file an appeal at any time within 60 days of the denial notice (plus three extra days if mailed). Beyond this window, providers must wait for the reconsideration resolution notice.

- Timeframe: Submit reconsideration within 120 days of the notice of denial (plus three extra days if mailed).

Required Appeal

Providers must complete the MCO appeal process before moving to a state fair hearing. The MCO must acknowledge appeals within 10 days and resolve 98% within 30 days and 100% within 60 days.

- Timeframe: Submit an appeal request within 60 days of the denial notice (plus three extra days if mailed).

State Fair Hearing

After receiving the MCO's appeal resolution notice, providers may request a state fair hearing.

- Timeframe: Submit a hearing request within 120 days of the appeal resolution notice (plus three extra days if mailed).

Medical Necessity, as Defined by KanCare

KDHE-DHCF added the following definitions per Kansas Register Volume 43 - Issue 50 - December 12, 2024:

Kansas Administrative Regulations (K.A.R.) define medical necessity as stated in K.A.R. 129-1-1(oo)(1), *"Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:*

(A) Authority. The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.
(B) Purpose. The health intervention has the purpose of treating a medical condition.
(C) Scope. The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
(D) Evidence. The health intervention is known to be effective in improving health outcomes. (i) For new interventions, effectiveness shall be determined by scientific evidence as described in paragraph (oo)(3). (ii) For existing interventions, effectiveness shall be determined by scientific evidence as described in paragraph (oo)(4).
(E) Value. The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. Cost-effective shall not necessarily be construed to mean lowest-priced. An intervention may be medically indicated and yet not be a covered service or benefit or meet the definition of medical necessity in this subsection. Interventions that do not meet this regulation's definition of medical necessity may be covered at the discretion of the secretary or the secretary's designee. An intervention shall be considered cost-effective if the benefits and harms relative to the costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the condition of the individual patient shall be determinative.

K.A.R. 129-1-1(oo)(2), *The following definitions shall apply to these terms only as they are used in this subsection:*
(A) "Effective," when used to describe an intervention, means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
(B) "Health intervention" means an item or covered service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For the definition of medical necessity in this subsection, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which the health intervention is being applied.
(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.
(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or biological or psychological condition that lies outside the range of normal, age-appropriate human variation.
(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.
(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or by potential experimental biases.
(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.

(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.
(I) "Treating physician" means a physician who has personally evaluated the patient.

K.A.R. 129-1-1(oo)(3) *Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the basis of professional standards of care or expert opinion as described in paragraph (oo)(4).*

K.A.R. 129-1-1(oo)(4) *The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet the definition of medical necessity in this subsection in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, convincing expert opinion.*

Federal Regulations Specific to Medicaid MCOs

- MCOs must adhere to additional regulations to ensure they do not use PA to limit access to necessary medical care (42 CFR § 438.210).
- MCO-provided medical services must be equivalent to those in FFS programs in terms of amount, duration, and scope (42 CFR § 438.210).
- They are required to implement practice guidelines based on clinical evidence and expert consensus for UM decisions (42 CFR § 438.236).
- Federal regulations specify the processes and timelines for MCOs to make PA decisions, ensuring consistent application of review criteria. Any service denial by MCOs must be decided by individuals with appropriate clinical expertise to address the beneficiary's health care needs. MCOs must also notify requesting providers of denials and give written notice to beneficiaries. (42 CFR § 438.210, Section 1932(b)(4) of the SSA).
- Regulations mandate standard decisions within 14 days and expedited decisions within 72 hours, with these timeframes being shortened under the 2024 Interoperability and PA final rule, effective January 2026 (42 CFR § 438.210, CMS 2024a).

Medicaid Inpatient vs Outpatient Definitions
Per 42 CFR § 440.2 (a) Specific definitions:

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who –

(1) Receives room, board and professional services in the institution for a 24-hour period or longer, or

(2) Is expected by the institution to receive room, board and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

Outpatient means a patient of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains in the facility past midnight.

Observation is not a term that is defined in the Code of Federal Regulations. KMAP provides the following in the Hospital Provider Manual:

Observation Room *– Observation in the outpatient setting is a service which requires monitoring the member's condition beyond the usual amount of time in an outpatient setting. Examples of the appropriate use of the observation room include:*

- *Monitoring head trauma*
- *Drug overdose*
- *Cardiac arrhythmias*
- *False labor*

The observation room stay must be medically necessary.

A physician must have personal contact with the member at least once during the observation stay. A registered nurse or an employee under his or her direct supervision must monitor members in the observation unit. A member can be in the observation unit no more than 48 hours. Observation hours in excess of 48 hours are not reimbursable. Ancillary charges (such as lab work or x-rays) can also be billed separately.

Medical supplies and injections (99070 and J7030-J7121) are considered content of service of the observation room service.

Observation services are considered content to any surgical procedure for which global surgery rules apply when performed by the same provider during the global surgery period. Observation services are considered content of service of respiratory services (94010-94700), when performed on the same date of service by the same provider unless the observation is a significantly, separately identifiable service.

The **Medicare Benefit Policy Manual** defines observation services:

Chapter 6, Section 20.6: Outpatient Observation Services – A. Outpatient Observation Services Defined

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients

who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient tests. In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.

Capitation Payments

Each MCO is paid a set Per Member Per Month (PMPM) rate (capitated rate) by KDHE, as specified in their contracts. Each monthly payment is calculated by the number of individuals enrolled in each eligibility category that month and the anticipated required services for these individuals.

The establishment of the rates paid to the MCOs requires KDHE to comply with federal regulations that state these rates are to be developed in accordance with accepted actuarial practices and certified by qualified actuaries. In other words, these rates must be high enough to attract a provider base that can meet the contractual requirements for availability and accessibility of services. Actuaries hired by KDHE routinely assess the MCO rates and adjust as necessary to ensure they are actuarially sound.

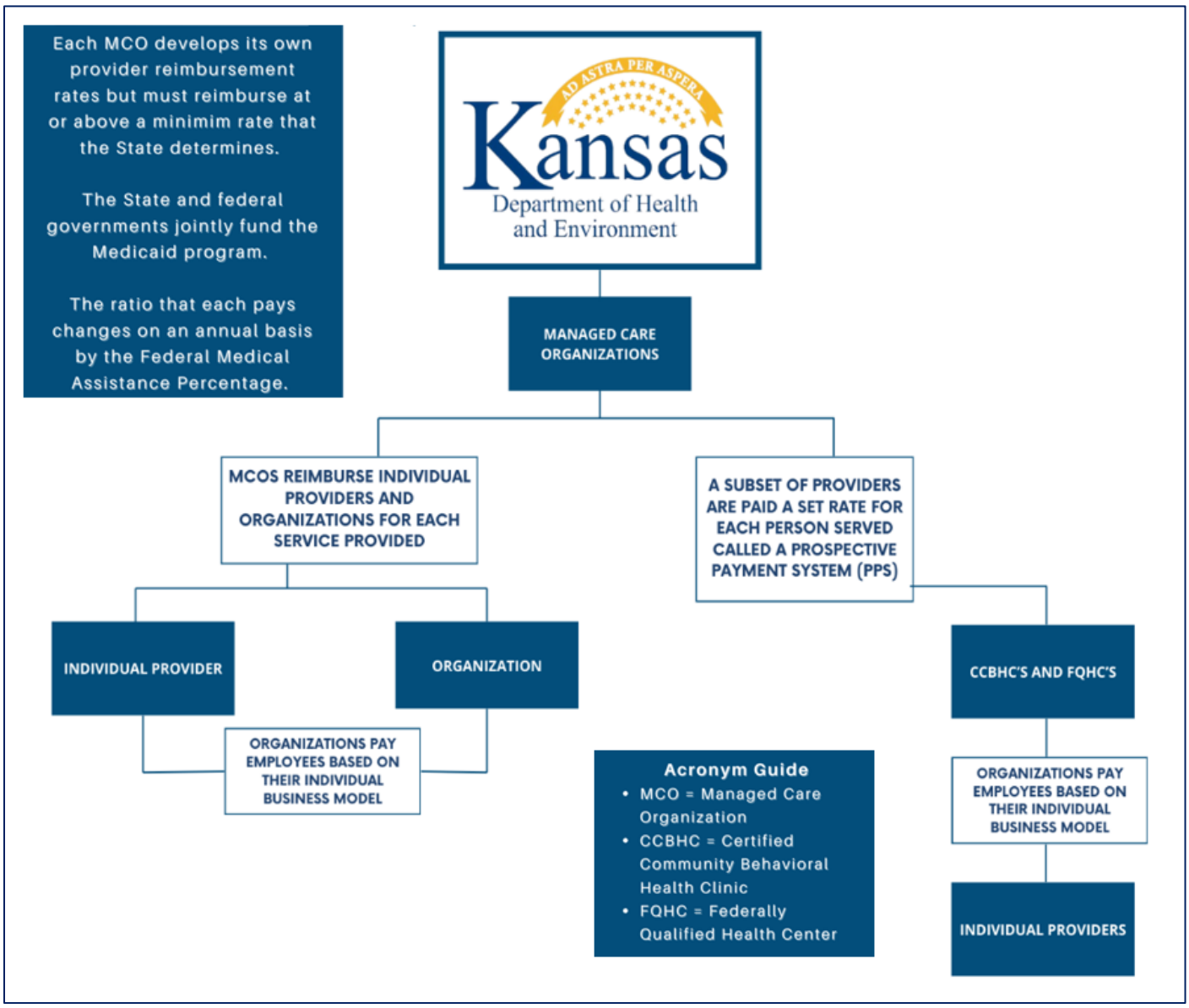
When medical services are delivered to Medicaid beneficiaries, the contracted MCO directly reimburses the medical providers. MCOs are contractually required to compensate providers at or above the FFS Medicaid rate determined by the State. Although the State mandates this minimum reimbursement rate for each MCO, MCOs have the flexibility to negotiate rates with providers independently of the State. These negotiations can result in varying reimbursement structures and rates among MCOs.

Generally, providers receive reimbursement on an FFS basis for the services offered to each beneficiary. For instance, when a doctor delivers a service, they submit a claim and are reimbursed by the MCO. However, certain facilities, such as federally qualified health centers (FQHCs) and certified community-based health centers (CCBHCs), utilize a prospective payment system (PPS), where they receive a fixed rate for each person served. This rate is based on the average cost per individual at each health center, resulting in variations between facilities. The State has the authority to set either a daily or monthly payment rate, which is reviewed and revised annually.

KanCare Provider Reimbursement

Under KanCare, the three MCOs contract with the State of Kansas to provide Medicaid services. These MCOs receive monthly payments from KDHE and reimburse hospitals and physicians for services provided to Medicaid beneficiaries.

Medicaid, although state-administered, must comply with federal laws, requiring coverage of certain services, including inpatient and outpatient hospital care, laboratory services, and immunization services. Federal regulations also mandate MCOs to maintain sufficient provider networks for adequate access. KDHE monitors network adequacy through quarterly Geographic Mapping Reports from MCOs. The State collaborates with the health plans to review and assess the MCOs' reports. The MCOs are continually expanding their provider networks and are required to have plans in place to enhance access for all KanCare members. Kansas can add additional required services, which MCOs must provide statewide. MCOs may offer value-added services, resulting in variations in covered services between MCOs. The value-added services can also fluctuate from year to year. Examples of these services include hospice, chiropractic, and occupational therapy.



Acute Inpatient PPS

According to CMS, Section 1886(d) of the SSA establishes the inpatient PPS for Medicare Part A, which determines payments for acute care hospital stays based on diagnosis-related groups (DRG). Each DRG has a payment weight reflecting average resources used. The base payment consists of labor-related and nonlabor shares, with geographic adjustments. Hospitals serving a significant number of low-income patients receive a disproportionate share hospital (DSH) adjustment, which increases their payment based on specific formulas. Approved teaching hospitals benefit from a graduate medical education (GME) adjustment, varying by resident-to-bed and resident-to-census ratios. Additionally, hospitals are eligible for outlier payments for unusually costly cases to mitigate financial loss, which are added to the DRG-adjusted base rate alongside any DSH or GME adjustments.

Diagnosis-Related Groups (DRG)

DRGs are a classification system used by Medicare and certain private health insurance companies to categorize and determine the payment for hospital stays. Kansas transitioned Medicaid inpatient claim reimbursement to the Medicare Severity-DRGs in January 2009. This system assigns a fixed reimbursement rate to hospitals based on a patient's diagnosis, procedures, and other relevant factors, rather than reimbursing hospitals for the actual costs incurred during the patient's care. The primary goal of DRGs is cost control, as it offers a fixed reimbursement rate, which incentivizes hospitals to provide efficient care and minimize unnecessary procedures, making them a significant component of the healthcare reimbursement landscape.
By grouping patients with similar conditions and treatment requirements into categories, DRGs offer a streamlined approach to hospital reimbursement.

Contributing factors to the assignment of a DRG for each patient include:

1. **Primary and Secondary Diagnoses:** The primary diagnosis refers to the main reason for the patient's hospitalization, while secondary diagnoses account for any other significant medical conditions that may affect the treatment or care provided during the stay.
2. **Procedures Performed:** DRG assignment also considers any surgical interventions or medical treatments performed during the hospitalization. This includes both major procedures (e.g., surgeries) and minor procedures (e.g., diagnostic tests or minor treatments).
3. **Patient Demographics:** The patient's demographic information, including age, sex, and other relevant characteristics. These factors may affect the course of treatment and resource utilization during the hospital stay.
4. **Severity of Illness:** The complexity of the patient's condition and the associated risk of complications are important for determining the DRG code. Patients with more severe or complicated conditions may be assigned to higher-severity DRGs that account for the greater resources required to manage their care.

The DRG system functions by first assessing the patient's condition upon admission to the hospital, during which medical professionals perform necessary diagnostic tests and administer appropriate treatments or procedures. Based on this information, the hospital assigns a specific DRG code that reflects the patient's diagnosis, procedures, and other relevant factors, typically using a DRG calculator or coding software. Once the DRG code is assigned, the hospital is reimbursed by Medicare or private insurance providers based on a predetermined payment amount linked to the DRG, with the payment being fixed and not dependent on the actual costs incurred by the hospital for the patient's care.

Hospitals are encouraged to reduce lengths of stay where possible and optimize resource utilization to maintain financial efficiency. Accurate coding and documentation ensure that hospitals receive appropriate payments; incorrect DRG assignments or underreporting of procedures can lead to payment mistakes. While the DRG system is primarily designed to control costs, it can also indirectly affect patient outcomes. The focus on efficiency may result in better-managed care and more timely treatments. However, a review of DRG-based Financing of Hospital Care[7] suggests that it could incentivize premature discharges or discourage hospitals from taking on more complex cases that require extended or intensive care.
For patients, awareness of how DRGs work allows them to make more informed decisions about their healthcare, better understand the financial implications of their hospital stays, and advocate for appropriate care. Knowledge of DRGs also helps patients navigate the complexities of insurance coverage and reimbursement processes. For healthcare providers, accurate DRG assignment aids in ensuring proper reimbursement for the services they provide. Correct coding helps hospitals avoid financial shortfalls, while also enabling them to manage resources efficiently, minimize waste, and maintain financial stability. Insurance companies also benefit from the DRG system, as it offers a structured way to manage healthcare costs while ensuring that hospitals are fairly reimbursed for their care. By standardizing payments across hospitals, DRGs help insurers maintain budget predictability and reduce the risk of overpayment for services.

The DRG reimbursement is calculated using a DRG calculator, which reflects several factors:

- Standard DRG Payment: If the patient is eligible for the entire hospital stay, the standard DRG payment is applied. This payment is a fixed amount set by Medicare or the insurance provider based on the assigned DRG code.
- Partial Eligibility: If the patient's hospital stay is shorter or involves limited services, a prorated payment may be used. The lesser of the standard DRG payment or the prorated amount is applied in these cases.

[7] Mihailovic N, Kocic S, Jakovljevic M. Review of Diagnosis-Related Group-Based Financing of Hospital Care. Health Serv Res Manag Epidemiol. 2016 May 12;3:2333392816647892. doi: 10.1177/2333392816647892. PMID: 28462278; PMCID: PMC5266471.

- Outlier Adjustments: In cases where patients have exceptionally long hospital stays or require unusually high treatment costs, the DRG system includes outlier adjustments. These adjustments increase the reimbursement to account for higher resource utilization. The reimbursement methodology under the DRG system is presented below:

Payment Categorization	Description	Formula
Standard DRG Payment	This calculation is used if the beneficiary is eligible for the dates of service billed	*(Provider Group Rate) x (DRG Weight)*
Beneficiary Eligibility Day Prorate	This calculation is used when a beneficiary is only eligible for a portion of the inpatient stay. It is the lesser of the two formulas.	*Standard DRG Payment* <u>*Or*</u> *Day Prorate Payment: (DRG Daily Rate) x (Eligible Days of the claim)*
Prorated DRG Payment with Day Outlier	A day outlier will not apply if the claim's eligible days are less than the DRG Day Outlier.	*([Eligible Days] − [DRG Day Outlier Limit]) x (DRG Day Rate) x (Day Outlier %) + (Standard DRG Payment)*
Prorated DRG Payment with Cost Outlier	Payment is adjusted for the patient's actual length of stay, incorporates a cost-outlier provision to account for exceptionally high-cost cases, and includes a standard DRG payment as a baseline.	*([Billed amount] x [Eligible Days]) ÷ (Length of Stay) x (Cost Charge Ratio) − (Cost Outlier Limit) x (Cost Outlier %) + (Standard DRG Payment)*
Standard DRG Payment with Day Outlier	A day outlier will not apply if the claim exceeds both the Cost outlier and Day outlier, the greater of the two would be paid.	*([Length of Stay] − [DRG Day Outlier Limit]) x (DRG Day Rate) x (Day Outlier %) + (Standard DRG Payment)*
Standard DRG Payment with Cost Outlier	In cases where a claim exceeds both the Cost outlier and Day outlier, the greater of the two would be paid.	*([Total Charges] x [Cost Charge Ratio]) − (Cost Outlier Limit) x (Cost Outlier %) + (Standard DRG Payment)*

Inpatient vs Outpatient vs Observation

The Medicare Benefit Policy Manual provides:

Chapter 1 - Inpatient Hospital Services Covered Under Part A, 10 - Covered Inpatient Hospital Services Covered Under Part A

An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use the expectation of the patient to require hospital care that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation.

However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

Factors to be considered when making the decision to admit include such things as:

• The severity of the signs and symptoms exhibited by the patient;

• The medical predictability of something adverse happening to the patient;

• The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and

• The availability of diagnostic procedures at the time when and at the location where the patient presents. Admissions of particular patients are not covered or noncovered solely on the basis of the length of time the patient actually spends in the hospital.

Medicare Benefit Policy Manual Chapter 6 - Hospital Services Covered Under Part B, 20.2 - Outpatient Defined

A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital or CAH. Where a tissue sample, blood sample, or specimen is taken by personnel that are neither employed nor arranged for by the hospital and is sent to the hospital for performance of tests, the tests are not outpatient hospital services since the patient does not directly receive services from the hospital. See section 70.5 for coverage of laboratory services furnished to nonhospital patients by a hospital laboratory unless the patient is also a registered hospital outpatient receiving outpatient services from the hospital on the same day and the hospital is not a CAH or Maryland waiver hospital. Similarly, supplies provided by a hospital

supply room for use by physicians in the treatment of private patients are not covered as an outpatient service since the patients receiving the supplies are not outpatients of the hospital. (See the Medicare Benefit Policy Manual, Pub. 100-02, Chapter 1, "Inpatient Hospital Services," section 10, for the definition of "inpatient.")

Where the hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is considered an outpatient. For information on outpatient observation status, refer to section 20.6 of this chapter and to the Medicare Claims Processing Manual, Pub.100-04, chapter 4, section 290, "Outpatient Observation Services." For information on conditions when an inpatient admission may be changed to outpatient status, refer to the Medicare Claims Processing Manual, Pub.100-04, Chapter 1, "General Billing Requirements," section 50.3. The inpatient of a SNF may be considered the outpatient of a participating hospital. However, the inpatient of a participating hospital cannot be considered an outpatient of that or any other hospital.

Outpatient hospital services furnished in the emergency room to a patient classified as "dead on arrival" are covered until pronouncement of death, if the hospital considers such patients as outpatients for record-keeping purposes and follows its usual outpatient billing practice for such services to all patients, both Medicare and non-Medicare. This coverage does not apply if the patient was pronounced dead prior to arrival at the hospital.

Hospitals may bill for patients who are directly referred to the hospital for outpatient observation services. A direct referral occurs when a physician in the community refers a patient to the hospital for outpatient observation, bypassing the clinic or emergency department (ED) visit. Effective for services furnished on or after January 1, 2003, hospitals may bill for patients directly referred for observation services.

KanCare Safety Net Care Pool (SNCP)
The KanCare SNCP supports hospitals in providing uncompensated care through payments covering Medicaid-eligible and uninsured patients. It consists of two sub-pools:

- Health Care Access Improvement Program (HCAIP)
- Large Public Teaching Hospital/Border City Children's Hospital Pool (LPTC/BCCH)

Kansas' HCAIP, established under Kansas Statutes Annotated (K.S.A.) 65-6207, imposes a provider tax on inpatient hospital revenues, securing federal matching funds to improve healthcare access. In 2020, legislation expanded the tax to include outpatient services, enhancing statewide support.

Uncompensated Care Pool (UC Pool)
The UC Pool helps hospitals absorb costs for uninsured and Medicaid-eligible individuals. Payments are made quarterly based on a UC Payment Application, which considers Medicare cost reports, excludes Disproportionate Share Hospital (DSH) payments, and aligns with federal

protocols. Each UC pool has distinct qualifications, requirements, and payment calculations, following the UC Payment Protocol, which has been in place since 2022. Only general and specialty hospitals qualify for HCAIP payments, while critical access hospitals, state agencies, LPTH, and BCCH hospitals are excluded.

Some states provide payments beyond Medicaid rates, including DSH and UPL supplemental payments. These critical funding sources help hospitals to maintain financial stability, enhance healthcare quality, and support vulnerable populations. In addition to KanCare Safety Net Care Pool payments, Kansas also provides the following supplemental payments to hospitals:

1. **DSH Payments** – Support hospitals serving high numbers of Medicaid and low-income patients.
2. **UPL Payments** – Bridge the gap between Medicaid FFS payments and Medicare rates.
3. **GME Payments** – Assist teaching hospitals with medical resident training costs.

Assurance of Budget Neutrality

Under Section 1115 of the SSA, Medicaid demonstrations must be budget-neutral, meaning federal costs associated with the program cannot exceed projected spending without the demonstration. This ensures fiscal responsibility while allowing states to explore innovative Medicaid solutions.

States must submit an annual assessment to CMS by October 1, comparing actual expenditures with projected federal spending. CMS monitors budget neutrality using specific methodologies and templates, which require states to provide detailed expenditure data and adhere to the approval conditions.

In September 2022, CMS updated its calculation methods, incorporating historical data and recent expenditure trends to support innovation while maintaining fiscal integrity.

Budget neutrality significantly affects Medicaid Section 1115 waivers, such as KanCare, requiring careful financial planning. While waivers allow states to test new approaches, neutrality requirements can limit experimentation, necessitating a balance between innovation and cost-effectiveness.

Methodology

Testimonial Evidence

Interviews were conducted with staff members from six Kansas hospitals, staff members from the three KanCare MCOs during the audit period, and staff members from KDHE and the Kansas Hospital Association (KHA) to gain an understanding of the UM processes and the operations of reimbursements for hospital services in Kansas for Medicaid recipients.

All parties interviewed were asked for information regarding the three audit objectives. Due to the volume of information provided during the interviews, the main points were summarized. All interviews conducted by the OIG were recorded, and interview reports were created to document the entire conversation for reference. The interviews began with three KHA staff members joined by hospital staff from four Kansas hospitals. During the interviews, KHA mentioned a Microsoft PowerPoint presentation titled, *Hospital & MCO Disruption Points,* presented by KHA for KanCare MCOs on November 1, 2022.

KHA also provided a roster of the attendees of the meeting, confirming that KDHE and representatives from each MCO attended, along with staff from nine hospitals in Kansas. Based on the interview with KHA and a review of the provided Microsoft PowerPoint, it was evident the three audit objectives would need to capture problematic areas of PAC transfers and transitions, the P2P process, and observation vs inpatient PA requests for hospitals providing services to the Medicaid managed care population in Kansas.

The KHA Vice President (VP) of Healthcare Finance and Reimbursement was asked to provide a list of at least three key individuals who could offer the most insight into the issues and processes relevant to the audit objectives and would be available. Their assistance was requested to coordinate these interviews once the individuals were identified. Additionally, they were asked to identify Kansas hospitals that would be available to conduct onsite interviews of essential personnel, such as the UM/UR teams and the billing department.

From the hospital interviews, testimonial information (evidence) was separated into two groups: objectives and observations. If the testimonial evidence answered one of the three audit objective questions, it was added to the audit objectives group. If the testimonial evidence did **not** answer an audit objective question, it was added to the observations group.

Testimonial Evidence: Objectives

For each audit objective, interview summaries from the hospitals are provided below. Following the interview summaries from the hospitals, we included interview summaries from the MCOs to each audit objective.

Objective 1: Are there delays in the peer-to-peer review process under each MCO?

Interviews with the Hospitals

One hospital shared its frustration with the administrative challenges and delays in securing P2P reviews, which vary by payer. Initially, hospitals' P2P requests often overturned inpatient denials. However, as many denials were overturned, MCOs started engaging in a back-and-forth process, resulting in significant administrative burdens. Short stays began facing upfront denials, even if they met InterQual or MCG criteria. MCOs used varying criteria to their advantage, which hospitals couldn't access. As a result, one hospital has shifted its UM to focus on approving more inpatient stays based on the severity or complexity of a patient's medical condition (acuity), using guidelines like MCG, InterQual, and CMS criteria. If a P2P denial is upheld, the hospital appeals after the patient's discharge. This hospital emphasized that updating contract language could protect hospital costs and prevent such practices, as the MCOs' current approach has negatively impacted hospital providers across multiple states. By 2024, at least 22 states have introduced or passed legislation on PAs, indicating the widespread nature of these issues beyond Kansas and including critical access hospitals.

The common statements listed below emphasize the ongoing challenges Kansas hospitals face with the P2P review process, communication with MCOs, and the administrative burden of managing PA denials and delays:

- Administrative Burden: P2P reviews and appeals are time-consuming and often do not result in overturned denials. Hospitals experience difficulties in scheduling P2Ps and getting MCOs to adhere to their agreements. Additionally, MCOs are not abiding by their contracts, leading to financial strain for hospitals.

- Communication Issues: There is a significant lack of communication and follow-up from MCOs. Inconsistent scheduling and missed calls by MCOs often lead to denials.

- Unfair P2P Practices: P2P calls are often conducted with physicians unfamiliar with the patient's case, leading to unjust denials. MCOs deny P2Ps based on the length of stay rather than clinical judgment, and they use their internal policies without sharing them with providers.

- Frustration Among Physicians: Physicians prioritize patient care over P2P disputes due to the time and effort required. There is growing fatigue among physicians with the P2P process.

- Denials and Delays: High denial rates for PA requests lead to repetitive cycles of appeals, overburdening hospitals. Delays in response for PA requests and P2Ps, including weekends, cause further complications for hospitals and patients.

MCOs claim they have staff to review P2P requests, but hospitals believe Artificial Intelligence (AI) is used. Scheduling and completing P2P calls can be challenging, as MCOs often provide inconsistent availability. Hospitals are not given the same accountability standards as MCOs, leading to unfair denials. Physicians often settle for observation status to focus on patient care. Over 50% of PA requests sent to MCO 1 result in denials. P2Ps are not conducted on weekends, which further delays the process. MCOs deny P2P requests and push hospitals towards lengthy and costly appeals. Hospitals suggest improving the P2P process by having standardized clinical criteria accessible to both hospitals and MCOs.

Interviews with the MCOs

MCO 1

The Chief Medical Officer (CMO) and the Director of Provider Relations and Networking Strategy were interviewed. The interviewees provided the following information related to Audit Objective #1:

- Availability: MCO 1 had a dedicated P2P team of doctors that were available Monday through Friday from 7:00 a.m. to 7:00 p.m. This team consisted of doctors of all specialties. There was no P2P staff member assigned to specific hospitals or locations.

- The Process: MCO 1 explained, when a provider submitted a PA request for inpatient admission the provider could receive adverse determination responses of either 'no' (inpatient admission is denied) and only observation admission can be approved, or 'no', the PA request is denied for inpatient admission.

Once the provider was notified that the PA request was denied, MCO 1 provided the process for requesting a P2P to the provider. Currently, MCO 1's process for requesting a P2P involves the provider calling the P2P scheduling phone number to schedule the meeting. The meeting is usually scheduled with an MCO 1 medical director who specializes in the type of condition related to the member's primary condition. Typically, it's a hospitalist or an internist who is requesting the P2P and MCO 1 tries to schedule the P2P meeting with someone who specializes in the condition member has. For example, if a member is being admitted for a cardiac reason, MCO 1 tries to schedule the P2P with one of their cardiac specialists. Scheduling is necessary to determine when the hospital's clinician and MCO 1's clinician, that MCO 1 deems most appropriate, is available for the P2P.

Once scheduled, the two physicians discuss the case. The admitting physician provides their explanation in support of the member meeting inpatient criteria and MCO 1's medical director either upholds the original decision or overturns it based on that discussion. MCO 1's medical director can also inform the provider of missing records that may have determined the PA

request's denial. The decision to overturn or uphold the denial is provided before the P2P call is completed.

If the denial is upheld by MCO 1 during the P2P meeting, the hospital can file an internal appeal with MCO 1. The formal appeal process requires the appeal request to be submitted in writing. The hospital can submit the appeal request online or through the portal. The appeal request includes a statement that the denial is being appealed and why it is being appealed. Clinical and other supporting documentation would also be submitted with the request. The appeal request is analyzed by MCO 1's appeals team who reviews the case and makes the appeal determination. MCO 1's appeals team consists of clinical staff that are independent of the original decision maker and the P2P decision maker so it is an independent review.

- Timeline changes: In late 2022, as a result of feedback from both the KHA and individual providers during MCO 1's Physicians Advisory Council meeting, MCO 1 extended the time frame to request and complete a P2P from three business days to seven business days. This change was published in an MCO 1 bulletin.

MCO 2

The Medicaid Compliance Officer, Operations Supervisor for P2P, Director of UM, Customer Service Supervisor, Director of Clinical Health Services, Service Operations Manager, Lead Director of Medicaid Claim Service Operations, Manager of Clinical Health Services, PI Manager, and Appeals Manager were interviewed. The interviewees provided the following related to Audit Objective #1:

- Adverse determinations for PA requests are often based on MCG criteria. MCO 2 will provide the specific guidelines used if requested by the hospital. P2P reviews are available for all adverse determinations except for administrative denials and must be requested within five business days. Hospitals can request a P2P review through a live phone line staffed by 14 agents, with voicemail options available. MCO 2 has 16 staff members working on P2P reviews, and seven physicians dedicated to conducting these reviews in Kansas. The aim is to schedule P2P reviews within a week or sooner if schedules allow. P2P discussions are scheduled for half-hour increments, with each doctor handling up to six cases per day.

- P2P discussions take place between the hospital's provider and MCO 2's doctor, with a verbal determination provided during the call and written notification sent within one business day. If the patient's condition changes, the hospital can submit an updated admission status request along with clinical information. A nurse and medical director from MCO 2 will review and approve or deny the request. If a case is denied by a medical director, it can be sent back for reconsideration or a P2P discussion. MCO 2 uses specific criteria to determine whether disputes go to reconsideration or appeals.

MCO 3

The VP of Population Health, who works closely with the VP of LTSS and the CMO were interviewed. The VP of Population Health's team oversees Clinical Operations, which includes Care Management and Care Coordination. The interviewees provided the following related to Audit Objective #1:

- P2P Review Process: P2P reviews can be requested by phone or through MCO 3's provider portal. Requests go to a shared inbox managed by MCO 3's administrative assistants, who also schedule the P2P reviews. Scheduling is challenging due to demanding physician schedules. MCO 3 aims to schedule P2Ps within 48-72 hours of receiving the request, and P2Ps are typically set for the next three to four days. P2Ps generally occur during business hours, Monday through Friday, 8 a.m. to 5 p.m. If the provider is unavailable, medical directors may accommodate by leaving voicemails or rescheduling.

- On-call Physicians Dedicated Exclusively to P2P Reviews: MCO 3 does not contract with external P2P providers but considers it if significant delays in patient care are consistent. The corporate team is reviewing ways to improve medical director availability for P2P reviews, including possible on-demand availability and after-hours services. It was suggested that an automated system for P2P physician selection by specialty would be advantageous to the process.

- Third-Party Involvement: If there's still disagreement after a P2P review, hospitals can request a third-party physician or initiate the appeal process. Providers can request P2P reviews proactively for complex cases to discuss treatment complexities with medical directors.

- Single-Case Agreements: Reviewed by medical directors and approved by the VP of Population Health. MCO 3 approves approximately 10 single-case agreements weekly, primarily for out-of-network providers, and the volume is increasing.

The CMO mentioned above, who worked with the VP of Population Health, was also interviewed. The CMO is teamed with three other medical directors to make all clinical decisions, two that oversee physical health and one that oversees behavioral health. This team makes the clinical decisions for PA requests and the CMO also oversees UM. The CMO provided the following information relating to Audit Objective #1:

- Purpose of P2P: A P2P is an opportunity for the hospital to get the PA request approved so there is less work for the claims side. Physicians are at times instructed to conduct a P2P by other personnel, such as the billing team, because they believe the admission should have

been an inpatient admission based on an evaluation of the coding. There have been times when physicians call MCO 3 to schedule a P2P and mention they have no idea why they were instructed to request a P2P because they agreed that the patient should not be on inpatient status. As a hospitalist, there were times the CMO remembered being asked to do this as well.

- P2P Process: The P2P is requested within 72 hours of receiving an adverse determination and conducted via phone call between hospital's and MCO 3's physicians. MCO 3 aims to accommodate the hospital's physician schedules.

- Physicians Involved: Three physicians conduct P2P reviews: a family physician, a psychiatrist, and a pediatric hematologist oncologist. The CMO oversees the process but usually does not participate in P2Ps.

- Improvement Suggestions: The CMO suggested increasing the NCQA requirement for P2P response times from 72 hours to 10 days. He proposed requiring a live person to answer P2P calls instead of an automated system, ensuring quicker human contact.

Objective 2: Are Medicaid beneficiaries being placed in observation status when they should be classified as an inpatient?

Interviews with the Hospitals

During an interview, one hospital revealed, "'Inpatient criteria' and 'observation criteria' do not exist in medical school (in medical textbooks or medical school literature). This terminology does not even exist in the clinical world and is considered a non-existent differentiation. It is an administrative line of demarcation that has been created for the purpose of payments. Frequent references are made to a patient not meeting 'inpatient criteria' for denials from payers. The criteria are purely subjective and were created by an administrative body to justify when to pay, or not pay, for a diagnosis as inpatient or outpatient. When the differentiation between inpatient and outpatient level of care was being abused, hospitals and providers began noticing more issues. The MCOs have decided that any person who is admitted to the hospital, regardless of their length of stay, should be declared an outpatient. The MCOs know they can get away with paying for outpatient."

Another hospital claimed their UM team noticed a trend, known as the "ethanol trend", for alcohol withdrawal patients. These patients were frequently denied inpatient admission status, even though they met InterQual inpatient criteria. This hospital tracked these occurrences, which also conflicted with what is stated in their contract. The hospital also shared that they had begun tracking the patients that fell victim to this pattern.

Auditor's Note: *Additional details regarding the outcomes of denied inpatient admission status and its impact on the responsible party for service costs are provided later in the report.*

The common statements below capture the recurring issues and common practices the hospitals faced in dealing with MCOs, particularly in relation to PA requests, observation status, denials, and administrative burden:

- Providers face arbitrary and inconsistent application of "inpatient criteria" versus "observation criteria." P2P reviews often maintain denials, wasting provider time and adding to the administrative burden. Providers are constantly deciding whether to fight cases or take them to a state fair hearing. PAC authorization delays and denials contribute significantly to these administrative burdens. Hospitals often wait up to 14 days for PAC PA responses, causing extended stays and delayed discharges. Although hospitals rarely take claims to a fair hearing due to the costs, when they do, it is a well-documented and lengthy process. For instance, one case was discussed that started in January 2021 and was not settled until November 2022.

- MCOs exploit InterQual or MCG criteria to deny inpatient status and justify observation status, aiming for high cost containment metrics. These guidelines are supposed to be used as screening tools, but MCOs misuse them to keep patients in observation status despite meeting inpatient criteria. They deny inpatient PA requests based on simplistic admission diagnoses, such as chest pain or headache, often without reviewing full medical records. MCOs use terminology in diagnosis to determine PA response, causing unjust denials. They commonly deny inpatient status PA requests, often requiring hospitals to rebill as outpatient. Examples include patients with complex medical conditions or those needing high-intensity care being placed in observation status instead of inpatient.

- InterQual and MCG help hospitals figure out if patients need certain types of care. These tools were developed by companies affiliated with UnitedHealth Group, which also operates health insurance programs, including those for Medicaid. Hospitals train their staff to use these tools so they can follow what insurance companies like UnitedHealthcare expect. But even when a hospital worker says a patient should be admitted as an inpatient based on these tools, the insurance company might still say the patient should be treated as an outpatient after talking with their own medical director.

  When this occurs, the care the hospital gives doesn't change, but the payment does. Hospitals spend the same amount on the care, but they get paid less if the patient is considered outpatient. Medical necessity decisions are being made by computer programs the insurance company owns, not by clear medical rules.

- Prior to the hospital submitting the claim to the MCO, they will submit it to one of their Correct Coding Initiative (CCI) vendors to ensure coding on the claim complies with KMAP. UnitedHealthcare owns both claim review service vendors used by hospitals.

- MCOs use criteria from unknown sources to justify denials, creating additional administrative burdens for providers. There is an increasing trend in medical necessity denials, despite Medicare's Two Midnight rule applying only to Medicare. These themes reflect ongoing challenges hospitals face with MCO practices, especially regarding administrative burdens, P2P reviews, criteria abuse, and delays in PAC authorization.

- Hospitals must remove room and board charges and add observation charges when changing a patient's status from inpatient to observation. This change is documented with a disclaimer form. MCOs often request claims to be updated from inpatient to observation to approve reimbursement. Patients in observation status can remain for extended periods, and MCOs may deny claims for stays beyond 48 hours. Observation status payments are significantly lower, impacting DSH qualifications and reimbursements.

- MCOs delay responses for PAC PA requests, sometimes resulting in patients being discharged without the needed PAC. Nursing staff shortages exacerbate issues with extended observation stays due to PAC PA denials and delays. Hospitals frequently change PA requests to observation status to increase the likelihood of approval. MCOs issue readmission denials when patients with similar diagnoses are readmitted within 30 days, citing administrative denials for readmission. These denials occur even when patients' conditions necessitate readmission.

- MCOs are not required to adhere to the Medicare inpatient list, resulting in lower levels of care for Medicaid recipients. Medicare's inpatient list specifies those services that are only paid when provided in an inpatient setting. These are services that require inpatient care because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. The MCO's policies often lead to automatic denials for high acuity short stays, preferring observation status for cost savings. The use of machine learning scoring systems, like Cortex, are employed to recommend inpatient status. Standardizing the use of MCG or InterQual criteria alone for determining inpatient status could reduce denials and administrative burdens. Administrative burdens and financial costs associated with PAs, denials, and appeals are significant. Hospitals frequently experience delays in PAC PA responses, contributing to extended hospital stays and resource allocation issues.

- The decision to approve inpatient status often considers underlying conditions such as whether the patient lives alone or is elderly and unable to care for themselves. MCO 1's

Medical Director has the authority to override core criteria based on these factors. Frequent overrides rely on InterQual clinical guidelines and the judgment of treating physicians. InterQual criteria are reviewed and updated annually based on current medical guidelines and are uniformly used by Medicare, private insurance, and Medicaid, including all three MCOs in Kansas. The Interrater Reliability (IRR) tool promotes consistent application of criteria among reviewers.

- A significant increase in observation usage in managed Medicaid programs due to MCO decisions has been noted. Although hospitals have standing meetings with the MCOs to address these concerns, the issues remain unresolved.

Interviews with the MCOs

MCO 1

MCO 1 reviews each member's individual needs and medical history before approving procedures as inpatient or outpatient, and conducts concurrent reviews every two days for inpatient admissions or every seven days for intensive care unit (ICU) patients. Providers may receive adverse determinations, such as "no" or "only observation can be approved," for PA requests and can appeal these denials. If a PA for inpatient admission is denied, hospitals can rebill for observation status for the first 48 hours, but additional days in observation status beyond 48 hours are not paid.

MCO 2

Hospitals can submit a change in condition to update a patient’s status from observation to inpatient, and denied cases can be sent back for reconsideration or P2P discussion. Hospitals must notify MCO 2 within two business days of admission, and MCO 2 reviews clinicals to determine if the patient meets the MCG medical necessity criteria; if not, the request is reviewed by MCO 2’s Medical Director. MCO 2 does not retract PA approvals and conducts concurrent reviews for subsequent days. In-network hospitals do not need to send a PA request for observation status admissions but must do so for changes to inpatient status.

MCO 3

MCO 3 requires a Notice of Admission (NOA) for inpatient admissions within one business day and processes PA requests based on urgency. Observation services do not require PA, leading to instances where MCO 3 receives NOAs after patient discharge. MCO 3 aims to decide on discharging observation patients or transferring them to inpatient status within 24 hours. Charges for observation and inpatient status differ, with room and board not covered in observation status. Medicaid’s low reimbursement rates lead to lower priority for transferring patients from observation to inpatient status.

Patients can remain in ER status for up to 24 hours, and billing is adjusted accordingly. Patients triaged in the ER should have their status updated to observation or inpatient if needed. MCO 3's UM team reviews medical records for medical necessity using InterQual criteria. When a patient's condition changes, they can be transitioned from observation to inpatient status, with each change documented in the medical record. Patients ready for discharge but unable to leave due to external factors remain in inpatient status with unauthorized days.

If outpatient services are provided before a patient is admitted to inpatient status, these services should be included on the inpatient claim per CMS guidelines. MCO 3's Authorization team receives extension requests for inpatient PAs for "social stays," but claims are billed as inpatient. A "social stay" refers to inpatient hospital days that continue after a patient is medically cleared for discharge, where non-medical factors (e.g., housing delays, caregiver unavailability, or administrative discharge barriers) prevent timely discharge. These days are not reimbursable under Medicaid because they do not meet the criteria for medical necessity.

Patients cannot be placed back into observation status after being admitted as inpatients. If the room and board codes do not match the admission and discharge dates, the claim will be denied. For patients truly transferred from inpatient to outpatient status, a separate observation claim may need to be billed.

Criteria used for PA requests are documented in MCO 3's system, which automatically records step-by-step decisions. Inpatient PA requests with unsafe discharge plans are often denied for lack of medical necessity, but reconsideration can be requested based on patient documentation. Knee replacements are considered outpatient surgeries for Medicare but are reviewed on a case-by-case basis for Medicaid admissions with comorbidities. New PA requests are required when inpatient PA approval expires, and patients await placement in a PAC facility. If the doctor's notes indicate the patient is stable and ready for discharge, further PA requests are likely to be denied due to a lack of medical necessity. Observation and outpatient status are interchangeable for hospital admissions and are reviewed the same way. No diagnosis automatically results in observation status; however, Medicaid covers observation stays for 48 hours or less, after which a new PA request for inpatient care is required.

Objective 3: Is there consistency in how each MCO determines the level-of-care (LOC) for post-acute care (PAC)?

Interviews with the Hospitals

One hospital reported at least 10%, or 50-80 patients, of the total of admitted patients are in some stage of the PAC PA request waiting period, daily. This hospital has patients who have been in observation status for over a year and have not received reimbursement or complete reimbursement for the patient's stay.

Another hospital provided several examples of patients waiting for PAC authorization from the MCOs, with some patients waiting up to 14 days for a PAC PA response. These PAC PAs are undergoing the appeal process, including the P2P reviews. Any patient staying additional days adds to the hospital's administrative burden of continually communicating with the MCO to obtain approval for the patient to be discharged to their respective destination based on their medical needs. This issue is particularly evident when all beds are full, and the hospital has reached capacity. The MCO will respond to an inpatient PA request that was either not submitted or has already received a response to delay the time the hospital received the PAC PA response. The MCO does not have to pay for any expenses accrued during this delayed period. These administrative burdens always revolve around PA decisions.

The hospital is not waiting for clinical acceptance before discharging a patient to a long-term acute-care hospital (LTACH) or a skilled nursing facility (SNF); the patient has already been clinically. The hospital is waiting for payer authorization for the PAC. Several hospitals have tracked these avoidable days. After a patient has been clinically accepted for PAC and an open bed has been located, the waiting period for PAC authorization begins. Another hospital explained that hospitals get reimbursed for services at a flat DRG rate, regardless of the patient's length of stay in the hospital. It is clear to providers that MCOs are primarily aiming to approve the most cost-effective PAC options, with the preferred PAC placement being home health, as it incurs the lowest reimbursement cost to the MCO. It is nearly impossible to get approval for an LTACH. For hospital rehabilitation, hospitals must communicate extensively with MCOs for several days to obtain PAC PA approvals.

KHA met with the MCO Medicaid medical directors in November 2022 and created a Microsoft PowerPoint presentation featuring examples of two issues: inpatient versus observation and PAC authorization delays and denials. The payers requested the opportunity to review the examples internally and acknowledged that they needed to educate their staff to use more than hours in the hospital as their criteria to determine observation status. When KHA contacted the directors three weeks after the presentation to check on the progress, the payers responded that the issue discussed was systemic and placed blame on the hospitals, stating that the hospitals did not provide enough documentation for them to make medically accurate decisions.

The consolidated common statements from the hospital interviews below highlight the significant challenges hospitals face regarding PAC authorization delays, inconsistencies in criteria application, and the financial and administrative burdens imposed by MCO practices:

- **PAC PA Delays:** MCOs have discovered another cost-containment strategy with PAC PA delays. If the patient's condition improves with extra days in the hospital, the MCO can avoid PAC payments. If the patient does not improve with extra days in the hospital, the

MCO will not approve a costly PAC option despite the medical necessity of the patient presenting a need for a specific PAC level. For example, if a patient needs to go to an LTACH, the MCO will deny and suggest the patient go to a lower-cost PAC. This often results in the patient being readmitted to the hospital and the MCO denying the readmission claim.

- Providers are frustrated because the re-admission could have been prevented if the medically appropriate PAC had been approved initially. MCOs will frequently deny a hospital re-admission within 30 days, even if the second admission is completely unrelated to the first admission. The PAC PA delays also reduce the availability of hospital beds, resulting in prolonged waiting periods for patients requiring acute care. This applies to both the ER and transfers from other hospitals.

- The hospital is supposed to receive a decision for the initial PAC PA requests from the MCO within 72 hours. The MCO has 24 to 48 hours to respond to P2P review decisions and 72 hours to respond with the appeal decision. If the recommended PAC LOC is denied, the process starts over if they must request a PAC PA for a lower/cheaper LOC to get the PAC approved by the MCO for discharge. MCOs often use the excuse for delays that more documentation is needed, even when the MCOs have open access to the hospital's electronic medical records (EMR), which is provided by the hospital.

- **Difficulties with Determinations of LOC for PAC:** The MCO would specify that the readmission claim was denied due to the hospital providing a faulty discharge plan concluding the patient's initial admission. The hospital would be held responsible for the failed PAC discharge plan, despite the MCO denying the PAC PA request for a medically necessary facility, and the hospital would not be reimbursed for the readmission. MCO 1 uses InterQual and its internal criteria, refusing to provide the criteria upon the hospital's request. Inconsistent responses, such as approving one claim and denying another claim with the exact diagnoses and length of stay, caused one hospital to believe MCO 1 lacks consistent internal structural criteria to evaluate PA requests. During the P2P for rehabilitation PAC, MCOs commonly disagree with rehabilitation PAC PA requests and advise the hospital to complete a PA request for the patient to be discharged to an SNF. After sending the PA request, an additional 24 hours is given to the MCO to respond, further prolonging the patient's stay in the hospital.

- **MCOs will deny higher levels of PAC PA requests without providing a reason for the denial**: For PA requests regarding admissions to the hospital, MCG or InterQual are used by MCOs and hospitals jointly to determine LOC status. These criteria are not used when the MCO determines if a PA request for PAC discharging should be approved or denied. The

MCOs have not shared a criterion for which they base their PAC PA decisions, making it difficult for the hospital to get PAC PA approvals.

- **Patients are not receiving appropriate levels of PAC for a healthy recovery:** Instead, patients are sent home with little or no PAC, often resulting in hospital readmissions. MCOs strive to approve PAC at the lowest rates as a cost containment strategy, knowing they can deny any readmissions to the hospital that fall within 30 days of the previous admission. The MCO is approving different criteria for medical diagnosis based on the insurance payer source. As a result of this difference in criteria, a claim submitted to Medicaid will be denied where it would have otherwise been approved had it been submitted by a non-Medicaid payer source.

Another hospital discussed unnecessary additional days in the hospital stay while the PAC is coordinated. The hospital arranges post-acute care and must wait for MCO authorization to the transferring facility. Often, the first LOC choice is denied by the MCO, a P2P is requested, and the denial is overturned. This process adds days to the hospitalization, especially when requesting transfer to rehabilitation. In addition to the denials and delays in post-acute authorization, many receiving facilities refuse Medicaid patients because their reimbursement level is so low, particularly if the individual needs significant care like intravenous therapy or wound care. Even the basic cost of a skilled stay for someone needing physical or occupational therapy is more than the MCO reimbursement, prompting reluctance to accept Medicaid patients. Due to the difficulty in placing patients in receiving facilities, hospitals often refer patients to inpatient rehabilitation hospitals, which can result in higher costs for the payer. However, if that LOC is denied, they cannot transfer to an SNF, and unfortunately, the patient's only option is to go home with home healthcare, which may not be the best option. Very few patients go to an LTACH, the highest post-acute LOC. Of the three MCOs, MCO 1 is least likely to approve patients for any level of PAC, especially when the request is for inpatient rehabilitation or LTACH. MCO 2 and MCO 3 practice the same tactics.

Hospitals further explained that in addition to the PAC difficulties in placement and MCO approval delays, the MCOs also deny payment for the extended hospital days while the patient waits for those processes to take place. Once the hospital indicates the patient is ready to be discharged to the next LOC, the MCO deems any days from that point on as unnecessary, even though the MCO is causing the extra days. The MCO's turnaround time for PAC can be several days, seeming to hope that if the process takes long enough, the hospital will send the patient home with a referral for home health or no help. This could be a legal issue due to the discriminatory nature of the practice. One hospital also mentioned concerns about the inconsistency in care levels being denied and reimbursement between Medicare and Medicaid recipients, which affects PAC services and the urgency to discharge patients.

Interviews with the MCOs

MCO 1

MCO 1 defined PAC as transferring a patient from a hospital to a LTACH or a SNF, excluding home healthcare. During the height of COVID, the requirement for PA for PAC caused problems and delays in transferring patients to the next LOC. As a result, MCO 1 removed the PA requirement for PAC in mid-2021 to facilitate smoother transitions. MCO 1 members are automatically approved in the PAC facility for the first seven days. After this period, the PAC facility must submit a PA request every seven days (weekly) to determine if the patient still meets the criteria for the level of PAC they are receiving.

The weekly reviews include assessing the member's clinical status, progress, and estimated time to discharge either to a lower LOC or home. If the current LOC is deemed no longer medically necessary, MCO 1 will facilitate the transition to the next appropriate LOC. MCO 1 can negotiate a higher per diem rate with PAC facilities that require additional resources for patients with higher needs, such as extensive physical, speech, or occupational therapy, wound care, or behavioral issues.

MCO 1's clinical teams assist with safe discharges from PAC settings, aiming to avoid hospital readmissions caused by unsafe discharges. For home health discharges, MCO 1's discharge team collaborates with hospital planners to establish home health services. Skilled nursing care at home requires PA approval.

MCO 1 Medicaid members on the LTSS waiver have care coordinators, while those not on a waiver have community health workers that align with whole person care. MCO 1 also has inpatient care and discharge planning teams that communicate with discharge planners in hospitals and PAC facilities to ensure patients' transition needs are met and that necessary services and equipment are available for home health discharges.

MCO 2

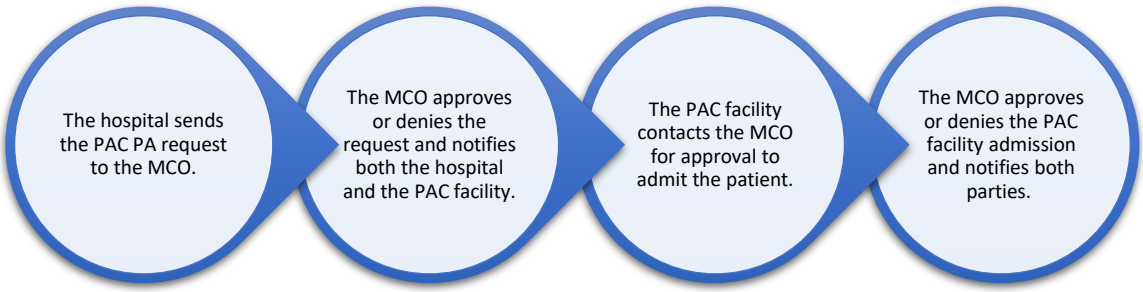
MCO 2’s intake methods for PAC PA requests include phone, fax, or uploading through the online portal, similar to other PA requests. MCO 2’s acute care UM nurse consultants who review the acute stay also work with the PAC facility on discharge planning. Ideally, if MCO 2 is aware of the discharge planning ahead of time, the discharge plan can be discussed with MCO 2’s case management team.

When notified that a PAC is needed for discharge, MCO 2’s PAC nurse reviews the acute stay and any additional clinical information sent with the PAC PA request. If the PAC nurse approves the request based on the provided information, they will send the approval notification to the facility. If the PA request does not meet MCG criteria, it must be reviewed by the medical

director for a final determination. The PAC PA response is communicated back to the requesters, with responses sent by fax and followed by a letter via mail. If the discharge planning team is communicating by phone, MCO 2 can also provide a verbal update.

The PAC PA request decision must be made within three calendar days from the PA request date. If approved, the fax is sent immediately. If not, the request is sent back to the nurse to complete the response for the provider, and the PA denial response is sent to the provider. When the hospital sends a PAC referral for a patient, the PAC facility must confirm bed availability. Once confirmed, the hospital sends the PAC PA request to MCO 2. Sometimes, both the hospital and PAC facility send a PAC PA request for the same patient. In such cases, MCO 2's intake team confirms that the requests are for the same member, facility, and service before notifying the requesters.

The communication flow between the hospital, PAC facility, and MCO is as follows:



Hospital providers often request a P2P review immediately for most PAC PA requests for LTACH, inpatient rehabilitation, or skilled nursing cases. MCO 2 considers these requests urgent and expedites them, conducting the P2P review within 24 hours. If the denial is overturned, the patient is transferred to the requested PAC level. If upheld, the hospital and MCO 2's case management discuss the patient's needs.

Patients may still require inpatient care after discharge plans are set up. Discharge planning begins on the day of admission. Patients may experience delays in discharge due to family-related issues, changes in their condition, or limited bed availability. MCO 2 confirmed that patients could still meet inpatient LOC while discharge plans are coordinated with the PAC facility.

If a LTACH PAC PA request is denied, and the hospital decides to send the patient to a SNF, a separate PA request is required. MCO 2 requires separate PA requests for each PAC facility level of care. Subsequent PAC PA requests during P2P review can be made verbally during the call or

by fax. Subsequent requests are processed more quickly as the UR team is already familiar with the patient's clinical information.

New PA requests are usually received within seven days of the denial. If received after seven days or more, MCO 2 requests a clinical update from the hospital to ensure the patient still meets the PAC admission criteria.

If the acute care facility has sent referrals and confirmed an accepting facility, MCO 2 aims to respond within 24 hours, with a maximum response time of three calendar days. MCO 2's PAC PA response time averages between 1.4 to 1.6 days. If a patient is not approved for a continued inpatient stay while awaiting PAC placement, the hospital must still have a safe discharge plan. If the delay in discharge is due to the hospital, there would be no payment for the extra week. In such situations, MCO 2's case management team assists the hospital. MCO 2's UM team can assess and provide a list of participating providers for the specific LOC, contacting the PAC facility to check acceptance.

MCO 3

There are instances where MCO 3's nurses are not notified of a patient's discharge or discharge location. Some hospitals discharge patients without a proper plan, even sending them back to homeless shelters, while larger hospitals have dedicated case managers ensuring safe discharge plans. These nurses also follow up with PAC facilities post-transition. Sometimes, patients ready for discharge cannot leave for reasons beyond their control. In such cases, they remain in inpatient status, accruing unauthorized days. Delays, particularly in behavioral health and nursing facilities, often necessitate backup plans. Additionally, a pediatric hospital requires 19 hours of direct caregiver support for home health agency discharge, causing delays. Access to dental care for MCO 3's Medicaid children is limited due to low Medicaid reimbursements, with few dental facilities accepting MCO 3's Medicaid children. The following information, in substance, was also learned from the interviews with MCO 3:

- Medicaid Member's PAC Facility Placement Challenges: Medicaid members face difficulties with PAC facility placement due to increased demand, decreased availability of PAC beds, short staffing, and lower Medicaid rates. Facilities prioritize privately-insured patients who pay higher rates. MCO 3 attempts to offset this by building strong relationships with local PAC facilities. If there is a disagreement between MCO 3's doctor and the hospital's doctor during a PAC discharge review, the P2P process begins, and appeals can be initiated by the patient or provider.

- PAC Discharge Planning: InterQual criteria determine the appropriate PAC facility or home health care for discharge. The care management teams collaborate to determine the PAC placement. If the patient requires an LTACH, the facility submits a PAC PA request. MCO 3

compares the patient's therapy and physician documentation with InterQual's LTACH criteria before deciding. If the request is not approved, the process repeats for each LOC in the discharge plan, with new PAC PA requests required for each LOC. Additional PAC PA requests are needed from each PAC facility.

- Continued Stays During PAC Facility Placement Process: When a patient's inpatient PA approval expires while waiting for PAC facility placement, a new PA request is required for a continued stay. If the patient is stable and ready for discharge, additional PA requests are likely denied for lack of medical necessity. However, if the patient's condition worsens, they may become eligible for medical coverage, with new medical records submitted for review. Claims are paid based on the PA request, making it crucial for the facility to submit their own request. DRG facilities receive DRG payments regardless of stay length, possibly reaching outlier status for additional payments. MCO 3 is willing to negotiate reimbursement for non-covered days to help cover expenses if requested by hospitals.

Testimonial Evidence: Observations

Once the grouping of the testimonial evidence was completed, the analyzed data from the interviews that did not answer an audit objective question were organized into 10 observation categories.

Below is a table of the observation categories. The table includes the number of hospitals that provided testimonial evidence for each category. If a hospital's interview included more than one observation category, the hospital was counted for each applicable category.

For each observation category identified below, an interview summary is provided following the chart. Following the interview summaries for each observation category, applicable interview summaries from the MCOs to each of the respective observation categories were also included.

Hospital Interviews – Observations								
Observation Category (OC)	**H1**	**H2**	**H3**	**H4**	**H5**	**H6**	**Total**	**%**
UM Policy Compliance	x						**1**	**16.7%**
Partial Approvals/Split Claims	x	x	x	x	x	x	**6**	**100%**
InterQual/MCG Abuse	x		x				**2**	**33.3%**
Continued Stay Denials	x			x			**2**	**33.3%**
Administrative Burdens	x	x	x	x	x	x	**6**	**100%**
Payer Source Discrimination	x	x	x	x	x	x	**6**	**100%**
MCO Patient Abandonment or Mistreatment	x	x	x	x			**4**	**66.7%**
Urgent PA Request Decision Delays		x					**1**	**16.7%**
Retroactive Denials		x		x	x	x	**4**	**66.7%**
MCO's EMR Access	x	x	x	x	x	x	**6**	**100%**

OC #1: UM Policy Compliance
Hospitals struggle with KMAP's UM policy[8] that states, "*A member can be in the observation unit no more than 48 hours. Observation hours in excess of 48 hours are not reimbursable.*" Medicaid reimburses hospitals at a lower reimbursement rate than Medicare despite providing the same care and using the same equipment. The length of stay (LOS) is never considered on Medicaid observation status claims. The difference in payment for a Medicaid patient for inpatient status would be $1000, versus $200 for outpatient status (also used for observation) for a Medicaid patient. The LOS when observation status is determined is *never* considered in claims.

OC #2: Adjusting Claims to Receive Reimbursement
The MCOs are not approving claims with complications and comorbidities (CC) and major complications and comorbidities (MCC), which will increase DRG. The claim is not approved until the claim is adjusted to exclude CCs and MCCs, decreasing the DRG. Hospitals are adjusting claims to exclude the patient's continued stay, the patient's additional days in the hospital past the originally approved days, and expenses solely to reflect the originally approved DRG in order to receive payment. This adjustment is also known as a contractual adjustment.

The MCOs are partially approving claims that include the expenses accrued during the patient's continued stay. The hospitals have resorted to billing the approved inpatient stay and the continued stay expenses on separate claims in an attempt to be reimbursed for all services rendered to the patient. This leads to a misrepresentation of both the hospital's inpatient stay and outpatient stay metrics, as the patient's actual length of stay is no longer reflected on the inpatient claim.

The MCOs are more likely to pay outpatient reimbursement rates than the inpatient, DRG, reimbursement rates. If the MCO has only approved the patient's continued stay for observation status and the hospital provides inpatient status-level services, per the patients care necessities, the hospital is not reimbursed at the inpatient status reimbursement rate, the DRG. Outpatient rates are roughly 75% less than the DRG inpatient rates.

OC #3: UM Criteria Abuse
Patients are defaulting to observation status when they are admitted to the hospital because the MCOs appear to be misusing the InterQual or MCG criteria. The InterQual or MCG criteria are created and sold by commercial companies and hospitals buy these products, paying for a license, to have access to these commercial clinical criteria. This criterion is not meant to override medical expertise, but the criteria is upheld over medical expertise when applied in this manner by the MCOs.

[8] KMAP 2022 Hospital_22331_22296

Any stay of less than two days requires intense scrutiny and P2P reviews, which almost always uphold the payer's denial solely based on the length of stay. The denial language in the denial letter lists the LOS as the rationale for the denial, but InterQual or MCG is cited. MCOs also use their internal policies to justify these denials.

OC #4: Continued Stay Denial

The MCOs typically deny continued stay PA requests and do not reimburse the hospitals for the continued stay expenses. These denials are common in the following situations:

- If the MCO has approved the patient for a set number of days for a stay and the physician believes the patient is not medically stable to be discharged at the end of their approved stay, the physician will submit a continued stay PA request.
- When the hospital submits a continued stay PA request to cover services that the patient received while they were in the hospital waiting for PAC PA approval to be transferred to a higher LOC facility or company.

If a continued stay PA request is denied, the hospitals may conduct a contractual adjustment of the claim that includes the continued stay charges. The adjustment consists of subtracting, from the claim, the expenses that were accrued during the continued stay from the previously approved inpatient DRG. The DRG is the only expense that is reimbursed.

Continued stay denials paired with PAC PA denials and delays cause the hospital to be in a constant diversion, as the hospital’s beds are unavailable for incoming patients. When the hospital is in a diversion they are unable to provide services to additional patients and must divert them to other facilities.

OC #5: Administrative Burdens

The volume of administrative tasks has increased because of PA determination delays, information requests, and fax communication. Hospitals have had to hire additional staff and even establish departments that solely handle and keep up with the increased volume of administrative tasks.

There typically is not an MCO liaison, or point of contact (POC), assigned to each hospital. This causes delays in response times from the MCOs, as well as inefficient communication between the MCOs and hospitals.

- Instead of communicating directly with the MCO liaison, communication and sharing EMRs between the MCO and hospitals is done via fax, email, or the online provider portal.
- UM communications are added to a “queue” for the next available MCO representative to process. Each time a new MCO representative works with any requests or claims for a patient, they must be updated on the patient’s clinicals, status, etc.

- If there is an MCO POC assigned to the hospital, the MCO does not notify the hospital about the change of POC.

Due to some MCOs inability to accept sensitive information electronically, medical records are also faxed. A hospital testified to receive between 80 and 200 faxes per day, requiring the hospital to add additional information to the EMR system.

The MCOs response time for PAs, P2P reviews, and appeals can be burdensome to the hospital and the patients. Providers explain the administrative burdens as "massive negotiations for admission to the hospital and massive negotiations to discharge out of the hospital."

- Hospital UM teams have had to start tracking the specific MCO representative and all related correspondence for specific instructions provided for each claim, due to the variation of outcomes.
- Hospitals have resorted to requiring physicians to take screenshots of approvals and to write down the patient's name, reference number, the time the PA request and related correspondence is sent, and when the claim was recorded.

The MCOs communicate with hospitals that PA responses are delayed because they are 90 to 120 days behind in processing their internal appeals. A hospital testified this delay is not in alignment with the prompt payment law for Medical Assistance:

K.S.A 39-709f. Medical assistance program and managed care organizations; contract; prompt payment. (a) Any contract between the Kansas medical assistance program and any managed care organization serving the state of Kansas shall require the processing and full payment of the allowed amount or processing and denial by the managed care organization of all clean claims within 30 days after receipt of the clean claim, and the processing and full payment of the allowed amount or processing and denial by the managed care organization of all claims within 90 days after receipt of the claim. The contract shall also include a late payment provision that requires the managed care organization to pay interest to the provider at the rate of 12% per annum for each month that the managed care organization has neither processed and fully paid the allowed amount nor processed and denied a submitted claim or clean claim after the time limits set forth in this section.

The Kansas medical assistance program shall also require managed care organizations to include a provision outlining the provider's rights under this section in the managed care organization's contracts with providers. A provider that has a claim that remains unpaid by a managed care organization after the time limits set forth in this section may bring a direct cause of action against the managed care organization for the interest provided for in this section in addition to the amount of the unpaid claim. and have considered sending additional complaints concerning the MCOs injustice in accordance with this law to the insurance commissioner.

Hospitals are placed under financial burden when taking claims to the state fair hearing (SFH) level of appeal.

- Legal representation, which the hospital pays for, is required to file the SFH level appeal. Many hospitals review each unpaid claim to determine if an SFH appeal should be filed.
- The SFH process can take years to complete. One Kansas hospital testified that the cases that reach the SFH level are primarily for Medicaid beneficiaries.
- Some Kansas hospitals have explored bundling unpaid claims of multiple cases filed for SFH to seek a higher amount of overturned denials or higher settlement totals because most unpaid Medicaid claims do not exceed $10,000.
- Many hospitals testified about the difficulty in deciding between appealing for reimbursements or accepting the MCO's denial for inpatient PA requests because of the financial and administrative burdens.

The inpatient electronic claim submission form layout, the 837-claim form, only allows for one PA number to be entered. When multiple PA numbers are involved in a single claim, it results in payment delays and adds to the administrative burdens of the hospital staff.

MCO 3 requires hospitals to send a daily file of patients who have been admitted and patients in observation status adding to the hospitals' administrative burden. This file has been requested in the past for MCOs to understand who was admitted and to contact the hospital if they had any questions. The hospitals, outside of this request, already notify the MCOs when one of their beneficiaries has been admitted.

Additional administrative burdens included:

- Tracking down denial letters and adding the letters to the patient's files.
- Billing form issues - unable to bill multiple PA #s on the electronic UB-04 form.

OC #6: Payer Source Discrimination

PAC facilities and home health companies are not accepting Medicaid patients into their facilities by claiming they have no available beds. The hospitals believed these facilities and companies make this claim to avoid the extensive and troublesome reimbursement process with the MCOs. PAC facilities and home health companies claim their "Medicaid beds" are full, instead of saying their beds are full as a collective.

Many PAC facilities refuse Medicaid patients because Medicaid's reimbursement rate is low, particularly if the individual needs significant care. For example, the basic cost of a stay for a patient that needs physical or occupational therapy is costlier than the reimbursement the facility would receive from the MCO for providing the services. This makes PAC facilities and home health companies reluctant to accept Medicaid patients.

The MCOs are setting up single-case agreements with out-of-network SNFs because of the discrimination against Medicaid patients attempting to receive PAC. Single-case agreements are used to transfer Medicaid beneficiaries to a PAC facility for medically necessary care. Patient discharge dates are delayed an additional two weeks because the single-case agreement contracts are done by a third-party contractor.

OC #7: MCO Patient Abandonment or Mistreatment

The MCOs place responsibility on the hospital to complete tasks the MCO is responsible for, such as:

- Finding a PAC facility that best suits the patient and their medical needs.
- Accommodating patients with social determinants (criminal background/behaviors or socially unacceptable behaviors such as alcoholism) regarding their PAC discharge plans.
- Paying for patient transportation. Medicaid patients have Medicaid transport benefits, but are often unable to use them.

The MCOs mistreat their beneficiaries by:

- Denying patient PAC PA for a facility and recommending a lower LOC facility despite the patient's medical necessity

OC #8: Urgent PA Request Delays

Hospitals experienced issues when attempting to get PA requests for transplants approved weekly, especially if they are urgent. When PAs are sent emergently, the MCOs required decision response time of 72 hours is maintained. The hospital has experienced patients with worsening conditions in need of a serious procedure, be admitted on a Friday afternoon and unable to receive the necessary treatment because the MCO was unavailable to provide an approval for the serious condition PA request during the weekend. Insurance payers do not have an escalation process in place for emergent PA requests, despite a patient’s life depending on these emergent PA approvals.

OC #9: Retrospective Review and Retroactive Denials

During their retrospective review, the MCOs deny previously approved inpatient PA requests due to lack of medical necessity. Hospitals had even experienced retroactive denials for PAs after patients had passed away, due to lack of medical necessity. The MCOs deny PA requests for nontraditional situations such as:

1. A patient who applies for Medicaid when they are admitted to the hospital: Patients without health insurance have the option to apply for Medicaid upon admission to the hospital. If the patient has yet to be approved for Medicaid, they are “Medicaid pending.” PA requests for patients that are “Medicaid pending” are always denied. Waiting for the Medicaid eligibility determination delays the discharge planning, as most post-acute facilities are not accepting

"Medicaid pending" patients. If the patient is approved for Medicaid coverage, the PA request is denied due to untimely submission of NOA.

2. A patient that does not have an MCO assigned to them when they are admitted: When a Medicaid application is completed without an MCO health insurance company preference selected, the patients are not always assigned an MCO before services are rendered. If a Medicaid beneficiary has not yet been assigned an MCO, the PA is denied by the MCO for untimely NOA. This adds additional days to the patient's stay that the hospital is not reimbursed for by the MCO.

OC #10: MCO's EMR Access

Although most hospitals' legal teams refuse MCOs access to their EMRs, one MCO's network team is working to reduce the administrative burden by advocating for such access. The MCOs highlight the benefits, such as minimizing the need to fax clinical information for each patient would expedite the UR process. This MCO has experienced some hospitals requiring the MCO staff to provide their own social security numbers to gain access to their EMRs, however, this violates the MCO's privacy policy for their staff. The MCO testified that having access to EMRs in a few facilities has led to a more efficient and quicker review process. They argue that providing MCOs with access to EMRs benefits both hospitals and MCOs by simplifying operations.

Analysis 1: Hospital Questionnaires

Questionnaires were sent to the hospitals interviewed by the OIG to gain further insight into the complaints discussed during their interviews. The hospitals provided responses based on information spanning one year within the audit period. To maintain confidentiality, each participating hospital was assigned an identifying code, consisting of the letter "H" followed by a number from one to six (H1, H2, H3, H4, H5, and H6). Hospital H2 did not participate in the questionnaire.

Hospital H5 also did not respond to the initial questionnaire. However, during its first interview, it was determined that H5 does not write off claims. As a result, a second interview was conducted to gather additional details about its hospital claims and related MCO payments. **In general, many hospitals revealed that they write off claims when insurance payers do not reimburse them, meaning they do not receive payment for those claims.**

Following H5's second interview, a separate questionnaire was emailed to the hospital to collect numerical data on unpaid claims, the P2P process, the appeal process, and the SFH process. H5 provided responses to this questionnaire. However, *only* the answers that corresponded to questions from the original questionnaire are included in the results below.

The questions asked and responses from participating hospitals are presented below.

1. *What percentage of your patients have Medicaid as their primary insurance?*
    - Hospital/Percentage:
        - H1 – 12.84%
        - H3 – 9.37%
        - H4 – 13.9%
        - H5 – did not provide a response
        - H6 – 5.93%

2. *How many Medicaid accounts are currently at an unpaid status and what is the average length of time they have been unpaid?*
    - H1 reported **15,799** unpaid claims, totaling **$61,184,205**. The average length of time claims remained unpaid was **211** days.
    - H3 had one account that was unpaid at the time they completed the questionnaire, but did not include the billed amount of this claim in their response. All other unpaid accounts were sent to collections.
    - H4 reported **1,386** unpaid claims, but did not include the total billed amount of these claims in their response. This hospital reported that an average of **15%** of claims remained unpaid for more than **30** days.
    - H5 did not provide data specific to unpaid claims.
    - H6 reported **31** unpaid claims. This hospital did not include the total billed amount of these claims or any average length of stay data in its response.

3. *Do you have contracts between your hospital and each MCO?*
    - Four out of five (4/5) hospitals reported having contracts with each of the MCOs. One hospital did not provide a response.

4. *Do you have a dollar amount threshold where you will not appeal a denial because, in your estimation, it is costlier to appeal than to write off the claim?*
    - Three out of five (3/5) hospitals have a monetary claim threshold amount they choose not to appeal because costs to dispute the claim would be too costly to pursue.
    - Two out of five (2/5) hospitals do not have a monetary threshold and will appeal any denial.
    - One out of five (1/5) hospitals provided their SFH threshold of **$4500** (H4)
        - Lowest threshold: **$25** from H6
        - Highest threshold: **$2500** from H1
    - H1 and H6 provided the amounts they have written off during their specified date data range.
        - H1: **$2,217,701**
        - H6: **$80,046.60**

5. How many accounts have moved into the state fair hearing (SFH) process?
    - One out of five (1/5) hospitals reported they did not have any patient claims that went into the SFH process.
    - H5 provided the following information: Eight accounts went into the SFH process between 2022 and 2023, totaling **$263,549.51**. These accounts were still going through the SFH process at the time they were provided.
    - Two out of five (2/5) hospitals provided a list of accounts that moved into the SFH process.

Summary of Hospital Responses

Medicaid usage among patients varies significantly, with H4 having the highest percentage (**13.9%**) and H6 the lowest (**5.93%**).

- Unpaid Medicaid Accounts:
    - H1: A significant number of unpaid claims (**15,799**) totaling over **$61 million,** with an extended unpaid duration (**211** days on average).
    - H3: Minimal unpaid claims were reported, but the billed amounts were not provided, making the impact unclear.
    - H4: A notable percentage (**15%**) of claims were unpaid for more than 30 days, though total values were not disclosed.
    - H6: Fewer unpaid claims (**31**), but the absence of total billed amounts and time-related data restricts deeper analysis.

- Most hospitals (4/5) maintain contracts with each MCO.

- Majority of hospitals (3/5) have set dollar thresholds for appeals, with the lowest (**$25**) from H6 and the highest (**$2500**) from H1. Two hospitals, however, appeal all claims regardless of value, showing a varying approach to cost-benefit evaluations. Significant write-offs include H1 at **$2.2 million** and H6 at **$80,000**; indicating differing impacts based on their policies.

- SFH activity is limited, with only H5 reporting eight cases totaling **$263,000**. Other hospitals reported little to no case information or provided incomplete data, which could indicate low reliance on this process or reporting inconsistencies.

- Two hospitals reported denial of PAC referrals when Medicaid was the primary payer, hinting at potential systemic issues or operational hesitations in handling Medicaid cases.

Analysis 2: Hospital Claims Analysis

Analyst Note

Global analysis cannot be performed due to inconsistent use of Third-Party Liability (TPL) and other fields when prior payments were made by either Medicare or a different primary insurance. Additionally, multiple claim submissions may be submitted for each hospitalization. Gainwell Technologies' subject matter experts (SME) indicated the only method to determine payments accurately was to look at combined claim submissions for each hospitalization.

Methodology

An Inpatient claim report for one hospital was generated through the Kansas Modular Medicaid System (KMMS). The report contained all inpatient hospitalizations with service dates between January 1, 2021, and December 31, 2023. The report was organized into a pivot table to facilitate data analysis.

The report contained:

All inpatient hospitalizations 1/1/21-12/31/23	
7,907	*Unique beneficiaries*
10,136	*Hospitalizations*
15,191	*Claim submissions*

The pivot table was organized by beneficiary ID, and a sample size of the first 104 rows of claim activity were analyzed. The 104 rows contained:

Audit Sample	
43	*Unique beneficiaries*
74	*Hospitalizations "claims"*

Analyst Note

From this point forward, "claim" will represent one hospitalization, regardless of how much claim activity occurred. The admission date on inpatient claims represents the date the beneficiary was approved for inpatient status. The first date of service on inpatient claims represents the date the beneficiary was physically present in the hospital. KMMS contains a field for "days covered." The days covered may be less than the number of days the beneficiary was present at the hospital. The number of days between the first and last day of service for each hospitalization was calculated, with the last day of service not counted. This calculation is categorized in the graphs below as "Actual hospital days."

All Sample Claims

Prior to research for payments by Medicare or by a different primary insurance, the results of the analysis were as follows for MCO claims:

Amount	All Sample Claims
74	*Sample claims analyzed*
42	*Paid (57%)*
32	*Unpaid (43%)*
$5,319,250.70	*All Inpatient billed*
$562,798.97	*All Inpatient DRG*
$205,189.64	*All Inpatient paid (4% of billed & 36% of DRG)*
392	*Actual hospital days*
378	*Days covered*
14	*Days of hospitalization not included (4%)*
$5,114,061.06	*Unpaid (96% of billed)*
$357,609.33	*Expected DRG that was not paid (64%)*

Paid Claims

MCO payments were present on 42 out of 74 claims. MCOs paid $205,189.64 (9%) out of $2,395,177.35 billed. Analysis was not conducted to determine if prior payments by Medicare or a different primary insurance existed.

Amount	42 Paid Claims
$2,395,177.35	*Inpatient billed*
$321,337.57	*Inpatient DRG*
$205,189.64	*Inpatient paid*
211	*Actual hospital days*
201	*Days covered*
10	*Days of hospitalization not included*
$2,189,987.71	*Unpaid*
$116,147.93	*Expected DRG that was not paid*

There were 42 inpatient hospitalizations that had Medicaid MCO payments. These claims can be submitted as Inpatient Claims (I) or as Crossover Claims (A). A crossover claim should signify that the beneficiary has both Medicare and Medicaid. Medicare pays its portion first as the primary payer and then Medicare sends the claim to Medicaid for any allowable payment.

Inpatient Claims

Both MCO 1 and MCO 2 paid most or all of the expected DRG for the following claims that were not submitted as crossover claims. MCO 3 paid 23% less than the expected DRG. The combined payment rate by the MCOs was 13%.

MCO	# Benes	# Admits	Days	Actual Days	Inpatient Claims Billed	DRG	MCO Paid	% of DRG Unpaid
MCO 1	8	12	40	40	485,786.18	76,881.58	$76,007.79	1%
MCO 2	5	9	39	42	$459,676.00	$46,633.56	$46,533.62	0%
MCO 3	8	11	55	57	$493,398.06	$89,871.04	$69,480.21	23%
Total	21	32	134	139	$1,438,860.24	$213,386.18	$192,021.62	

Inpatient Crossover Claims

Analysis was not conducted to determine whether Medicare paid the claims. The 87% average for the unpaid DRG suggests that there were prior payments. The MCOs paid an average of 1% of the billed amount.

MCO	# Benes	# Admits	Days	Actual Days	Inpatient Crossover Claims Billed	DRG	MCO Paid	% of DRG Unpaid
MCO 1	4	5	27	32	$382,853.91	$30,332.28	$5,388.58	82%
MCO 2	3	4	38	38	$538,092.22	$70,083.34	$6,883.75	90%
MCO 3	1	1	2	2	$35,370.98	$7,535.77	$895.69	88%
Total	8	10	67	72	$956,317.11	$107,951.39	$13,168.02	87%

Unpaid Claims

As shown above, 42 out of 74 claims received a payment by an MCO, leaving 32 claims with no payment by MCOs. These claims were reviewed in-depth to determine if they were denied entirely, denied as inpatient and subsequently rebilled as outpatient, or if there were prior payments by Medicare or a different primary insurance.

Outpatient Claims

Analysis of the 32 unpaid inpatient claims revealed two claims were initially denied but subsequently rebilled as outpatient. Outpatient payments of $2,221.35 were 5% of both the original inpatient billed amount of $45,021.32 and the outpatient billed amount of $48,007.32. Outpatient claims do not follow the DRG expected payment calculation. Because these claims were paid as outpatient rather than inpatient, the payment of $2,221.35 was 75% less than the expected inpatient DRG. Each beneficiary spent two days in the hospital.

MCO	# Benes	Days	Act Days	Inpatient Billed	Expected DRG	Outpatient Billed	Outpatient Paid	Exp DRG v. Outpatient
MCO 1	1	2	2	$37,255.49	$4,231.70	$14,777.11	$972.87	$3,258.83
MCO 2	-	-	-	-	-	-	-	-
MCO 3	1	1	2	$7,765.83	$4,651.77	$33,230.21	$1,248.48	$3,403.29
Total	2	3	4	$45,021.32	$8,883.47	$48,007.32	$2,221.35	$6,662.12

Prior Payments by Medicare or Other Primary Insurance

A review of the remaining unpaid claims found that 13 out of 30 had prior payments of $185,248.06 by Medicare or other primary insurance. The combined prior payments were 16% of the $1,182,953.53 billed.

MCO	# Benes	Days	Act Days	Inpatient Billed	KMMS CM DRG	UB04 Other Payer Xover Allowed	Prior Other Ins Payment	% Paid by Other Payer
MCO 1	1	2	2	$70,209.68	$8,208.15	$12,257.33	$12,257.33	17%
MCO 2	5	20	21	$518,244.49	$100,890.39	$94,703.73	$100,330.88	19%
MCO 3	7	38	38	$594,499.36	$56,378.65	$47,253.52	$72,659.85	12%
Total	13	60	61	$1,182,953.53	$165,477.19	$154,214.58	$185,248.06	16%

Undetermined Claims

Incorrectly completed fields were identified for 11 out of 30 unpaid claims, or 15% of the 74 analyzed, which resulted in confusing data. It is unknown if the negative amount in the "Prior Other Ins Payment" column represented payments on claims or if it represented a write-off. Conclusive determination of payments was unable to be made.

MCO	# Benes	Days	Act Days	Inpatient Billed	KMMS CM DRG	UB04 Other Payer Xover Allowed	Prior Other Ins Payment
MCO 1	11	65	67	$736,322.11	$110,390.28	$4,800.00	($140,854.54)

Claims with No Payments

There was no evidence of prior payments by Medicare or a different primary insurance in 6 out of 30 unpaid claims. Neither was there evidence of MCO payments, resulting in the hospital receiving $0 of $959,776.39 billed. The hospital received no reimbursement for expenses for 8% of the 74 claims analyzed.

MCO	# Benes	Days	Act Days	Inpatient Billed	KMMS CM DRG	UB04 Other Payer Xover Allowed	Prior Other Ins Payment
MCO 2	1	0	0	$3,527.67	$0	-	-
MCO 3	2	11	11	$158,161.15	$29,488.90	$1,600.00	$0
MCO 1	3	38	39	$798,087.57	$10,052.54	$0	$0
Total	6	49	50	$959,776.39	$39,541.44	$1,600.00	$0

Analysis 3: Challenges to Retrieving Accurate Hospital Inpatient Claims in KMMS

Communication Challenges

KDHE requested that all questions be sent to one representative at KDHE, who would then forward the questions to the party they thought was appropriate. This process became very cumbersome. The OIG understands how important it is to have one contact, and suggests that going forward, once a Subject Matter Expert (SME) is identified, they will be addressed directly and the main POC will be copied on any email communications.

On one occasion, when communicating with KDHE, verification of data by an SME was requested. However, KDHE reached out to the SME employed by the MCO whose data was requested to be verified.

Claim and Report Challenges

Claims with a status of 'paid' and with a $0 payment are common and often the final ruling. A claim can also have a status of paid, with a paid amount associated, but then be voided in another transaction, and then a third transaction showing a paid status but with $0 paid.

The initial screen in KMMS Claims Management totals all instances of the billed amount. Therefore, it is not accurate. The Amt Paid does not show the amount paid by MCOs. Therefore, it is not accurate. This area of KMMS Claims Management is used differently for FFS vs MCO claims. It would be helpful if this could be accurate for any type of claim.

A KMMS Claims Management example reviewed shows claims for only one beneficiary, submitted by one hospital, during a one-and-a-half-year period. The actual number of hospitalizations was 12, but the number of times claims have been submitted, voided, and resubmitted was 38.

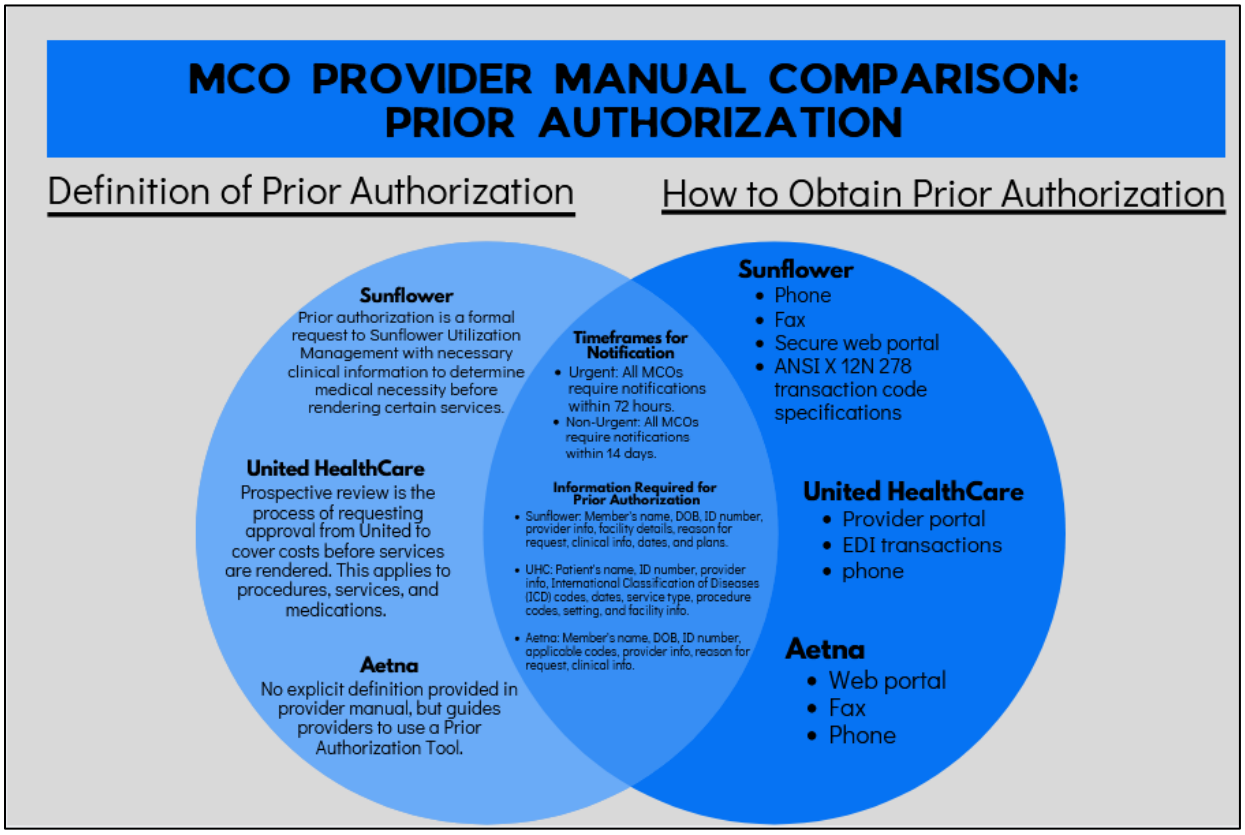
Although the KMMS screen shows the Total Billed as $787,322.64, the actual total billed is $166,832.55. The paid amount always shows $0 because these are MCO claims. The actual paid amount could be $0 or more than $0. One claim had 10 submissions, comprised of 6 valid submissions and 4 voids.

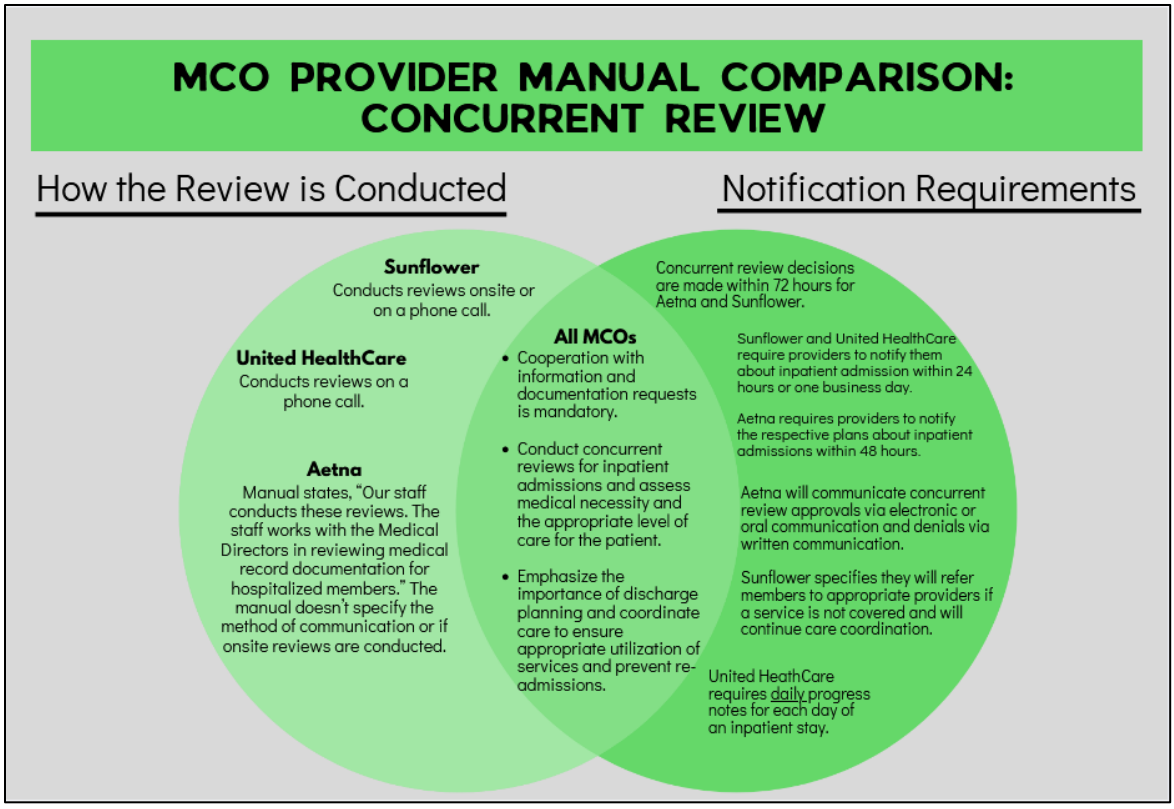
There were 4 submissions for another hospitalization for the same beneficiary. The first was an inpatient claim. Then it was rebilled as outpatient, then voided, and rebilled as outpatient again with the last two submissions occurring 38 months after the hospitalization.

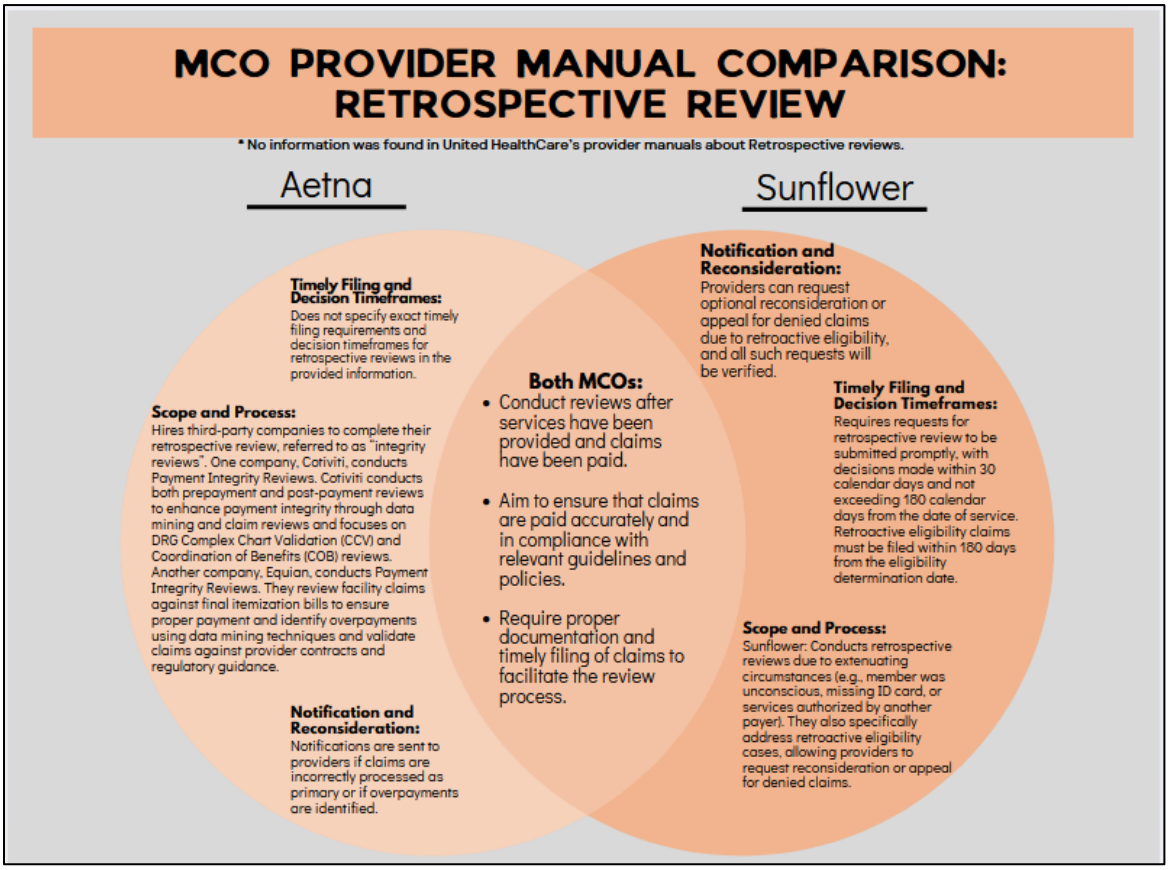
Analysis 4: MCO Provider Manual Comparison

Following our interviews, we reviewed each MCO's provider manual and compared them to the hospital's complaints. The purpose of comparing the MCO's provider manuals with the hospitals' complaints was to assess whether the actions of the MCO, as described by the hospitals, were consistent with the processes outlined in the provider manuals.

Below, we compared the MCO provider manuals per UM review type:




MCO PROVIDER MANUAL COMPARISON: CONCURRENT REVIEW
How the Review is Conducted
Notification Requirements
Sunflower
Conducts reviews onsite or on a phone call.
United HealthCare
Conducts reviews on a phone call.
Aetna
Manual states, "Our staff conducts these reviews. The staff works with the Medical Directors in reviewing medical record documentation for hospitalized members." The manual doesn't specify the method of communication or if onsite reviews are conducted.
All MCOs
• Cooperation with information and documentation requests is mandatory.
• Conduct concurrent reviews for inpatient admissions and assess medical necessity and the appropriate level of care for the patient.
• Emphasize the importance of discharge planning and coordinate care to ensure appropriate utilization of services and prevent re-admissions.
Concurrent review decisions are made within 72 hours for Aetna and Sunflower.
Sunflower and United HealthCare require providers to notify them about inpatient admission within 24 hours or one business day.
Aetna requires providers to notify the respective plans about inpatient admissions within 48 hours.
Aetna will communicate concurrent review approvals via electronic or oral communication and denials via written communication.
Sunflower specifies they will refer members to appropriate providers if a service is not covered and will continue care coordination.
United HeathCare requires daily progress notes for each day of an inpatient stay.


MCO PROVIDER MANUAL COMPARISON: RETROSPECTIVE REVIEW
* No information was found in United HealthCare's provider manuals about Retrospective reviews.
Aetna
Sunflower
Timely Filing and Decision Timeframes:
Does not specify exact timely filing requirements and decision timeframes for retrospective reviews in the provided information.
Scope and Process:
Hires third-party companies to complete their retrospective review, referred to as "integrity reviews". One company, Cativiti, conducts Payment Integrity Reviews. Cativiti conducts both prepayment and post-payment reviews to enhance payment integrity through data mining and claim reviews and focuses on DRG Complex Chart Validation (CCV) and Coordination of Benefits (COB) reviews. Another company, Equian, conducts Payment Integrity Reviews. They review facility claims against final itemization bills to ensure proper payment and identify overpayments using data mining techniques and validate claims against provider contracts and regulatory guidance.
Notification and Reconsideration:
Notifications are sent to providers if claims are incorrectly processed as primary or if overpayments are identified.
Both MCOs:
• Conduct reviews after services have been provided and claims have been paid.
• Aim to ensure that claims are paid accurately and in compliance with relevant guidelines and policies.
• Require proper documentation and timely filing of claims to facilitate the review process.
Notification and Reconsideration:
Providers can request optional reconsideration or appeal for denied claims due to retroactive eligibility, and all such requests will be verified.
Timely Filing and Decision Timeframes:
Requires requests for retrospective review to be submitted promptly, with decisions made within 30 calendar days and not exceeding 180 calendar days from the date of service. Retroactive eligibility claims must be filed within 180 days from the eligibility determination date.
Scope and Process:
Sunflower: Conducts retrospective reviews due to extenuating circumstances (e.g., member was unconscious, missing ID card, or services authorized by another payer). They also specifically address retroactive eligibility cases, allowing providers to request reconsideration or appeal for denied claims.

Results

After analyzing the comparisons between the consistency of the processes outlined in the MCO provider manuals and the testimonial evidence provided by the hospitals, the following conclusions were made:

- The hospital testimonial evidence consistently mentions significant delays in PAC PA responses (up to 14 days) and complaints about these delays violating "clean claim" laws. The provider manuals emphasize timeframes (72 hours for urgent/emergent and 14 days for non-emergent). Yet, the actual experiences reported by hospitals shows these timeframes are often not met, leading to extended delays and resource issues.

- The retrospective review practices mentioned in hospital testimonials, especially about retroactive coverage for deceased patients, are not well-covered or acknowledged in MCO 1's provider manual. This highlights a significant area of concern for hospitals that is not transparently addressed by MCO 1.

- Hospitals report needing comprehensive documentation for PA requests and often face delays due to additional documentation requests from MCOs. Provider manuals outline the necessary information for prior authorization; however, the detailed requirements and potential delays caused by additional documentation requests are not fully mirrored in the manuals.

- While MCO 1's and MCO 2's provider manuals emphasize safe discharges and collaboration with hospital discharge teams, hospitals testify to unsafe discharges and inadequate support, particularly when facing delayed or denied PA responses. The practical challenges hospitals could potentially face in ensuring safe discharges due to delayed responses or a lack of timely support are not fully captured in the provider manuals.

- Hospitals mention difficulties in coordinating with MCOs and receiving timely responses, particularly during retrospective reviews and internal appeals. The provider manuals indicate structured communication processes and guidelines for information submission; however, hospitals' experiences suggest these processes may not be as seamless or effective in practice.

Analysis 5: KDHE Appeals and Grievance Data

The KanCare Section 1115 demonstration is Kansas' Medicaid program, operating under a federal waiver that allows the state to test new managed care approaches beyond standard Medicaid rules. Through this waiver, Kansas can adjust eligibility, services, and care coordination while ensuring periodic renewals and reporting effectiveness data to CMS.

As stated on KDHE's website for KanCare 1115 Demonstration Reports, "Annually and each quarter, Kansas submits progress reports to the Centers for Medicare and Medicaid Services to present the State's analysis and status of operations under the KanCare Section 1115 demonstration."

The 1115 Demonstration Reports include appeal and grievance data for each of the MCOs. The annual reports for each year of the audit period were reviewed to determine the volume of appeals and grievances for hospital inpatient and outpatient claim denials. This data was gathered to compare the testimonial evidence from hospitals regarding the administrative burden and the costs associated with these dispute processes.

Sections of the report that were reviewed:

- MCO Reconsideration Trends – Provider
- MCO Reconsideration Database – Provider (reconsiderations resolved)
- MCO Appeals Trends – Provider
- MCO Appeals Database – Provider (appeals resolved)
- State of Kansas Office of Administrative Fair Hearings (OAH) – Provider
- KanCare Summary of Claims Adjudication Statistics per MCO

2021 MCOs' Reconsideration Trends – Provider

Claim Payment Dispute (CPD) data for either Hospital Inpatient (Non-Behavioral Health) or Hospital Outpatient (Non-Behavioral Health) was included in the top five trends for each MCO in CY2021.

MCO 1: There were 883 categorized as PR (provider reconsiderations) – CPD – Hospital Outpatient (Non-Behavioral Health) which is an ***increase*** of 175 from 708 reported third quarter.

Total # of Resolved Reconsiderations	6,410	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	3,131	49%
Trend 2: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	883	14%
Trend 3: PR – CPD – Durable Medical Equipment	785	12%
Trend 4: PR – CPD – HCBS	434	7%
Trend 5: PR – CPD – Behavioral Health Outpatient and Physician	283	4%

MCO 2: There were 137 categorized as PR – CPD – Hospital Inpatient (Non-Behavioral Health), which is an ***increase*** of 28 from 109 reported in the third quarter. There were 132 categorized as PR – CPD – Hospital Outpatient (Non-Behavioral Health) which is a ***decrease*** of 43 from 175 reported third quarter.

Total # of Resolved Reconsiderations	1,622	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	959	59%
Trend 2: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	137	8%
Trend 3: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	132	8%
Trend 4: PR – CPD – Durable Medical Equipment	97	6%
Trend 5: PR – CPD – Laboratory	71	4%

MCO 3: There are 272 categorized as PR – CPD – Hospital Inpatient (Non-Behavioral Health), which is a ***decrease*** of 78 from 350 reported in the third quarter.

Total # of Resolved Reconsiderations	5,776	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	2,717	47%
Trend 2: PR – CPD – Durable Medical Equipment	812	14%
Trend 3: PR – CPD – Out of network provider, specialist or specific provider	619	11%
Trend 4: PR – CPD – Behavioral Health Outpatient and Physician	448	8%
Trend 5: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	272	5%

2021 MCOs' Appeals Trends – Provider

MCO 1: There were 62 categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health), which is a ***decrease*** of 83 from 145 reported in the third quarter.

Total # of Resolved Member Appeals	176		Total # of Resolved Provider Appeals	653	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	57	32%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	136	21%
Trend 2: MA – CNM – Radiology	23	13%	Trend 2: PA – CNM – Pharmacy	130	20%
Trend 3: MA – CNM – Other	16	9%	Trend 3: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	62	9%
Trend 4: MA – CNM – Medical Procedure	14	8%	Trend 4: PA – CPD – Behavioral Health Outpatient and Physician	61	9%
Trend 5: MA – CNM – PT/OT/ST and MA – CNM – Inpatient Behavioral Health	14	8%	Trend 5: PA – CPD – Radiology	42	6%

MCO 2: There were 69 categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health), which is an ***increase*** of 27 from 42 reported in the third quarter.

Total # of Resolved Member Appeals	156		Total # of Resolved Provider Appeals	483	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	62	40%	Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	180	37%
Trend 2: MA – CNM – Medical Procedure (NOS)	39	25%	Trend 2: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	69	14%
Trend 3: MA – CNM – Behavioral Health Outpatient and Physician	12	8%	Trend 3: PA – CPD – Laboratory	45	9%
Trend 4: MA – CNM – Durable Medical Equipment	11	7%	Trend 4: PA – CPD – Hospice	43	9%
Trend 5: MA – CNM – Radiology	11	7%	Trend 5: PA – CPD – Durable Medical Equipment	30	6%

MCO 3: There were 340 categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health) and 123 categorized as PA – CPD – Hospital Outpatient (Non-Behavioral Health), ***yet the increase or decrease of these counts from the previous quarter was missing from this section in the report.***

Total # of Resolved Member Appeals	223		Total # of Resolved Provider Appeals	1,242	
Top 5 Trends			Top 5 Trends		
Trend 1: MA – CNM – Pharmacy	118	53%	Trend 1: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	340	27%
Trend 2: MA – CNM – Inpatient Admissions (Non-Behavioral Health)	27	12%	Trend 2: PA – CPD – Medical (Physical Health not Otherwise Specified)	197	16%
Trend 3: MA – CNM – Durable Medical Equipment	21	9%	Trend 3: PA – CPD – Pharmacy	160	13%
Trend 4: MA – CNM – Medical Procedure (NOS)	12	5%	Trend 4: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	123	10%
Trend 5: MA – CNM – Dental	11	5%	Trend 5: PA – CPD – Laboratory	117	9%

2021 MCOs' SFH Reversed Decisions – Provider

There were 46 provider state fair hearings for all three MCOs. ***No decisions were reversed by OAH.***

MCO 2					
Total # of Member SFH	2		Total # of Provider SFH	9	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

MCO 1					
Total # of Member SFH	5		Total # of Provider SFH	5	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

MCO 3					
Total # of Member SFH	2		Total # of Provider SFH	32	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

2022 MCOs' Reconsideration Trends – Provider

Claim Payment Dispute (CPD) data for either Hospital Inpatient (Non-Behavioral Health) or Hospital Outpatient (Non-Behavioral Health) was included in the top five trends for each MCO. Below are some provider trend findings for each MCO in CY2022.

MCO 1: There were 3,444 provider reconsiderations categorized as PR – CPD – Hospital Outpatient (Non-Behavioral Health), which is a ***significant decrease*** of 5,350 from 8,794 reported in CY2021.

Total # of Resolved Reconsiderations	25,419	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	11,469	45%
Trend 2: PR – CPD – Durable Medical Equipment	4,613	18%
Trend 3: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	3,444	14%
Trend 4: PR – CPD – Behavioral Health Outpatient and Physician	1,522	6%
Trend 5: PR – CPD – Laboratory	1,209	5%

MCO 2: There were 1,725 provider reconsiderations categorized as PR – CPD – Hospital Outpatient (Non-Behavioral Health), which is a ***significant increase*** of 1,007 from 718 reported in CY2021. There were 822 provider reconsiderations categorized as PR – CPD – Hospital Inpatient (Non-Behavioral Health), which is a ***significant increase*** of 307 from 515 reported in CY2021.

Total # of Resolved Reconsiderations	9,153	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	3,663	40%
Trend 2: PR – CPD – Hospital Outpatient (Non-Behavioral Health)	1,725	19%
Trend 3: PR – CPD – Durable Medical Equipment	895	10%
Trend 4: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	822	9%
Trend 5: PR – CPD – Ambulance (Include Air and Ground)	669	7%

MCO 3: There were 1,732 provider reconsiderations categorized as PR – CPD – Hospital Inpatient (Non-Behavioral Health), which is a ***significant decrease*** of 10,397 from 12,129 reported in CY2021.

Total # of Resolved Reconsiderations	32,269	
Top 5 Trends		
Trend 1: PR – CPD – Medical (Physical Health not Otherwise Specified)	15,321	47%
Trend 2: PR – CPD – Durable Medical Equipment	4,286	13%
Trend 3: PR – CPD – Behavioral Health Outpatient and Physician	3,033	9%
Trend 4: PR – CPD – Out of network provider, specialist or specific provider	2,611	8%
Trend 5: PR – CPD – Hospital Inpatient (Non-Behavioral Health)	1,732	5%

2022 MCOs' Appeals Trends –Provider

MCO 1: There were 479 categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health) and 471 categorized as PA – CPD – Hospital Outpatient (Non-Behavioral Health), ***yet the increase or decrease of these counts from the previous quarter/CY were missing from this section in the report for MCO 3.***

/Provider Appeal Trends

Total # of Resolved Provider Appeals	3,765	
Top 5 Trends		
Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	590	16%
Trend 2: PA – CNM – Pharmacy	538	14%
Trend 3: PA – CPD – Behavioral Health Outpatient and Physician	481	13%
Trend 4: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	479	13%
Trend 5: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	471	13%

MCO 2: There were 321 provider appeals categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health), which is a ***significant increase*** of 71 from 250 reported in CY2021. There were 193 provider appeals categorized as PA – CPD – Hospital Outpatient (Non-Behavioral Health), which is a ***significant increase*** of 68 from 125 reported in CY2021.

Provider Appeal Trends

Total # of Resolved Provider Appeals	1,545	
Top 5 Trends		
Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	449	29%
Trend 2: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	321	21%
Trend 3: PA – CPD – Laboratory	220	14%
Trend 4: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	193	12%
Trend 5: PA – CPD – Durable Medical Equipment	147	10%

MCO 3: There were 1,131 categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health), ***yet the increase or decrease of these counts from the previous quarter/CY was missing from this section in the report for MCO 1.*** There were 606 provider appeals categorized as PA – CPD – Hospital Outpatient (Non-Behavioral Health), which is a ***significant increase*** of 219 from 387 reported in CY2021.

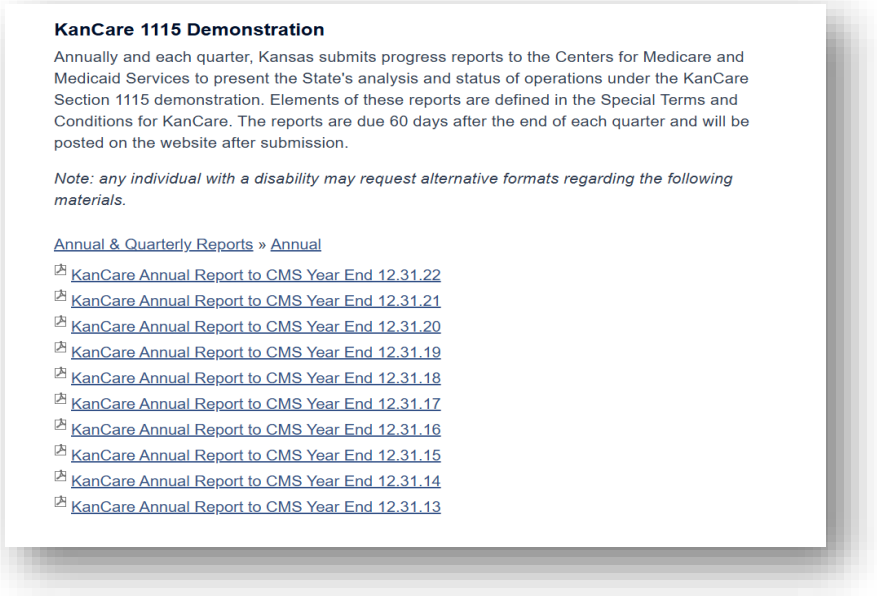
Provider Appeal Trends		
Total # of Resolved Provider Appeals	5,427	
Top 5 Trends		
Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	1,207	22%
Trend 2: PA – CPD – Hospital Inpatient (Non-Behavioral Health)	1,131	21%
Trend 3: PA – CPD – Home Health	635	12%
Trend 4: PA – CPD – Hospital Outpatient (Non-Behavioral Health)	606	11%
Trend 5: PA – CPD – Pharmacy	523	10%

2022 MCOs' SFH Reversed Decisions – Provider

There were 126 provider state fair hearings for all three MCOs. ***OAH reversed one decision.***

MCO 2					
Total # of Member SFH	6		Total # of Provider SFH	42	
OAH reversed MCO decision	1	17%	OAH reversed MCO decision	1	2%
MCO1					
Total # of Member SFH	23		Total # of Provider SFH	29	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%
MCO 3					
Total # of Member SFH	27		Total # of Provider SFH	55	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

When we attempted to review the 1115 Waiver Report for CY2023, it was not listed on the website with the previous year's annual reports. This screenshot was taken on 3/17/2025:



KanCare 1115 Demonstration

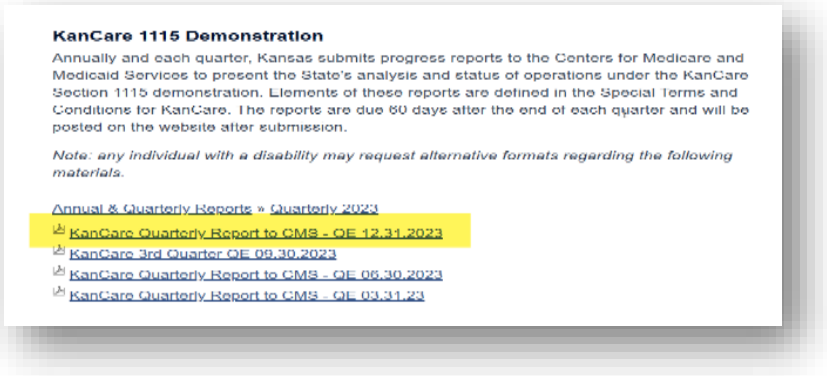
Annually and each quarter, Kansas submits progress reports to the Centers for Medicare and Medicaid Services to present the State's analysis and status of operations under the KanCare Section 1115 demonstration. Elements of these reports are defined in the Special Terms and Conditions for KanCare. The reports are due 60 days after the end of each quarter and will be posted on the website after submission.

Note: any individual with a disability may request alternative formats regarding the following materials.

Annual & Quarterly Reports » Annual

- KanCare Annual Report to CMS Year End 12.31.22
- KanCare Annual Report to CMS Year End 12.31.21
- KanCare Annual Report to CMS Year End 12.31.20
- KanCare Annual Report to CMS Year End 12.31.19
- KanCare Annual Report to CMS Year End 12.31.18
- KanCare Annual Report to CMS Year End 12.31.17
- KanCare Annual Report to CMS Year End 12.31.16
- KanCare Annual Report to CMS Year End 12.31.15
- KanCare Annual Report to CMS Year End 12.31.14
- KanCare Annual Report to CMS Year End 12.31.13

We were able to locate the end of the fourth quarter report under the Quarterly Reports section. Although, when we opened the report, it had the same title as the CY2021 and CY2022 reports that were located in the annual reports section. This screenshot was taken on 3/17/2025:



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Note: any individual with a disability may request alternative formats regarding the following materials.

Annual & Quarterly Reports » Quarterly 2023

- KanCare Quarterly Report to CMS - QE 12.31.2023
- KanCare 3rd Quarter QE 09.30.2023
- KanCare Quarterly Report to CMS - QE 06.30.2023
- KanCare Quarterly Report to CMS - QE 03.31.23

2023 MCOs' Reconsideration Trends – Provider

MCO 1: There were 400 provider reconsiderations categorized as PR – CPD – Hospital Outpatient (Non-Behavioral Health), which is a **decrease** of 166 from 566 reported in the third quarter.

Total # of Resolved Reconsiderations	4,630	
Top 5 Trends		
Trend 1: PR - CPD - Medical (Physical Health not Otherwise Specified)	1,919	41%
Trend 2: PR - CPD - Durable Medical Equipment	871	19%
Trend 3: PR - CPD - Behavioral Health Outpatient and Physician	406	9%
Trend 4: PR - CPD - Hospital Outpatient (Non-Behavioral Health)	400	9%
Trend 5: PR - CPD - HCBS	360	8%

MCO 2: There were 277 categorized as PR – CPD – Hospital Inpatient (Non-Behavioral Health) and categorized as 353 PR – CPD – Hospital Outpatient (Non-Behavioral Health), **yet the increase or decrease of these counts from the previous quarter/CY were missing from this section in the report for MCO 3.**

Total # of Resolved Reconsiderations	2,712	
Top 5 Trends		
Trend 1: PR - CPD - Medical (Physical Health not Otherwise Specified)	1,201	44%
Trend 2: PR - CPD - Laboratory	411	15%
Trend 3: PR - CPD - Hospital Outpatient (Non-Behavioral Health)	353	13%
Trend 4: PR - CPD - Hospital Inpatient (Non-Behavioral Health)	277	10%
Trend 5: PR - CPD - Durable Medical Equipment	234	9%

MCO 3: There were 616 provider reconsiderations categorized as PR – CPD – Hospital Outpatient (Non-Behavioral Health), which is an **increase** of 156 from 460 reported in the third quarter.

Total # of Resolved Reconsiderations	10,644	
Top 5 Trends		
Trend 1: PR - CPD - Medical (Physical Health not Otherwise Specified)	4,733	44%
Trend 2: PR - CPD - Durable Medical Equipment	1,445	14%
Trend 3: PR - CPD - Behavioral Health Outpatient and Physician	1,337	13%
Trend 4: PR - CPD - Out of network provider, specialist or specific provider	880	8%
Trend 5: PR - CPD - Hospital Outpatient (Non-Behavioral Health)	616	6%

2023 MCOs' Appeals Trends – Provider

MCO 1: There were 293 provider appeals categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health), which is a ***decrease*** of 61 from 354 reported in the third quarter.

Provider Appeal Trends		
Total # of Resolved Provider Appeals	1,440	
Top 5 Trends		
Trend 1: PA - CPD - Medical (Physical Health not Otherwise Specified)	386	27%
Trend 2: PA - CPD - Hospital Inpatient (Non-Behavioral Health)	293	20%
Trend 3: PA - CPD - Durable Medical Equipment	117	8%
Trend 4: PA - CPD - Laboratory	113	8%
Trend 5: PA - CNM - Pharmacy	102	7%

MCO 2: There were 93 provider appeals categorized as PA – CPD – Hospital Outpatient (Non-Behavioral Health), which is an ***increase*** of 40 from 53 reported in the third quarter. There were 155 categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health). Yet, ***the increase or decrease of these counts from the previous quarter/CY were missing from this section in the report for MCO 2.***

Provider Appeal Trends		
Total # of Resolved Provider Appeals	749	
Top 5 Trends		
Trend 1: PA – CPD – Medical (Physical Health not Otherwise Specified)	177	24%
Trend 2: PA - CPD - Hospital Inpatient (Non-Behavioral Health)	155	21%
Trend 3: PA - CPD - Laboratory	150	20%
Trend 4: PA - CPD - Durable Medical Equipment	106	14%
Trend 5: PA - CPD - Hospital Outpatient (Non-Behavioral Health)	93	12%

MCO 3: There were 311 provider appeals categorized as PA – CPD – Hospital Inpatient (Non-Behavioral Health), which is an ***increase*** of 90 from 221 reported in the third quarter.

Provider Appeal Trends		
Total # of Resolved Provider Appeals	1,629	
Top 5 Trends		
Trend 1: PA - CPD - Nursing Facilities - Total	333	20%
Trend 2: PA - CPD - Medical (Physical Health not Otherwise Specified)	323	20%
Trend 3: PA - CPD - Hospital Inpatient (Non-Behavioral Health)	311	19%
Trend 4: PA - CPD - Home Health	182	11%
Trend 5: PA - CPD - Pharmacy	134	8%

2023 MCOs' SFH Reversed Decisions – Provider

There were 37 provider state fair hearings for all three MCOs. ***OAH reversed one decision.***

MCO 2					
Total # of Member SFH	13		Total # of Provider SFH	14	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	1	7%

MCO 1					
Total # of Member SFH	1		Total # of Provider SFH	11	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

MCO 3					
Total # of Member SFH	11		Total # of Provider SFH	12	
OAH reversed MCO decision	0	0%	OAH reversed MCO decision	0	0%

The KanCare Fourth Quarter & Annual Report to CMS included appeal and grievance trends for both members and providers, but only reported data on the ***resolved*** appeals and grievances and never provided a total of either appeals or grievances filed, per the calendar year reported. The data in the table below consists of provider trends that were extracted from the **KanCare 1115 Demonstration Reports** for each MCO in each CY.

Overall findings per table/per year for Hospital Inpatient and Outpatient Dispute Types											
KanCare Fourth Quarter/Annual Report to CMS			Resolved: Year Ending 12.31.2021			Resolved: Year Ending 12.31.2022			Resolved: Year Ending 12.31.2023		
Table	Claim Payment Dispute Level	Dispute Type	MCO 1	MCO 2	MCO 3	MCO 1	MCO 2	MCO 3	MCO 1	MCO 2	MCO 3
MCO Reconsideration Database – Provider (reconsiderations resolved)	Provider Reconsideration (PR) Claim Payment Disputes (CPD)	Hospital Inpatient (Non-Behavioral Health)	230	137	272	245	161	651	195	277	377
MCO Reconsideration Database – Provider (reconsiderations resolved)	Provider Reconsideration (PR) Claim Payment Disputes (CPD)	Hospital Outpatient (Non-Behavioral Health)	883	132	263	565	791	321	400	353	616
State of Kansas Office of Administration Fair Hearings – Providers	Provider Hearing (PH) Claim Payment Disputes (CPD)	Hospital Inpatient (Non-Behavioral Health)	2	4	4	3	15	33	1	8	1
State of Kansas Office of Administration Fair Hearings – Providers	Provider Hearing (PH) Claim Payment Disputes (CPD)	Hospital Outpatient (Non-Behavioral Health)	no data	1	no data	2	3	no data	no data	no data	no data
MCO Appeals Database – Provider (appeals resolved)	Provider Appeal (PA) Claim Payment Disputes (CPD)	Hospital Inpatient (Non-Behavioral Health)	62	69	340	235	58	236	293	155	311
MCO Appeals Database – Provider (appeals resolved)	Provider Appeal (PA) Claim Payment Disputes (CPD)	Hospital Outpatient (Non-Behavioral Health)	31	24	123	26	44	189	66	93	113

Analysis 6: KanCare Summary of Claims Adjudication Statistics

Within 1115 Waiver Reports, we reviewed the *KanCare Summary of Claims Adjudication Statistics per MCO* section for each year of the audit period. Below is a screenshot of each year's statistics, Hospital Inpatient and Hospital Outpatient are outlined in red. Below each year's image is a summary of the audit's findings:

KanCare Fourth Quarter & Annual Report to CMS, January – December 2021

In CY2021, while denied claims for Hospital Inpatient and Hospital Outpatient services accounted for an average of 7% of total claims, they represented a disproportionate 64% of the total denied claim values.

- **MCO 1**: Total denied claim value was $1,427,654,908, with $921,732,748 (65%) attributed to Hospital Inpatient and Outpatient services.

- **MCO 2**: Total denied claim value was $876,443,203, with $633,157,066 (72%) attributed to Hospital Inpatient and Outpatient services.

- **MCO 3**: Total denied claim value was $1,258,015,913, with $696,988,584 (55%) attributed to Hospital Inpatient and Outpatient services.

CY 2021						
MCO	**Service Type**	**Total Count**	**Total Count Value**	**Total Denied**	**Total Denied Value**	**% Claims Denied**
MCO 1	Hospital Inpatient	35,718	$2,260,520,530	8,546	$717,774,197	23.93%
	Hospital Outpatient	382,154	$1,212,261,656	41,165	$203,958,551	10.77%
	Hospital IP & OP	***417,872***	***$3,472,782,186***	***49,711***	***$921,732,748***	***11.90%***
	Total All Services	6,202,312	$5,963,029,239	937,115	$1,427,654,908	15.11%
	IP/OP % of all services	***6.74%***	***58.24%***	***5.30%***	***64.56%***	
MCO 2	Hospital Inpatient	23,706	$1,438,212,958	4,863	$465,694,311	20.51%
	Hospital Outpatient	260,884	$907,904,514	47,293	$167,462,755	18.13%
	Hospital IP & OP	***284,590***	***$2,346,117,472***	***52,156***	***$633,157,066***	***18.33%***
	Total All Services	4,780,268	$3,962,414,154	936,790	$876,443,203	19.60%
	IP/OP % of all services	***5.95%***	***59.21%***	***5.57%***	***72.24%***	
MCO 3	Hospital Inpatient	29,267	$1,727,516,953	6,022	$398,971,243	20.58%
	Hospital Outpatient	383,784	$1,347,251,340	78,892	$298,017,341	20.56%
	Hospital IP & OP	***413,051***	***$3,074,768,293***	***84,914***	***$696,988,584***	***20.56%***
	Total All Services	6,116,259	$5,561,485,568	936,110	$1,258,015,913	15.31%
	IP/OP % of all services	***6.75%***	***55.29%***	***9.07%***	***55.40%***	

In CY2022, while denied claims for Hospital Inpatient and Hospital Outpatient services accounted for only 7% of total claim counts, they represented a disproportionate 65% of the total denied claim values.

- **MCO 1**: Total denied claim value was $1,658,564,120, with $1,022,239,851 (62%) attributed to Hospital Inpatient and Outpatient services.

- **MCO 2**: Total denied claim value was $926,806,509, with $659,333,189 (71%) attributed to Hospital Inpatient and Outpatient services.

- **MCO 3**: Total denied claim value was $1,477,490,969, with $899,546,297 (61%) attributed to Hospital Inpatient and Outpatient services.

CY 2022						
MCO	**Service Type**	**Total Count**	**Total Count Value**	**Total Denied**	**Total Denied Value**	**% Claims Denied**
MCO 1	Hospital Inpatient	35,660	$2,444,909,557	8,746	$804,369,825	24.53%
	Hospital Outpatient	384,230	$1,310,520,790	43,993	$217,870,026	11.45%
	Hospital IP & OP	***419,890***	***$3,755,430,347***	***52,739***	***$1,022,239,851***	***12.56%***
	Total All Services	6,347,370	$6,480,243,334	972,164	$1,658,564,120	15.32%
	IP/OP % of all services	***6.62%***	***57.95%***	***5.42%***	***61.63%***	
MCO 2	Hospital Inpatient	25,090	$1,548,146,601	5,400	$536,710,463	21.52%
	Hospital Outpatient	294,113	$1,013,014,684	51,886	$122,622,726	17.64%
	Hospital IP & OP	***319,203***	***$2,561,161,285***	***57,286***	***$659,333,189***	***17.95%***
	Total All Services	5,383,284	$4,521,101,170	1,041,303	$926,806,509	19.34%
	IP/OP % of all services	***5.93%***	***56.65%***	***5.50%***	***71.14%***	
MCO 3	Hospital Inpatient	28,175	$1,787,258,258	6,682	$504,416,613	23.72%
	Hospital Outpatient	407,021	$1,559,049,494	90,254	$395,129,684	22.17%
	Hospital IP & OP	***435,196***	***$3,346,307,752***	***96,936***	***$899,546,297***	***22.27%***
	Total All Services	6,390,176	$5,974,121,984	1,052,262	$1,477,490,969	16.47%
	IP/OP % of all services	***6.81%***	***56.01%***	***9.21%***	***60.88%***	

In CY2023, while denied claims for Hospital Inpatient and Hospital Outpatient services accounted for only 5% to 9% of total claim counts, they represented a disproportionate 62% to 70% of the total denied claim values.

- **MCO 1**: Total denied claim value was $1,833,302,065, with $1,276,162,988 (70%) attributed to Hospital Inpatient and Outpatient services.

- **MCO 2**: Total denied claim value was $1,019,967,786, with $707,664,730 (69%) attributed to Hospital Inpatient and Outpatient services.

- **MCO 3**: Total denied claim value was $1,838,971,701, with $1,135,230,556 (62%) attributed to Hospital Inpatient and Outpatient services**.**

CY 2023						
MCO	**Service Type**	**Total Count**	**Total Count Value**	**Total Denied**	**Total Denied Value**	**% Claims Denied**
MCO 1	Hospital Inpatient	33,387	$2,686,436,501	8,299	$1,033,063,115	24.86%
	Hospital Outpatient	355,774	$1,400,268,884	38,756	$243,099,873	10.89%
	Hospital IP & OP	***389,161***	***$4,086,705,385***	***47,055***	***$1,276,162,988***	***12.09%***
	Total All Services	6,164,529	$7,172,633,988	979,877	$1,833,302,065	15.90%
	IP/OP % of all services	***6.31%***	***56.98%***	***4.80%***	***69.61%***	
MCO 2	Hospital Inpatient	26,262	$1,716,824,330	5,695	$557,504,776	21.69%
	Hospital Outpatient	300,852	$1,146,137,061	55,561	$150,159,954	18.47%
	Hospital IP & OP	***327,114***	***$2,862,961,391***	***61,256***	***$707,664,730***	***18.73%***
	Total All Services	5,819,189	$5,097,221,346	1,199,866	$1,019,967,786	20.62%
	IP/OP % of all services	***5.62%***	***56.17%***	***5.11%***	***69.38%***	
MCO 3	Hospital Inpatient	27,652	$1,772,731,765	7,025	$512,235,750	25.41%
	Hospital Outpatient	400,374	$1,764,272,959	106,279	$622,994,806	26.54%
	Hospital IP & OP	***428,026***	***$3,537,004,724***	***113,304***	***$1,135,230,556***	***26.47%***
	Total All Services	6,494,991	$6,466,884,217	1,240,329	$1,838,971,701	19.10%
	IP/OP % of all services	***6.59%***	***54.69%***	***9.13%***	***61.73%***	

Findings and Recommendations

A draft report of our preliminary findings and recommendations was forwarded to KDHE prior to a planned exit conference. The draft report was amended to clarify items addressed at the exit conference. KDHE provided a response letter to the report. The letter includes additional comments and explanations from KDHE that are included in this section in italics. Where appropriate, a rebuttal to KDHE's responses has been added.

1. **Finding: Hospitals are paid 75% less than the expected DRG when inpatient claims are denied and forced to be resubmitted as outpatient claims.**

   Recommendations

   1.1 Advocate for Policy Changes: Work with MCOs to minimize inpatient claim denials and prevent financial losses due to claim downgrades.

   2.1 Strengthen Appeals Processes: Enhance workflows to recover expected inpatient DRG values through appeals.

KDHE Response:

KDHE agrees with the overall finding: that if inpatient claims must be rebilled as outpatient this will result in a lower reimbursement. There are some valid reasons that this would occur such as when an inpatient admission does not meet the established criteria for medical necessity. In accordance with Policy E2020-054, hospitals are permitted to re-bill those services as outpatient if the inpatient admission is deemed not medically necessary. In such instances, the Managed Care Organization (MCO) recoups the original payment. Hospitals then have two options: they may re-bill the claim under the outpatient billing guidelines or submit additional documentation to support the medical necessity of the original inpatient claim.

For Recommendation 1.1, KDHE will continue to work with the MCOs as appropriate under KanCare 3.0 to assure claims are accurate and that MCOs are not, in fact, incorrectly forcing outpatient claims. Medical necessity for inpatient claims remains a mitigating factor in the application of this criteria. Policy will be rewritten if appropriate as KDHE works to ascertain if the policy is being applied correctly.

For Recommendation 2.1, KDHE affirms that the current appeals process is consistent with applicable federal recommendations. However, KDHE will use the lens provided through this audit to examine the potential for enhanced workflows around recovering inpatient DRG values through appeals.

2. **Finding: 8% of claims had no evidence of MCO payments or prior insurance payments. 15% of claims had inaccurate prior payment data.**

Recommendations

1.1 Investigate Claims with No Payment Evidence: Conduct root cause analysis to identify issues and collaborate with MCOs to resolve non-reimbursed claims.

2.1 Enhance Data Transparency: Ensure hospitals provide complete and accurate claim details to prevent errors in prior payment fields.

KDHE Response:

KDHE agrees with the finding that some claims contained inaccurate prior payment data, however there were some claims that were denied correctly. One of the MCOs did have a system error during this time frame that was fixed 12/1/23. Their system was not capturing or sending other payer Clain [sic] Adjustment Reason Code (CARC)/Remittance Advice Remark Code (RARC)/Coordination of benefits (COB) information received by the provider. This caused them to send the information incorrectly on the encounter claim and it resulted in a negative Third-Party Liability (TPL) amount.

For Recommendation 1.1, KDHE will continue to investigate claims with no payment evidence and work with the MCOs to resolve any substantiated findings to determine the root cause and solutions as part of our management of KanCare 3.0.

For Recommendation 2.1, KDHE has no control over final hospital claim submission; however, we will continue to work with the MCOs as they offer multiple training opportunities each year to focus on proper claims submission. We are also committed to continuing to work collaboratively with providers to ensure ongoing education and compliance.

3. Finding: 14 hospital days (4%) were not included in the "days covered."

Recommendations

1.1 Reconcile Coverage Data: Verify hospital day coverage to ensure claims accurately reflect total eligible hospital days.

2.1 Audit Claims Regularly: Conduct routine audits to prevent missing or incomplete coverage data.

KDHE Response:

KDHE agrees with the finding that there is a discrepancy in the days covered. KDHE ensures the claims system allows editing to align the billed days with the days covered field, as payment is calculated based on this alignment.

For Recommendation 1.1, KDHE will look into ways to edit for these types of cases and may utilize our External Quality Review Organization (EQRO) contract to review some types of high dollar claims.

For Recommendation 2.1, KDHE confirms the claims team conducts an annual audit that includes each MCO as part of our standard oversight process. Our annual contract review varies by subject matter/contract requirements. Additionally, KDHE is enhancing our EQRO (External Quality Review Organization) as part of the management of KanCare 3.0 which will allow for additional targeted reviews if deemed necessary.

4. **Finding: MCO 2 and MCO 1 paid 100% and 99% of expected DRG on inpatient claims, while MCO 3 paid 77%.**

   Recommendation

   1.1 Engage with MCO 3: Initiate discussions to understand why payments are below the DRG and request corrective action in order to come into compliance with the DRG payment policy.

KDHE Response:

KDHE agrees with the finding that MCOs can pay different rates. MCOs are generally obligated to use the DRG reimbursement methodology for most inpatient hospital services, but the possibility of negotiated rates exists. Additionally, based on current MCO contracts with providers, this is allowable. KDHE acknowledges that MCO 3's rates may differ from MCO 1 and 2 per the report's data, as reimbursement rates vary based on Managed Care Organization's (MCOs) individual contracts with hospital providers. While the state contract mandates the MCOs reimburse providers at no less than the Medicaid floor rate, it also provides MCOs with flexibility to negotiate and pay higher rates. This enables hospitals to negotiate more favorable reimbursement terms with some MCOs, while others may choose an amount closer to the standard Medicaid rate.

For Recommendation 1.1, KDHE does not audit or monitor for variations in DRG rates and has elected to maintain the current processes. Receiving higher reimbursement from certain MCOs can assist in the offset of lower rates from others. If all MCOs were required to pay only the Medicaid floor rate, hospitals could potentially face reduced financial incentive to contract with Medicaid, resulting in removing a key incentive for provider participation.

Furthermore, standardizing reimbursement rates across all MCOs would conflict with existing contractual provisions and state regulations, and limit hospitals' ability to negotiate rates above the Medicaid fee schedule. For these reasons, KDHE supports maintaining the current contracting structure, which balances fiscal responsibility with provider engagement and access to care.

5. **Finding: There was a 13% payment rate for non-crossover inpatient claims lacking prior insurance payments, lower than Medicare's 16% payment rate. MCOs pay an average of 1% on inpatient crossover claims.**

   Recommendations

1.1 Clarify Prior Payment Tracking: Work with MCOs to refine tracking and ensure proper reimbursement for inpatient crossover claims.

2.1 Revisit Reimbursement Policies: Advocate for higher crossover reimbursement rates to ease financial strain on hospitals.

KDHE Response:

While KDHE agrees with the finding that MCOs paid an average rate of 1% on these claims, there is a reason. Per the Medicare Savings Programs (MSPs) outlined in the Social Security Act, States are only obligated to participate in cost sharing (member deductible, coinsurance). KDHE policy E2013-048 - Medicare Related Claims Pricing Algorithm states if Medicare paid more than Medicaid's allowed amount for the service, no additional reimbursement will be made. For the majority of the crossover claims the Medicare allowed amount is more than the Medicaid allowed - this results in no additional payment. Most of the claims will have a zero paid amount.

For Recommendation 1.1, the administration of KanCare 3.0 provides for the monitoring and tracking of claims. System logic is designed to compare allowable payments to other payments listed on claims or encounters.

For Recommendation 2.1, KDHE is following current federally required Third Party Liability (TPL) Medicaid policy and the advocacy requested is not in KDHE scope. This policy requires Medicaid to be the payor of last resort. The Provider Manual regarding the TPL Pricing Algorithm stipulates KMAP will reimburse for services also covered by other insurance only when the Medicaid payment rate exceeds the payment made by the primary insurer. In such cases, KMAP will pay only the amount necessary to satisfy the member's cost-sharing liability, up to the Medicaid allowable rate. For additional information on the federal requirements governing the processing of TPL claims, please refer to 42 CFR § 433.139 – Payment of Claims.

Historically, KMAP rarely issues payment on crossover claims, as the majority fall below the Medicaid reimbursement threshold. The MCOs are contractually obligated to adhere to the TPL policy. KDHE continues to monitor compliance through ongoing oversight.

6. Finding: Incorrect data entry in prior payment fields and complex claim structures prevent global analysis in KMMS.

Recommendations

1.1 Standardize Data Entry: Implement mandatory training and quality checks to improve prior payment accuracy.

2.1 Streamline Claims Processes: Revise claim organization in KMMS to enhance data retrieval and allow for comprehensive analysis.

KDHE Response:

KDHE agrees with this finding. KDHE acknowledges the complexity of the data within the KMMS system but would like to point out the possibility that inaccurate conclusions may result from analyses that exclude encounter voids, claim adjustments from analysis of a provider, or fail to fully account for MCO billing activity on behalf of members. In some situations, encounter data may need to be voided and replaced to file a correct claim copy, particularly when resolving issues with either KMMS or the MCOs.

For Recommendation 1.1, KDHE disagrees with this recommendation. What the analyst identified as "errors" were not data entry errors. The issue with the negative TPL amounts was an MCO system issue. Our current audit process identified the issue, and the system has been fixed. Because the majority of the claims are submitted electronically – this means the data entered on the claim was entered by the biller - we have no control over what they entered but we do have some checks in place to catch possible errors. We use our current auditing process to identify areas where training may be needed. We will continue to use any auditing process to help us identify improvement opportunities. Both the MCOs and KDHE currently utilize data checks that align with HIPAA guidelines and apply edit checks to ensure programmatic compliance. Expanding these checks beyond current requirements may result in a significant work effort and could potentially lead to an increase in claim rejections or denials.

For Recommendation 2.1, KDHE agrees with this recommendation. We will look at how we can strengthen existing processes and collaborate with the MCOs to help improve the accuracy and complexity of the data, especially in cases where claim resubmissions occur. While there is currently an indicator that identifies the most recent claim when resubmissions occurred, this is dependent on both the MCOs, and providers consistently following the void and replace process. When standard processes are not followed, the reliability of the claim indicators is compromised. This is further complicated by the requirement to process each claim as it is submitted. KDHE must still accept those submissions if they meet HIPAA guidelines. To address these challenges, for future reviews, KDHE would like to work directly with OIG to develop the most efficient method of analysis of the data.

7. **Finding: Payment rates for inpatient claims vary, with a combined 13% payment rate for claims without prior insurance payments.**

   Recommendations

   1.1 Develop Performance Metrics: Establish key performance indicators to track payment rates, denial trends, and coverage accuracy.

   2.1 Foster Collaboration: Hold regular discussions with MCOs to resolve payment discrepancies and improve claim outcomes.

KDHE Response:
KDHE agrees with the finding that MCOs can pay different rates.

For Recommendation 1.1, KDHE actively monitors and validates that MCOs comply with the requirement to pay at minimum the Medicaid floor rate. KDHE will review our key performance indicators that track payment rates, denial trends and coverage accuracy to seek improvements.

For Recommendation 2.1, KDHE notes that we currently collaborate with MCOs on payment discrepancies. It is important to note that, per policy, Medicaid is the payer of last resort. As outlined in our response to Finding 4's recommendation, MCOs are required to pay the Medicaid floor rate, which is established and approved by the Legislature for covered services provided. However, hospitals and other providers are permitted to negotiate higher rates with the MCOs.

8. Finding – Unsecure UM Communication via Fax

Fax-based UM communication for PAs is outdated, causing security risks, miscommunication, lost or incomplete content transmitted, and overall delays in the PA process. House Bill 2283 (2023) addresses these issues, advocating for more transparent electronic alternatives.

Industry leaders, including Saint Luke's Health System CEO Robert L. Olm-Shipman, support shifting to electronic processes for faster approvals and appeals, improving care delivery. Similarly, MACPAC highlights the excessive time and resources spent on manual prior authorization methods, with physicians averaging 43 requests per week and 12 hours spent processing them, according to an American Medical Association physician survey.[9]

Interviews with Kansas hospitals suggest intentional delays in UR by MCOs. A ProPublica report revealed a $13M lawsuit settlement against Carelon**,** formerly AIM Specialty Health,[10] for practices obstructing coverage approvals, including limiting fax pages to deny documentation.

To address inefficiencies, CMS issued a final rule (Jan. 17, 2024) requiring Medicaid Managed Care payers to adopt an API for PAs by 2027, streamlining approvals and reducing administrative burdens.

Recommendations

1.1 Hospitals must have all paper-based fax machines or multifunction printers (MFPs) in a secure location that can only be accessed by authorized individuals. These paper-based devices can be a breach risk if the device is not in a secured location and limited to authorized access only.

[9] American Medical Association (AMA). 2024b. 2023 AMA Prior Authorization (PA) Physician Survey. Washington, DC: AMA. https://www.ama-assn.org/system/files/prior-authorization-survey.pdf.
[10] AIM Specialty Health was formerly known as American Imaging Management (AIM). AIM Specialty Health changed its name to Carelon Medical Benefits Management on March 1, 2023.

2.1 Update all paper-based devices to a digital fax solution. These digital solutions exchange content electronically and deliver it directly to its intended recipient. Recipients can access the content at their computer, within an application or secured network folder. This allows the content to remain private and only can be viewed by authorized users. Digital fax solutions also normally adapt to electronic medical records (EMRs) for ease of uploading or delivering protected health information (PHI) from within an application. Removing the administrative burden of handling paper documents, scanning, and processing paperwork. Digital fax also aids in minimizing the risk of lost or misplaced fax content.

KDHE Response:

KDHE agrees with this finding. While providers do sign the Provider Agreement that states they must read the Hospital Manual before providing services and must follow all HIPAA regulations, the KMAP Provider Agreement itself could more explicitly address HIPAA compliance. KDHE intends to update the KMAP Provider Agreement to help strengthen the HIPPA language and ensure a more secure process for fax transmissions. KDHE has a plan to implement the APIs required by CMS Final Rule 0057 with our current interoperability vendor. This is part of our roadmap of system changes.

For Recommendation 1.1, although the State does not have authority to mandate changes to hospital operations or equipment, KDHE can collaborate with MCOs to update their MCO provider enrollment agreements. These updates may encourage hospitals to either relocate fax machines to secure areas or transition to electronic fax submissions. The State will monitor and work with MCOs to ensure that contracts with hospitals include strong language supporting secure and timely fax-based utilization management (UM) communication for prior authorizations. To help safeguard PHI, KDHE will review and evaluate these contracts for inefficiencies and work to address any gaps, then remediating by applying the CMS Final Rule.

For Recommendation 2.1, KDHE acknowledges the importance of hospitals utilizing a digital fax solution. All three MCOs currently have the capability to receive prior authorization requests electronically through their provider portals, which is their preferred method. While Sunflower and Aetna continue to accept faxed requests, United Healthcare no longer allows this form of submission. Due to the availability of receiving prior authorizations electronically through the MCO's provider portal, any effort to implement this recommendation should be initiated and coordinated between the MCOs and the hospitals. KDHE can work with the MCOs to raise awareness of this issue and recommend stronger contract language between the MCOs and hospitals.

KDHE understands the issue of unsecure paper-based or multifunction printers not only affects Medicaid, but other insurance companies as well. KDHE is committed to strengthening HIPAA compliance efforts for the benefit of all patients, regardless of insurance coverage.

9. Finding – Hospital-Issued Notices of Noncoverage (HINN)

Hospitals may provide HINNs to Medicaid beneficiaries before admission, at admission, or during an inpatient stay. HINNs are provided when the hospital determines that the beneficiary's items or services are not covered. However, HINNs are not used to inform beneficiaries who are receiving observation services in outpatient status, or to communicate they are not on inpatient status while in the hospital. K.A.R. 30-5-59(e)(4) states that each participating provider shall *not charge any Medicaid/MediKan program consumer for noncovered services unless the provider has informed the consumer,* ***in advance and in writing,*** *that the consumer is responsible for noncovered services;*

Recommendations

1.1 Medicaid beneficiaries should receive notice similar to the Medicare Outpatient Observation Notice (MOON). MOON informs Medicare beneficiaries who are receiving observation services as outpatients that they are not inpatients and explains the implications of outpatient status on Medicare cost-sharing and coverage for post-hospitalization SNF services.

2.1 The Medicaid notice, like the MOON, should be provided within 36 hours of observation services initiation or upon release, whichever is sooner.

KDHE Response:

KDHE does not agree with this finding.

For Recommendation 1.1, A MOON or something similar is delivered by a hospital. The MOON is required by statute to be delivered by hospitals to Medicare beneficiaries. KDHE currently does not have a way to inform Medicaid beneficiaries who are receiving observation services as outpatients that explains the implications of outpatient status and the coverage for post-hospitalization SNF services. While a MOON is not currently used in Medicaid, the current Explanation of Benefits (EOBs) is used by the MCOs meet the requirements suggested within the KanCare contract. Within an Issue Brief issued by your office on 5/27/25 your recommendation was as follows: "Update contract or Kansas statute to require MCOs (UnitedHealth Care, Healthy Blue, and Sunflower) to provide electronic EOB notifications on a per-claim or monthly basis. The contents of the EOB should consist of:

A list of services provided and billed to the health plan:

- *The name of the provider furnishing the service.*
- *The date on which the service was furnished.*
- *Clear contact for recipient services.*
- *Instructions for reporting suspected fraud.*

All three KDHE MCOs (Healthy Blue, Sunflower, and United Healthcare) offer EOB access to members through their member portals on their websites. Their EOBs include the following items that detail claim service payment or denials, and meet the requirements within our contract:

- *Dates of services.*
- *Procedure codes.*
- *Amount billed; amount allowed, & amount paid.*
- *Patient liability.*
- *Provider that submitted the claim.*
- *MCO contact instructions.*

Additionally, both Healthy Blue and United Healthcare have a paper copy available to members. Healthy Blue also lists suspected fraud instructions. We could request that Sunflower and United Healthcare add this as well. We agree that electronic delivery is by far the most cost-effective way to deliver this information to members and is already figured into the MCOs capitated payments. By offering through the member portals, KDHE is meeting the electronic delivery. If KDHE were to require paper notices be sent to all members, that would increase costs to the program and funding would be required to support paper versus electronic delivery.

For Recommendation 2.1, KDHE reiterates that a MOON or a HIIN would be provided by the hospital. Medicaid does not provide any kind of notice to a member prior to or while in the hospital for an observation stay. KDHE understands the value of this type of notification, however, feel that we do not have the staffing or budget to be able to accomplish this task. Medicaid member EOBs are available in MCO member portals once claims have been processed.

10. Finding – Conflicts of Interest with KanCare MCO

Two related conflict-of-interest scenarios were identified involving UnitedHealthcare, a KanCare MCO:

- **Clinical Criteria Screening Tool Ownership**: UnitedHealthcare owns and utilizes its own proprietary clinical decision support tool to evaluate prior authorization (PA) requests. These tools apply a series of decision rules using diagnosis, symptoms, medical history, and laboratory results to determine medical necessity. By controlling the tool's logic, design, and algorithms, the MCO has the ability to influence approval rates, reduce medical expenditures, and enhance internal performance metrics without independent validation.

- **Claim Review Vendor Affiliation**: Hospitals reported utilizing claim review services offered by Optum and Change Healthcare—subsidiaries of UnitedHealthcare. These vendors apply Correct Coding Initiative (CCI) edits to verify compliance with Kansas Medical Assistance Program (KMAP) standards. The ownership arrangement enables vertical integration between payer and review functions, introducing a self-monitoring dynamic that can compromise neutrality in claims validation.

These circumstances stem from limited restrictions in vendor selection and ownership disclosure requirements within the KanCare program. Current policies do not explicitly prohibit MCOs from owning decision-making tools or claim review vendors, nor do they mandate external audits of affiliated systems

Recommendation

1.1 Prohibit Ownership of Clinical Screening Tools
KanCare MCOs should be restricted from using or owning proprietary PA decision tools. Prior authorization determinations must rely on independently validated clinical criteria to ensure fairness, transparency, and consistency across payers and providers.

2.1 Require Third-Party Claim Review Vendors
The state should mandate the use of independent, unaffiliated claim review entities for all MCOs. This safeguards objectivity in coding validation and ensures compliance with KMAP standards without influence from the MCO's financial interests.

3.1 Enhance Disclosure Requirements
MCOs must disclose ownership ties to any vendors involved in clinical or billing operations, with mandatory reporting on algorithmic logic and outcomes for both PA decisions and coding edits.

4.1 Strengthen State Oversight
KDHE and other oversight bodies should conduct regular audits of PA tools and claim review platforms, especially those linked to MCOs. These audits should verify fairness, review denial patterns, and assess coding error suppression.

5.1 Revise Procurement and Contracting Standards
Future KanCare contracts should include explicit language prohibiting vertical integration that compromises impartiality in medical necessity determinations or claim validation.

KDHE Response:
KDHE agrees with this finding. We acknowledge the use of Interqual, which is United Healthcare's proprietary clinical criteria screening tool, along with claim review services, also offered by Optum and Change Healthcare, presents a perceived conflict of interest. The health care industry is changing quickly with health plans now acquiring billing, health screening and other such companies creating new dynamics not only for Medicaid but all payors. CMS does have conflict of interest provisions that state Medicaid programs must follow, but to date United acquiring billing and other health care companies and continuing to use those products is not a conflict per the current standards. KDHE also recognizes these tools are used by all three contracted MCOs in Kansas which creates additional dynamics if KDHE were to try and restrict United use but allow other MCOs to use

such tools. These tools are widely used and accepted by healthcare providers across the nation to make medical decisions and validate claims.

For Recommendation 1.1, KDHE agrees that restricting the KanCare MCO, United Healthcare from using their proprietary tool, or owning any proprietary PA decision tool, would likely ensure fairness, transparency, and consistency across payers and providers. Kansas will evaluate options in its capacity to limit the use of such a proprietary tool. United Healthcare is a large health corporation with many subsidiaries across the United States. It would be difficult to convince United Healthcare to agree contractually with our recommendations and KDHE currently does not have any statutory or CMS regulation to require United to accept such restrictions.

As for Recommendation 2.1, KDHE agrees with using independent, unaffiliated claim review entities. This practice can help safeguard objectivity in coding validation, ensure compliance with KMAP standards, and allow the state to operate without the influence of the MCOs financial interests. MCOs are required to follow KDHE specific policies and Medicaid National Correct Coding Initiative (NCCI) structured by CMS when utilizing their own tools. United Healthcare is a large company that acquired Change Healthcare (their subsidiary). This has afforded United Healthcare a large portion of the national market in claims and coding. It would be difficult to convince United Healthcare to agree to moving away from the use of this vendor.

For Recommendation 3.1, KDHE agrees MCOs should disclose ownership ties to any vendors or subsidiaries involved in clinical or billing operation with mandatory reporting on algorithmic logic and outcomes for both PA decisions and coding edits. Currently the MCOs have full responsibility and oversight of their own claims. KDHE will be notified by the providers of claim denials that should normally be covered by Medicaid. If said reporting is supplied to KDHE, we would need full time employees (FTE) hired to audit the given reports.

As for Recommendation 4.1, KDHE agrees that PA tools and claim review platforms, especially those linked to MCOs should have more oversight and regular auditing. As mentioned in recommendation 3.1, the MCOs have full responsibility and oversight of their own claims. KDHE would need FTEs hired to have the capacity of auditing said reports.

For Recommendation 5.1, KDHE agrees that future KanCare procurement contract standards should include explicit language that the state will have tight auditing and oversight standards to safeguard objectivity in claims review and PA standards. Also, an expectation of the contractor to show in the RFP response how they will safeguard impartiality in medical necessity determinations or claim validation.

11. Finding – Multiple methods of communication used in hospitals to submit prior authorizations and appeals has contributed to the administrative burden of the hospital UM teams.

Testimonial evidence revealed that hospitals are often left uncertain as to what method is supposed to be used for sending or receiving information to or from the MCOs. The various methods of communication for UM teams are provider portals, phone calls, fax, or mail. Various communication methods paired with the lack of one designated method of communication has contributed to the administrative burden of hospital UM teams.

Recommendation

1.1 Standardize the method of communication between hospitals and MCOs for sending or receiving information to or from the MCO.

KDHE Response:

KDHE agrees with this finding. KDHE recognizes the approach of MCOs utilizing the same communication platform could offer potential efficiencies and standardization.

For Recommendation 1.1, while the recommendation is certainly ideal, implementation would be highly complex due to each MCO currently operating on their own proprietary platform. This requirement may increase administrative overhead for the MCOs, which would be captured in future capitation rates. KDHE would need to conduct a cost benefit analysis to determine whether this provides a return on investment or other alternatives that would improve current state.
In addition to costs, KDHE has concerns regarding the potential risks associated with sharing a single platform across all MCOs. Specifically, there is a heightened risk that member information could be misrouted or disclosed to the incorrect MCO. Advancements in technology likely mitigate some of these risks, any shared system would require rigorous safeguards to protect member privacy and ensure data accuracy. Given the volume of users across multiple entities and locations, the potential for user error remains a concern.

In alignment with CMS, KDHE plans to implement the CMS Final Rule 0057 (linked below), which aims to promote more efficient and transparent prior authorization processes through technological advancements and standardized information exchanges via API's (Application Programming Interfaces). CMS intends for these changes to improve the patient experience and enhance access to care. By finalizing several new requirements for prior authorization processes, CMS seeks to reduce the administrative burden on patients, providers, and payers.

To streamline the prior authorization process, CMS is requiring impacted payers to implement and maintain a Prior Authorization API. In the proposed rule (linked below for reference), CMS refers to this as the "Prior Authorization Requirements, Documentation, and Decision API (PARDD API). On

January 1, 2027 (or the actual compliance date), payers will be required to make available data about all active prior authorizations, regardless of how long they have been active, and any requests that have had a status update within the previous 1 year period (that is since January 1, 2026, if a payer implements on these changes on that day).

https://www.cms.gov/files/document/fact-sheet-cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.pdf

https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability.

12. Finding – MCOs frequently do not honor the scheduled time for P2P calls

MCOs frequently do not honor the scheduled time for P2P calls, resulting in the working physician taking the call instead of the treating physician. This lack of familiarity with the patient's condition often renders the P2P to be less effective. Furthermore, when the treating physician is unavailable on the day of the scheduled P2P, the working physician may be specialized in a different area of care (specialty) than the treating physician, further leading to unjust denials. As a result, physicians conduct extensive monitoring and effort to justify the medical necessity of the patient's status or requested services.

As mentioned in testimonial evidence, each MCO has its own availability for P2Ps.

- **MCO 1** – has a dedicated P2P team of doctors that are available Monday through Friday from 7:00 a.m. to 7:00 p.m.

- **MCO 2** – did not provide a specific time that they are available for P2Ps.

- **MCO 3** – P2Ps generally occur during business hours, Monday through Friday, 8 a.m. to 5 p.m. If the provider is unavailable, medical directors may accommodate by leaving voicemails or rescheduling.

The variation in P2P availability can also contribute to the treating physician being unavailable on the day of the scheduled P2P if their normal work schedule is outside the MCO's P2P team hours.

Recommendations

Hospitals can improve the effectiveness of P2P calls, reduce physician fatigue, and ensure fairer decision-making regarding patient care by implementing the following:

1.1 Standardized Scheduling Protocol **–** Establish a standardized scheduling protocol that mandates MCOs to adhere to the agreed-upon P2P call times. This could include penalties for missed scheduled calls to ensure compliance.

2.1 Advance Notice Requirement – Require MCOs to provide advance notice of any changes to the P2P schedule. This would allow the treating physician to be available or to arrange for another suitable physician familiar with the patient's case.

3.1 Dedicated P2P Coordinators – Appoint dedicated P2P coordinators within hospitals to manage and oversee the scheduling and conduct of P2P calls. This could help ensure that the appropriate physician is always available for the call.

4.1 Use of Telemedicine Platforms – Implement telemedicine platforms that provide real-time notifications and reminders to both MCOs and physicians about scheduled P2P calls. This can help in minimizing scheduling conflicts.

5.1 Policy Advocacy – Advocate for policy changes at the state level to mandate stricter regulations on MCO scheduling practices. This could include legislation that enforces timely and effective P2P calls.

KDHE Response:

KDHE agrees with the finding. KDHE acknowledges that implementing a standardized scheduling protocol would enhance efficiency and coordination.

For Recommendation 1.1, KDHE believes there is a level of complexity to implementing these recommendations. To effectively evaluate the recommendations and determine appropriate next steps, the state would like to assess additional MCO data on missed P2P calls that were scheduled. In KanCare 3.0, new contract language has been included that requires a like-trained physician to conduct P2P calls. These applicable contract changes will be evaluated in the data as well. This data will enable KDHE to assess the scope of the issue and inform a data-driven approach. KDHE would then evaluate the data and form a workgroup consisting of KDHE and MCO clinical teams to address identified barriers with P2P scheduling and calls to form a more efficient P2P implementation strategy.

For Recommendations 2.1, 3.1, If such implementation strategy is established, accompanying rules and regulations (such as an advance notice requirement) may be adopted as part of the implementation process. Should an advance notice requirement be formalized, the state believes there would be no need for dedicated Peer-to-Peer (P2P) coordinators. Decisions regarding staffing or process changes would remain at the discretion of each hospital, in consultation with MCOs and their Medical Directors.

For Recommendation 4.1, on the use of telemedicine platforms, KDHE does not believe that their use is necessary in this context. P2P calls are scheduled directly on the MCO Medical Director's calendar,

and the call is initiated by the MCO to the facility physician. In most cases, the facility physician is aware of the nature of the call. While there may be instances, particularly in larger hospital systems, where the call is received by a third-party physician representing the facility, telemedicine would add another complex layer of communication, that in KDHE's opinion, does not substantiate the need for this communication platform for P2P interactions.

For Recommendation 5.1, KDHE does not plan to pursue policy advocacy. P2P calls are sometimes unavoidable, because clinical staff at provider facilities are often operating under high-demand schedules, and where interruptions are common.

13. Finding – MCOs frequently deny hospital claims for readmissions within 30 days, even if the new admission is unrelated. Labeling these denials as "administrative denials" allows them to reject claims and avoid payment.

Hospitals report that MCOs frequently deny requests for LTACH placements, steering patients toward lower-cost PAC options instead. These denials often lead to preventable hospital readmissions, which the MCOs then refuse to cover—frustrating providers. Additionally, MCOs frequently reject readmission claims within 30 days of discharge, even if the subsequent admission is unrelated. This results in the hospital losing money when claims associated with readmissions are denied. The delays in PAC PAs also reduce hospital bed availability, resulting in longer wait times for ER patients and hospital transfers.

Hospitals further report that MCOs blame them for failed discharge plans when readmissions occur, even when PAC PA requests for medically necessary facilities were denied. Some MCOs rely on proprietary criteria, such as InterQual, but refuse to share these standards with hospitals. As expressed through their testimonies, the hospitals experienced inconsistent approval rates for claims. If the hospital submitted PA requests with identical diagnoses and length of stay, the identical requests would receive different PAC determinations.

This inconsistency suggests there is a lack of structured internal criteria for evaluating PA requests. Ultimately, patients are not receiving appropriate PAC for recovery. Instead, many are sent home with insufficient care, increasing the likelihood of readmission. The MCOs demonstrate prioritizing cost containment by approving PAC at minimal levels while leveraging KMAP policy loopholes to deny hospital readmissions within 30 days of the previous admission.

Recommendation

1.1 Update KMAP, FFS Provider Manual, Hospital Services, Section 8410 to include language that removes the loophole which MCOs appear to be using to deny hospital payments

for readmissions when PAC PA requests for medically necessary facilities were denied inappropriately by the MCO (underlined below):

Kansas Medical Assistance Program (KMAP), FFS Provider Manual, Hospital Services, Section 8410

Readmissions may be subject to utilization review. Utilization review of readmissions will occur for members who are readmitted as an inpatient to a general hospital between 1 and 15 days of discharge. Readmission guidelines for days 2-15 of a hospital stay do not apply if Medicaid is not the primary payer of the initial inpatient stay claim.

Shall be reviewed to determine if the readmission was the result of an inappropriate discharge from the initial admission based on one of the following criteria:

- *A medical readmission for a continuation or recurrence for the initial admission or* ***closely related condition*** *(e.g. readmission for diabetes following an initial admission for diabetes).*
- *A medical complication related to an acute medical complication related to a care during the initial admission (e.g. patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).*
- *An unplanned readmission for a surgical procedure to address a continuation or a recurrence of a problem causing the initial admission (e.g. readmitted for appendectomy following a primary admission for abdominal pain and fever).*
- *An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection).*
- ***The unplanned readmission is the result of a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards prior to discharge or during the post-discharge follow-up period.***
- ***An issue caused by a premature discharge from the same facility.***
- ***Readmission is medically unnecessary.***

KDHE Response:

KDHE agrees with this finding. KDHE appreciates the concern expressed regarding patients potentially not receiving appropriate post-acute care (PAC) necessary for optimal recovery. Based on the data reviewed, this may not solely lay on the MCO. Yet, KDHE recognizes that if a MCO is reviewing at 16-30 days post-discharge, there is violation of state regulatory language and that will be reviewed.

For Recommendation 1.1, KDHE is concerned the recommendation may suggest covering all hospital readmissions without sufficient regard for potential quality issues that often contribute to those readmissions. It is important that readmissions be reviewed on a case-by-case basis as there are a variety of reasons why readmission may occur. Some reasons may be related to quality or care

issues that need to be addressed, as it is not appropriate that Medicaid expenditures would increase due to these issues not being overseen. Eliminating scrutiny in such cases may inadvertently allow systemic quality concerns to go unaddressed. Unfortunately, the State has no other way of encouraging hospitals to address quality surrounding hospital discharges except to not cover diagnostically related readmissions. KDHE will discuss further internally regarding this recommendation.

KDHE will do further research regarding the assertion that delays in PAC prior authorizations are the primary driver of post-acute care (PAC) bed unavailability. KDHE understanding from the MIG reports, the information suggests many PAC facilities decline to admit complex Medicaid patients (which is the population involved in much of the chronic readmission work) due to the financial mismatch between reimbursement rates and the true cost of care. As a result, these admissions often represent a financial loss for the facilities, which understandably influences admission decisions. It is important to recognize that challenges related to PAC prior authorization and the timing of decisions are not the sole responsibility of the MCOs. These issues typically involve a triad of entities: the discharging hospital, the PAC provider, and the MCO. Each plays a role in the process, and resolution requires coordinated effort and accountability among all three parties. Ultimately, to support improvements in the PAC process, including solutions to PAC PA delays, KDHE will consider collaborating with MCOs to tracking challenging situations, monitor related processes, and facilitate real-time resolution of difficult PAC placements.

In addition, and recognizing hospital's financial losses with these processes, KDHE submitted a budget enhancement request that was sent to the legislature for a partial hospitalization fund for patients who no longer met medical necessity but had no viable discharge option. The request did not get included as a budget enhancement as it was appealed in November and was not approved to move forward in the budget process last year.

14. Finding – The language in K.A.R. § 129-1-1(oo)(1) lacks clarity and specificity, creating opportunities for misinterpretation and misuse.

KAR 129-1-1 Definitions were amended by Kansas Register Volume 43, No. 50; effective 12/27/2024. A review of the definition was conducted to determine if insurance providers could potentially exploit vague or flexible wording in the definition. The amended definition language is provided below:

K.A.R. § 129-1-1(oo)(1) *"Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:*
(A) Authority. The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.

(B) Purpose. The health intervention has the purpose of treating a medical condition.
(C) Scope. The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.
(D) Evidence. The health intervention is known to be effective in improving health outcomes.
(i) For new interventions, effectiveness shall be determined by scientific evidence as described in paragraph (oo)(3).
(ii) For existing interventions, effectiveness shall be determined by scientific evidence as described in paragraph (oo)(4).
(E) Value. The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. Cost-effective shall not necessarily be construed to mean lowest-priced. An intervention may be medically indicated and yet not be a covered service or benefit or meet the definition of medical necessity in this subsection. Interventions that do not meet this regulation's definition of medical necessity may be covered at the discretion of the secretary or the secretary's designee. An intervention shall be considered cost-effective if the benefits and harms relative to the costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the condition of the individual patient shall be determinative.

K.A.R. § 129-1-1(oo)(2) *The following definitions shall apply to these terms only as they are used in this subsection:*
(A) "Effective," when used to describe an intervention, means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
(B) "Health intervention" means an item or covered service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For the definition of medical necessity in this subsection, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which the health intervention is being applied.
(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.
(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or biological or psychological condition that lies outside the range of normal, age-appropriate human variation.
(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.
(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be

considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or by potential experimental biases.
(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.
(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.
(I) "Treating physician" means a physician who has personally evaluated the patient.

***(3)** Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the **basis of professional standards of care or expert opinion** as described in paragraph (oo) (4).*
***(4)** The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, **professional standards of care shall be considered.** If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet the definition of medical necessity in this subsection in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, **convincing expert opinion**.*

Our review concluded that insurance providers could potentially exploit the vague or flexible wording in the definition of "medical necessity" above in several ways. These loopholes could lead to delays, denials, or restrictions on care, impacting patients who rely on timely and necessary treatments.

Identified potential loopholes are:

- Subjective Approval Process – Since approval depends on a physician's recommendation and the judgment of an authority, insurers could impose stricter criteria or override physician recommendations, leading to denials.

- Cost-Effectiveness Clause – The requirement that an intervention be "cost-effective" compared to alternatives allows insurers to favor cheaper treatments, even if less effective, by arguing they still provide some benefit.

- Vagueness in Scientific Evidence – While controlled trials are preferred, insurers could selectively interpret research, dismiss observational studies, or demand higher standards of proof to deny coverage.

- Exclusion of Certain Treatments – Even if an intervention meets the criteria for necessity, the definition allows exclusions from coverage, meaning insurers could deny payment based on policy restrictions rather than patient need.

- Discretionary Coverage – The definition states that some medically indicated treatments might still not be covered, leaving room for insurers to deny services they deem too expensive or unnecessary, even if experts agree they are beneficial.

- Limited Consideration for Individual Cases – While individual patient needs are supposed to be considered in cost-effectiveness decisions, insurers might apply broad policies without fully evaluating unique circumstances.

Further, K.A.R. § 129-1-1(oo)(3-4) references professional standards of care without providing a clear definition or guidance on their application. This absence of well-defined terminology undermines the consistent application of the regulation and increases the risk of abuse. Additionally, paragraph ***(4)*** relies on expert opinion as a determining factor, but the phrasing suggests that such opinions are only valid if they are deemed persuasive in the context of defining medical necessity. This approach may compromise the objectivity and reliability of expert assessments.

Recommendations

1.1 Update the statutory language to include a clear definition for 'professional standards of care' to eliminate the abuse of this regulation.

2.1 Update the statement and remove the word 'convincing' in paragraph (4) of this current statute when used in *convincing expert opinion*, removing the implication that the expert opinion is only valid when it is successfully persuasive in consideration of the definition of medical necessity.

KDHE Response:

KDHE disagrees with this finding. KDHE would like to clarify that while KAR 129-1-1 ("Definitions") was amended in December, the definition of medical necessity was not modified during that update.

KDHE understands the assertion that the current approval process for medical necessity is subjective. There is a level of subjectivity involved in service decisions of claims. KDHE regulates the

MCOs' subjectivity by requiring use of our medical necessity regulation (which contains safeguards for the agency), our PRTF medical necessity criteria, our policies for services/DME, and our authorization criteria for medications. The MCOs are required to utilize State resources first, then may use clinical policies of their own where needed. In the managed care model, the State has delegated the authority to determine medical necessity to the managed care organizations (MCOs), as per their contractual agreement with the State. These contracts explicitly require that MCOs apply the provisions of KAR 129-1-1 when making medical necessity determinations. Specifically, KAR 129-1-1(oo)(1)(A) mandates that the treating physician and the State agency's Secretary (or the Secretary's designee) agree that a proposed health intervention is medically necessary for it to be approved. When there is disagreement between both parties, the MCO may override the physician's recommendation and deny the request.

All denials are subject to an appeal. KDHE monitors the volume and subject matter of denials that are appealed and reviews every State Fair Hearing case related to denials. Importantly, the State must agree with the MCO's decision before it will defend that denial in a State Fair Hearing. The MCOs are required to support each adverse denial decision of by referencing all resources they used in the notices. That documentation is part of the documentation for every State Fair Hearing. Annually, KDHE will also audit the MCO's decision process by reviewing all documentation and every step that led to a State Fair Hearing.

KDHE also disagrees with the assertion that the cost-effectiveness clause skews the approval or denial of claims. KAR 129-1-1(oo)(1) requires that all five criteria outlined in subparagraphs (A) through (E) must be met for a treatment to be deemed medically necessary. An argument that a cheaper treatment will be more cost-effective is appropriate only if all required medical necessity criteria are met. Given the complexity and variability of scientific evidence, MCOs do not base their determinations exclusively on clinical studies. Instead, they follow KAR 129-1-1's medical necessity definition and use State-approved clinical guidelines. Clinical studies may be referenced for particularly complex, rare, or specialized services, treatments, or durable medical equipment (DME).

KDHE acknowledges that certain excluded services may not align with individual patient needs. However, under federal guidance from the Centers for Medicare and Medicaid Services (CMS), certain exclusions are permissible. For instance, Medicaid restricts coverage for adult dental services, even when such services may be medically necessary.
KDHE also clarifies that while some services may appear discretionary, CMS permits Medicaid programs to cover non-traditional services under the "In Lieu of Services" (ILOS) authority—those provided services are on the CMS-approved ILOS list. Additionally, under KAR 129-1-1(oo)(1)(E), coverage discretion is afforded to the Medicaid program's Secretary or the Secretary's designee (i.e., the MCO), allowing interventions that do not meet the strict definition of medical necessity, when appropriate. Therefore, KDHE disagrees that individual cases receive limited consideration. With

State approval, MCOs have flexibility to cover services that fall outside the standard regulatory definition of medical necessity. The monitoring of the KanCare 3.0 contract allows for additional validation of the application of these practices among the three MCOs.

For Recommendation 1.1, KDHE disagrees. The Department that these are overseen by the Medicaid program's Medical Director (a licensed physician) and the Deputy Director of Clinical Services (a licensed nurse). It is not necessary to define these standards within regulation, as they can be addressed contractually with the MCOs for clearer and more adaptable guidance. KDHE agrees that the State can more clearly define professional standards of care in its contract with the MCOs. This will ensure the MCOs' medical necessity decisions meet the professional standards of care required for the Medicaid program and for maintenance of State licensure.

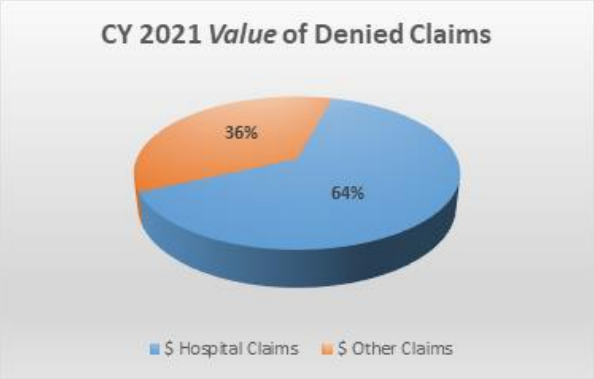
For Recommendation 2.1, KDHE disagrees. KDHE supports the language in paragraph (4) regarding the use of expert opinion in the absence of consistent and up-to-date professional standards of care. While this situation is expected to be rare, it is essential that expert opinion remain an option. In such cases, the Medicaid program's Medical Director would consult with the MCOs' Chief Medical Directors to reach appropriate determinations. KDHE supports retaining the term "convincing expert opinion" in the regulation, as placing the term "convincing" in front of expert opinion narrows its application and makes the use of expert opinion more precise.

15. Finding – Significant trends for Hospital Claims from the KanCare Summary of Claims Adjudication Statistics

CY 2021: The ***number*** of denied claims for Hospital services averaged only 7% of all denied claims. However, the ***value*** of denied Hospital claims disproportionately averaged 64% of all denials.

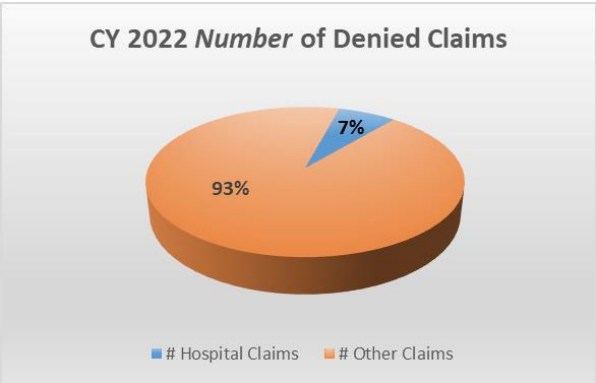
- MCO 1: The value of all services denied was $1,427,654,908. Hospital claim denials accounted for $921,732,748 (65%).
- MCO 2: The value of all services denied was $876,443,203. Hospital claim denials accounted for $633,157,066 (72%).

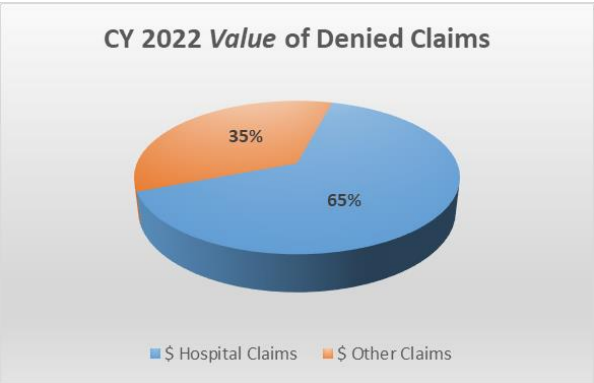
- MCO 3: The value of all services denied was $1,258,015,913. Hospital claim denials accounted for $696,988,584 (55%).



CY 2022: The ***number*** of denied claims for Hospital services averaged only 7% of all denied claims. However, the ***value*** of denied Hospital claims disproportionately averaged 65% of all denials.

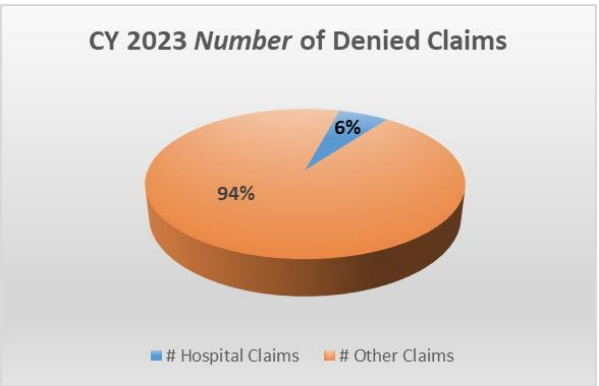
- MCO 1: The value of all services denied was $1,658,564,120. Hospital claim denials accounted for $1,022,239,851 (62%).
- MCO 2: The value of all services denied was $926,806,509. Hospital claim denials accounted for $659,333,189 (71%).
- MCO 3: The value of all services denied was $1,477,490,969. Hospital claim denials accounted for $899,546,297 (61%).

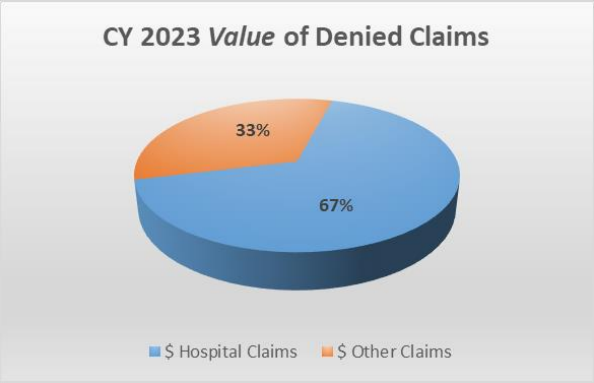


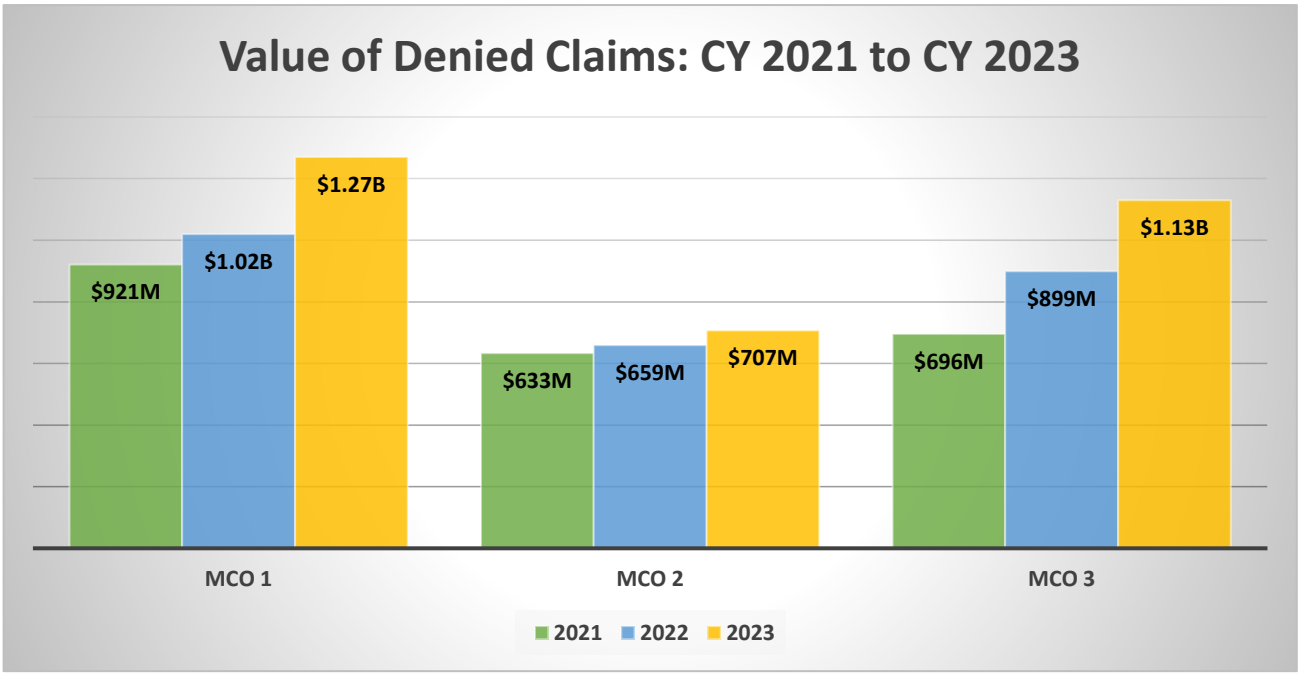


CY 2023: The ***number*** of denied claims for Hospital services averaged only 6% of all denied claims. However, the ***value*** of denied Hospital claims disproportionately averaged 67% of all denials.

- MCO 1: The value of all services denied was $1,833,302,065. Hospital claim denials accounted for $1,276,162,988 (70%).
- MCO 2: The value of all services denied was $1,019,967,786. Hospital claim denials accounted for $707,664,730 (69%).
- MCO 3: The value of all services denied was $1,838,971,701. Hospital claim denials accounted for $1,135,230,556 (62%).







Recommendations

1.1. Investigate Root Causes of High Denied Claim Values: Perform a detailed analysis of why Hospital Inpatient and Outpatient services contribute disproportionately to total denied claim values, even though their claim count remains low (5%–9%).

1.2. Identify common reasons for denials (e.g., coding errors, incomplete documentation, policy changes) and target these for corrective action. A reduction in denial rates as hospitals address documentation errors and payer-specific inconsistencies leads to fewer denied claims overall.

1.3. Enhance Claims Submission Processes: Provide training for providers on proper documentation, coding practices, and compliance with payer-specific requirements to reduce claim denial rates. Consider implementing automated claim-check systems that flag potential errors before claims are submitted.

1.4. Engage with Payers: Open communication with MCOs to clarify denial patterns and resolve systemic issues causing higher denial rates for Hospital Inpatient and Outpatient claims. Negotiate for clearer and more consistent denial criteria. Better collaboration with payers may foster mutual understanding and alignment on claim criteria, minimizing systemic denials and strengthening provider-payer relationships.

1.5. Monitor and Benchmark Performance: Establish a continuous monitoring system to track denied claim trends by year, payer, and service type. Benchmark against industry standards to identify potential inefficiencies or best practices for improvement. Continuous monitoring and benchmarking will support sustained improvement, enabling data-driven adjustments and long-term enhancements in denied claim management.

1.6. Strengthen Appeals Processes: Focus resources on appealing high-value denied claims, especially those for Hospital Inpatient and Outpatient services, as they constitute a significant portion of total denied claim values. Optimize internal workflows to speed up the appeal resolution process. Improved financial outcomes are expected, as lower denial rates and enhanced appeals processes contribute to higher recovery of denied claim values, strengthening the financial position of providers and organizations.

1.7. Allocate Resources Strategically: With total denied claim values increasing year-over-year, allocate more resources to areas where denials are most frequent and costly. Target interventions at specific payers or service categories contributing the most to denied claim values. Targeted interventions for high-value claims may stabilize or reduce the disproportionate impact of denied claims, which currently accounts for up to 70% of Hospital Inpatient and Outpatient services. Increased efficiency in claim processing through streamlined submission and automated error-checking systems could accelerate approvals and reduce delays.

1.8. Predictive Analytics for Future Trends: Use the data from CY2021–2023 to develop predictive models for future denied claim trends. Identify potential problem areas early and take preemptive measures to reduce denials. Predictive analytics can facilitate early detection of denial trends, allowing organizations to proactively mitigate emerging issues.

KDHE Response:

KDHE agrees with the finding that there was a steady increase of Hospital denied claim values across all three MCOs over a three-year period. This is to be expected with medical costs rising. KDHE appreciates the recommendations related to investigating and monitoring denied claims.

For Recommendation 1.1 and 1.2, the KDHE focus is to ensure claims are processed in accordance with policy with State and Federal guidelines. We agree there is value in analyzing denied claims in the suggested manner, but that would require additional staff and specialized training. While KDHE could address the specialized training within existing resources, there are not FTEs available to take on the additional workload. Additional FTEs would require legislative approval. In the absence, of internal capacity, KDHE does have a Health Improvement Partner, the Kansas Foundation for Medical Care (KFMC), that reviews and reports on high-dollar claims. KDHE will explore an extension of our current contract with KFMC to include the analysis of high dollar denied claims and will determine of costs could be covered within existing appropriation.

For Recommendation 1.3, KDHE has assigned the responsibility for training of providers to the MCOs. KDHE approves all training materials. In the future KDHE will work to enhance the training materials and will scrutinize current documents for areas to improve. If providers require additional training to ensure accurate and proper claims submission, KDHE can encourage and guide the MCOs to provide that support.

For Recommendation 1.4, KDHE agrees open and transparent communication with MCOs regarding denial criteria is essential to strengthening provider-payer relationships. This will help address recurring issues at their source, potentially leading to a significant reduction in claim denials. By proactively negotiating and clarifying these criteria, the State has an opportunity to influence policy rather than merely respond to outcomes. Reducing unnecessary denials will also minimize care disruptions for members.

For Recommendation 1.5, KDHE monitors and benchmarks as specified in KanCare 3.0. Enhanced monitoring and benchmarking would require additional FTEs and legislative approval for such.

For Recommendation 1.6, KDHE recognizes the importance of a robust appeals process and agrees denied claims should be appealed when appropriate. However, the State is not positioned to lead or prioritize claim appeals as the State is not the entity receiving appeals, the hospitals receiving the denials of payment are. Hospitals have informed us that they often set thresholds for the dollar amount of denied claims and choose to only appeal some. In other cases, the hospitals may write off certain denials as administrative burdens or because of legal costs. Understanding this process, KDHE does not see a benefit in allocating resources toward the appeals process for high-dollar claims. That said, we do acknowledge the appeal resolution process could benefit from improvements, and KDHE will work to collaborate with the MCOs to enhance this.

For Recommendation 1.7, KDHE agrees with allocating resources strategically but with a small claims team (6 FTE's) at KDHE, this request must be examined in the overall schema of Medicaid claims processing. Additional resources would likely be needed but further analysis is required.

For Recommendation 1.8, KDHE does not agree with this recommendation. We will refrain from using data from calendar years 2021–2023 to develop predictive models for denied claims. The data from this period is skewed due to extended member retention driven by COVID-19-related protocols, resulting in inflated monthly figures. We will revisit this approach once enrollment and claim trends stabilize and are no longer impacted by the residual effects of the pandemic.

16. Finding – All appeal and reconsideration data metrics within 1115 Waiver reports provided by KDHE contained 'resolved' data only.

The "KanCare Section 1115 demonstration" refers to the State of Kansas' Medicaid program, known as KanCare, which operates under a federal waiver granted by Section 1115 of the Social Security Act, allowing Kansas to implement a unique managed care system with greater flexibility in how they deliver healthcare to Medicaid recipients compared to standard Medicaid guidelines; essentially, it's a pilot program that lets Kansas test new approaches to managing their Medicaid program.

Kansas must periodically submit renewal applications to the Centers for Medicare and Medicaid Services (CMS) to continue operating under the Section 1115 waiver. As part of the demonstration, Kansas is required to track and report data on the effectiveness of its program to CMS. Excluded 'unresolved' appeal and reconsideration data within the 1115 Waiver reports removes the holistic view of the ratio of the total appeals or reconsiderations compared to the resolved appeals or reconsiderations.

Recommendation

1.1 Restructure the reporting metrics to include the total number of appeals and reconsiderations. Reporting the holistic view of the ratio of the total appeals or reconsiderations compared to the resolved appeals or reconsiderations.

KDHE Response:

KDHE disagrees with the finding. KDHE recognizes the importance of tracking and reporting metrics related to appeals and reconsiderations, as well as those resolved.

For Recommendation 1.1, KDHE disagrees that its grievance and appeal reporting metrics for the MCOs needs to be restructured. KDHE clarified that the State requires the MCOs to report all grievances and appeals received. Reporting requirements include the resolutions for all appeals and grievances received. Resolutions for grievances include whether the issue was substantiated or unsubstantiated. Resolutions for appeals include whether the original denial decision was upheld or reversed following appeal review. The ratio of total appeals and reconsiderations to those resolved is consistently 1:1.

Per federal regulations, managed care members submit grievances and appeals to the MCO in which they are enrolled. KDHE requires the MCOs to submit detailed monthly reports of all resolved appeals and reconsiderations. A reconsideration or appeal is considered resolved once it has been received by the MCO, reviewed by the appropriate MCO review team, the MCO has a determination, and the MCO has issued a notice of that determination to the member. The MCOs are not required to report the resolutions of each reconsideration and appeal until the MCO makes a determination, establishes a date of resolution, and issues the notice of resolution within 30 calendar days of the determination. The State requires a detailed level of categorization and explanations in the MCO's monthly report so KDHE can pinpoint increases in volumes and types of service or payment issues involved in the reconsiderations and appeals. This level of detail also shows differences between the MCOs. KDHE also requires the MCOs to provide monthly data that allows the State to see how many reconsiderations and appeal decisions the MCOs have reversed due to an internal error by the MCO, reversed after corrections by the member/provider, or upheld. KDHE reviews each MCO's compliance with contractual requirements each month. KDHE and we will continue to monitor this data.

Rebuttal: This practice obscures visibility into program responsiveness, the timeliness of determinations, and potential bottlenecks in the resolution process.

- **While MCOs may internally track all cases, the public-facing waiver data shared with CMS includes *resolved outcomes only*, limiting oversight into trends in delays or appeals left pending beyond regulatory timeframes.**
- **KDHE's claim of a 1:1 resolution ratio lacks independent validation and omits aging data or breakdowns of unresolved appeals by MCO.**

- **CMS guidance encourages full-cycle reporting to support transparency, especially in pilot programs under Section 1115.**

17. Finding – Inconsistencies in MCO Provider Manuals

While the provider manuals provide structured guidelines and processes for prospective, concurrent, and retrospective reviews, the testimonial evidence from hospital interviews highlighted significant gaps and discrepancies in the implementation and experience of the processes stated in each of the MCO's provider manuals.

Recommendations

1.1 Provider manuals and MCO practices should be reevaluated and improved to align better with hospitals' needs and realities for Kansas Medicaid beneficiaries.

2.1 Ensure the requirements are being met with internal audits and tracking for coverage of services and for a provider manual are as follows:

Kansas Medicaid Managed Care Request for Proposal, KanCare 2.0, BID Event Number: EVT0005464

Pg. 22 – 5.2.1 Enrollment, G. CONTRACTOR(S) Responsibilities

3. Coverage of services, including inpatient hospital care, will be the responsibility of the CONTRACTOR(S) as of the beginning of the month enrollment becomes effective. All other (ancillary) charges, not reimbursed by the inpatient hospital payments, are the responsibility of the CONTRACTOR(S). Non-inpatient (ancillary) charges are the responsibility of the CONTRACTOR(S) if the Admission date occurs before assignment. If an Admission date occurs during the assignment to the CONTRACTOR(S), **that CONTRACTOR(S) is responsible for the cost of the entire Admission regardless of assignment or eligibility.**

Pg. 93 – 5.6.1. Requirements for a Provider Manual

A. Develop and submit to the State for approval, a Provider Manual that:

1. *Contains dated CONTRACTOR(S) policy and procedure information, including, in part, credentialing criteria, UM policies and procedures, billing and payment procedures, Provider and Member Grievance and Appeal processes, and network management requirements.*
2. *Is distributed electronically to all Participating Providers following approval of the State no later than thirty (30) calendar days following the CONTRACT effective date, and then to Participating Providers and Non-Participating Providers upon request thereafter.*
3. *Is updated regularly, and distributed electronically in whole or in part to Participating Providers at least thirty (30) calendar days in advance of any policy or*

procedure change substantive revisions to the Provider Manual must be submitted to the State for approval. Changes must be posted on the CONTRACTOR(S) website and notify Providers via bulletins.

4. *Is posted as an electronic version of the Provider Manual to the CONTRACTOR(S)' web site with hard copies made available upon request.*
5. ***Is consistent with State Medicaid Provider Manuals (KMAP) in regards to services covered and who can provide the services.***

KDHE Response:

KDHE agrees with this finding. KDHE acknowledges that there have been reports of instances in which the MCOs may not always follow the criteria within their provider manuals. When KDHE receives reports of these instances, we work with the MCOs to correct their procedures.

For Recommendation 1.1, KDHE recognizes the importance of regularly evaluating and improving Provider Manuals and MCO practices. The manuals are reviewed annually by KDHE and are evaluated to ensure they contain any new or updated information. KDHE will add the lens of the hospitals' needs and the realities of Kansas Medicaid beneficiaries in their reviews. KDHE will strategically connect with the Kansas Hospital Association (KHA) annually to obtain feedback on each MCO's Provider Manual content. Additionally, updates to the manuals may be requested at any time throughout the year by KDHE. Once a change has been approved, the respective MCO is responsible for notifying providers of the updates. The revised manuals are then published on the MCO's website and made accessible to the public. The Provider Manual applies to both individual providers and healthcare facilities. The contract also outlines the specific content requirements for each manual. KDHE will perform ongoing assessments to align the Provider and KMAP manuals.

For Recommendation 2.1, KDHE will continue to work with providers to identity occurrences of the MCOs not following the practices and guidelines stated within their provider manuals. KDHE will reinforce to providers that they may contact the KDHE MCO Manager staff at any time to report these instances or that they may request assistance with these type of issues by emailing KDHE.MCOInquires@ks.gov.

Observations

1. **Updates made to Kansas Administrative Regulations for Agency 129: Department of Health and Environment – Division of Health Care Finance, during the audit completion period.**
   Kansas Register Volume 43, No. 50; effective 12/27/2024, includes the following updates:

   - Amendments to K.A.R. 129-1-1, Definitions and 129-9-9, External independent third-party review for providers.
   - Revocation of K.A.R. 129-7-65, Notice to recipients of intended action.
   - Establishment of regulations for eligibility hearings under Article 7, Medical assistance grievances and state fair hearings for eligibility and fee-for-service
   - Creation of regulations for managed care hearings under Article 8, Medical assistance grievances, appeals, and state fair hearings for managed care enrollees
   - Development of regulations for Medicaid providers under Article 9, Medical assistance grievances, reconsideration, appeals, external independent third-party review, and state fair hearings involving providers

   Summarized from testimony provided by Brian Vazquez, KDHE Legal Counsel (Former), to the Joint Committee on Administrative Rules and Regulations during the 2024 Kansas legislative session:

   The changes address five key areas: amendments to K.A.R. 129-1-1 and 129-9-9; revocation of K.A.R. 129-7-65; the establishment of regulations for eligibility hearings under Article 7; the creation of regulations for managed care hearings under Article 8; and the development of regulations for Medicaid providers under Article 9.
   Kansas Medicaid has been exploring the implementation of its own administrative hearing procedures for several years. Historically, it relied on regulatory provisions established in the late 1980s and 1990s by the Kansas Department of Social and Rehabilitation Services (SRS). Over time, the state Medicaid agency transitioned to the Kansas Health Policy Authority in 2005 and subsequently to KDHE in 2011.
   In 2013, Kansas adopted KanCare, a managed care model for Medicaid, which introduced additional federal requirements for MCOs and their stakeholders. Federal Medicaid regulations were subsequently amended by CMS in 2016, driven in part by the Affordable Care Act. Additional revisions to grievance and appeal systems followed in 2016, 2019, and 2020. In 2020, the Kansas Legislature introduced provisions for external third-party reviews of provider claims to enhance the fairness of hearings.

2. **Kansas Focused Program Integrity Review Final Report, published October 2024**
   Appendix A: Status of Prior Review Kansas's last CMS PI review was in June 2018, and the report for that review was issued in January 2019. The report contained seven recommendations for improvement. During the virtual review in May 2023, the CMS review team conducted a thorough review of the corrective actions taken by Kansas to address all recommendations reported in CY2019. The findings from the 2019 Kansas focused PI review report have not all been satisfied by the state.

   CMS Findings: The state should conduct data mining using outliers or exception processing of claims to identify patterns of fraudulent, abusive, unnecessary, or inappropriate utilization by MCO network providers, in addition to the data mining contractually required and conducted by the MCOs. The state should require the MCOs to provide regular updates on performance improvement plans for changing algorithms and data mining updates. ***Status at time of the CMS review: Not Corrected***

3. **American Medical Association (AMA) Surveys**
   In 2021, AMA surveyed physicians to rate the administrative burdens associated with the PA process. 88% of the physicians who participated characterized the administrative burden as high or extremely high. The survey also included physicians stating that prior authorization often delays the care patients receive, which can result in negative clinical outcomes.

   Currently, there are no reporting requirements from health plan insurers for how often prior authorization is used and for what treatments, how often authorization is denied, or how prior authorization affects patient care and costs.

4. **Kaiser Family Foundation (KFF) Reports and Managed Care Program Reporting Requirements**

   Per KFF, beginning in June 2021, states were required to submit the Managed Care Program Annual Report (MCPAR) to CMS (no later than 180 days after each contract year) for each managed care program the state administers. The first reports were due to CMS in December 2022[11]. The MCPAR must provide information on and an assessment of the availability and accessibility of covered services within managed care contracts, including network adequacy standards.

[11] 2022: https://www.kancare.ks.gov/home/showpublisheddocument/3954/638585338087770000
2023: https://www.kancare.ks.gov/home/showpublisheddocument/3952/638585337669100000

The MCPAR must also include the results of any sanctions or corrective action plans imposed by the state (or other formal or informal intervention) with a contracted managed care plan (described in more detail below). CMS plans to make the MCPAR publicly available on Medicaid.gov once a page is established and CMS has completed an initial review of the reports but will make these reports available upon request until then.

5. **In 2023, an evaluation of prior authorizations was conducted for transplant recipients at an urban institution.** [12] **Out of the 15% that were denied, almost half were comprised of Medicaid beneficiaries.**

   If a treatment is almost always approved through prior authorization, it may indicate that the authorization process is unnecessary and could delay important care. For instance, 85% of nearly 900 requests for immunosuppression medications after organ transplants were approved. Out of the 15% that were denied, almost half were comprised of Medicaid beneficiaries. Delays in receiving these standard-of-care medications could lead to adverse outcomes.

6. **Gainwell self-reported they are capable of adapting to CMS's final rule regarding API implementation per this informational release. CMS's final rule will provide a solution to fax insecurities starting January 1, 2027, but until then the administrative burden remains.**

   On March 7, 2023, Gainwell Technologies utilized the GlobeNewswire[13], a news distribution platform, to report the following:
   "Gainwell Technologies (Gainwell), a leading innovator in healthcare technology solutions, today announced that the nine-module Medicaid system it designed and implemented for Kansas is the first fully modular system to achieve the Centers for Medicare & Medicaid Services (CMS) Streamlined Modular Certification.
   Kansas will also become the first state with a completely modular system to receive federal matching funds from the day the system went live only ten months ago. Significantly, CMS found zero findings, which means it found no deficiencies in the platform that needed immediate attention. This is an unprecedented achievement for such a comprehensive and complex system."

[12] Muran, C., N. Khamo, R. Patel, et al. 2023. Evaluation of prior authorizations in transplant recipients at an urban institution. Clinical *Transplantation* 37, no. 6. https://pubmed.ncbi.nlm.nih.gov/36940175/.
[13] From Globe Newswire website: GlobeNewswire is one of the world's largest newswire distribution networks, specializing in the delivery of corporate press releases, financial disclosures and multimedia content to media, investors, and consumers worldwide.

7. A provider agreement between one of our selected hospitals and one of the MCOs appears to be in conflict with KMAP's billing instructions

Section 3.1.4 of the MCO's provider agreement with the hospital, which references Section 2.6 of the same agreement, reads:

3.1.4: Payers may reduce or deny payment for services which are not submitted for payment in accordance with the provisions of Section 2.6 or which are not billed or coded in accordance with Payer's criteria and standards for billing and coding practices, which includes the use of software to edit claims to ensure appropriate billing and coding practices. Payers may require appropriate documentation and coding to support payment for Covered Services. Hospital shall have the opportunity to correct any billing or coding error within one hundred and eighty (180) days of denial related to any such claim submission.

2.6 Claim Submission: Hospital may not bill a Payer for inpatient Covered Services prior to the date of discharge and shall not separate bills for Covered Services for purposes of additional payments under the Agreement, except Hospital may interim bill Payer when hospitalizations of a Member exceed 30 days, and when hospitalizations of Member are greater than or equal to sixty (60) days, interim billing is required. Hospital understands and agrees that failure to submit claims in accordance with the requirements of this section may result in the denial of such claims. Hospital understands and agrees that Hospital has one (1) year from the date of service to appeal payment by Payer. After one (1) year from the date of service, no further adjustments to payments shall be made.

KMAP FFS Provider Manual –Hospital

Pg. 8-46: Services identified in this Hospital Fee-for-Service Provider Manual as denied in an outpatient setting may also be reviewed during inpatient cost outlier review to determine if these services are medically appropriate and separately billable from the room and board charge.

Pg. 8-47: When an inpatient hospital admission is determined not to be medically necessary by the utilization reviewer and results in recoupment of payment, the provider may resubmit the claim as an outpatient service. Providers will need to review the inpatient admission recoupment letter for instructions and time frames for resubmittal.

8. KHA Recommendations for KanCare 3.0

KHA wrote a letter to the Kansas Medicaid Director, Sarah Fertig, on June 13, 2022. The letter aimed to enhance operational efficiency, improve provider engagement, and ensure patient access to necessary care within Kansas Medicaid. The barriers within the MCOs

mentioned below resulted in hospitals and providers to frequently question whether they should continue as Medicaid providers.
Kansas Hospital Association (KHA) identified significant barriers within Medicaid Managed Care Organizations (MCOs), particularly the rising prior authorization denials that disrupt provider operations and patient care. Communication inefficiencies, lengthy authorization processes, and peer-to-peer review issues have contributed to provider dissatisfaction, forcing some to reconsider their participation in Medicaid.

KHA recommended reforms under KanCare 3.0, emphasizing expedited authorization decisions, accountability in care coverage, standardization of processes, and an improved appeals system. The association further urged the elimination of prior authorization for critical services, the enforcement of clinical judgment in care determinations, the limitation of observation stays, and standardized patient transfer protocols. Additional recommendations include capping the number of Medicaid MCOs for consistency, centralizing credentialing at KDHE, and restricting provider audits and recoupment timelines.

We were not able to confirm that all issues mentioned in the KHA letter were addressed or included in the KanCare 3.0 contracts with the MCOs.

9. Impact of Prior Authorization

Prior authorization is designed to ensure appropriate, cost-effective medical care by restricting unnecessary treatments and preventing fraud. While it promotes patient safety and program integrity, research on its cost-saving effects is mixed. It helps control prescription misuse, like opioids, but can also delay access to needed treatments.

Its cost implications vary—sometimes reducing spending but also increasing administrative burdens for providers and insurers. Medicaid agencies benefit from negotiated drug rebates, but providers bear high costs, with a growing number of staff dedicated to processing authorizations.

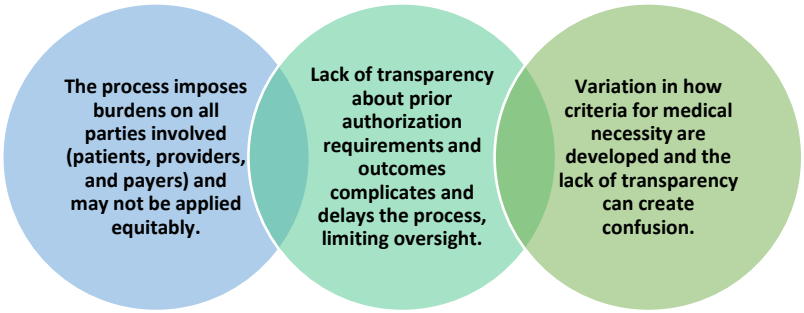
Access to care is impacted, as prior authorization often reduces service utilization and leads to delays, influencing clinical decisions and potentially worsening patient outcomes. Administrative burdens affect both providers and patients, with lengthy processes and limited adoption of electronic systems.

Health equity concerns arise due to disparities in prior authorization requirements across insurance types, racial groups[14], and geographic regions. Efforts to reform these challenges

[14] Association of Black Cardiologists, Inc. (ABC). 2019. *Identifying How Prior Authorization Impacts Treatment of Underserved and Minority Patients.* Washington, DC: ABC. https://abcardio.org/wp-content/uploads/2019/03/AB-20190227-PA-White-Paper-Survey-Results-final.pdf., as stated in Issue Brief by MACPAC in August 2024: Prior Authorization in Medicaid.

exist, but barriers remain. Transparency in reporting approval and denial rates can improve oversight, and recent regulatory efforts aim to enhance the process.

Top Issues Nationwide in Medicaid Prior Authorization[15]



10. Reform Effort Trends in State Prior Authorization Laws and Regulations

The AMA created chart[16] of states that have enacted various laws to tackle the issues discussed above. These reform efforts, outlined below, aim to address the challenges associated with the prior authorization process:

- **Gold Carding**: Temporarily exempts providers from prior authorization requirements if they achieve a high approval rate for a specific medication or service.
- **Electronic Prior Authorization**: Mandates automated systems or electronic portals for prior authorization.
- **Exceptions**: Exempts certain medications or services from prior authorization.
- **Shortened Timelines**: Requires faster prior authorization decisions.
- **Limits on Retrospective Denials:** Limits denials of payment after the service is provided.
- **Clinical Criteria**: Sets standards for developing clinical criteria.
- **Reviewer Requirements**: Ensures that qualified individuals make adverse decisions without financial incentives.
- **Transparency**: Requires payers to publish prior authorization requirements and provide the clinical basis for decisions.
- **Data Reporting**: Mandates reporting of prior authorization data to state authorities.

11. MCO POC Hospital Assignments

[15] https://www.macpac.gov/publication/prior-authorization-in-medicaid-2/

[16] American Medical Association (AMA). 2024a. 2024 Prior Authorization (PA) State Law Chart. Washington, DC: AMA. https://www.ama-assn.org/system/files/prior-authorization-state-law-chart.pdf.

During our interviews, the hospitals expressed that having an MCO POC either located within the hospital or assigned to the hospital would be advantageous to the UM process. Furthermore, they explained this would help reduce the administrative burden on both the hospital's UM staff and the MCO's UM staff, as it was a process previously followed by many Kansas hospitals.

Furthermore, testimonial evidence revealed that when a new MCO POC specifically for PA requests is hired, the MCO fails to notify the hospital of the change. Many hospitals suggested the following:

- MCOs should notify the hospitals of a new MCO POC as soon as possible.
- This notification should include the new POC's contact information.
- A new POC should be provided access to the MCO's provider portal within one month of employment to access UM-related information.

12. MACPAC, a non-partisan legislative agency, suggests ways to improve Medicaid and CHIP:

- More Transparency: Make payment data public so people understand where the money goes.
- Better Oversight: Require thorough evaluations to ensure funds are used effectively.
- Fairer Access: Track Medicaid experiences with surveys and better data collection.
- Clearer Appeals Process: Improve notices and allow independent reviews of denied claims.
- Smarter Payment Methods: Standardize payment data to help direct funds to those who need them most.

Appendix A – KDHE Response

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Janet Stanek, Secretary

Laura Kelly, Governor

July 28, 2025

Mr. Steven Anderson
Kansas Medicaid Inspector General
Office of the Attorney General
120 SW 10th Ave., 2nd Floor
Topeka, KS 66612-1597

Re: KDHE Response to Audit Report — MIG-23-000101 MCO PA & Reimbursements to Hospitals 2023

Dear Mr. Anderson,

KDHE appreciates the opportunity to review the Kansas Medicaid Inspector General's final performance audit report outlining your observations and findings regarding the Kansas Medicaid Managed Care Organizations' (MCO) utilization management (UM) processes and their impact on the hospital reimbursements from January 1, 2021, through December 31, 2023. We value our ongoing partnership and remain committed to upholding the State's high standards for quality assurance within the Medicaid Program.

KDHE concurs with several of the audit's findings and appreciates the insights provided. However, we respectfully disagree with certain conclusions drawn in the report. Where there is disagreement, we have provided additional context and clarification in our responses to the specific recommendations. KDHE remains committed to working collaboratively to strengthen program performance and accountability.

Finding #1:

Hospitals are paid 75% less than the expected DRG when inpatient claims are denied and forced to be resubmitted as outpatient claims.

Recommendations:

1.1 Advocate for Policy Changes: Work with MCOs to minimize inpatient claim denials and prevent financial losses due to claim downgrades.

2.1 Strengthen Appeals Processes: Enhance workflows to recover expected inpatient DRG values through appeals.

KDHE Response:

KDHE agrees with the overall finding: that if inpatient claims must be rebilled as outpatient this will result in a lower reimbursement. There are some valid reasons that this would occur such as when an inpatient admission does not meet the established criteria for medical necessity. In accordance with Policy E2020-054, hospitals are permitted to re-bill those services as outpatient if the inpatient admission is deemed not medically necessary. In such instances, the Managed Care Organization (MCO) recoups the original payment. Hospitals then have two options: they may re-bill the claim under the outpatient billing guidelines or submit additional documentation to support the medical necessity of the original inpatient claim.

For Recommendation 1.1, KDHE will continue to work with the MCOs as appropriate under KanCare 3.0 to assure claims are accurate and that MCOs are not, in fact, incorrectly forcing outpatient claims. Medical necessity for inpatient claims remains a mitigating factor in the application of this criteria. Policy will be rewritten if appropriate as KDHE works to ascertain if the policy is being applied correctly.

For Recommendation 2.1, KDHE affirms that the current appeals process is consistent with applicable federal recommendations. However, KDHE will use the lens provided through this audit to examine the potential for enhanced workflows around recovering inpatient DRG values through appeals.

Finding #2:

8% of claims had no evidence of MCO payments or prior insurance payments. 15% of claims had inaccurate prior payment data.

Recommendations:

1.1 Investigate Claims with No Payment Evidence: Conduct root cause analysis to identify issues and collaborate with MCOs to resolve non-reimbursed claims.

2.1 Enhance Data Transparency: Ensure hospitals provide complete and accurate claim details to prevent errors in prior payment fields.

KDHE Response:

KDHE agrees with the finding that some claims contained inaccurate prior payment data, however there were some claims that were denied correctly. One of the MCOs did have a system error during this time frame that was fixed 12/1/23. Their system was not capturing or sending other payer Clain Adjustment Reason Code (CARC)/Remittance Advice Remark Code (RARC)/Coordination of benefits (COB) information received by the provider. This caused them to send the information incorrectly on the encounter claim and it resulted in a negative Third-Party Liability (TPL) amount.

For Recommendation 1.1, KDHE will continue to investigate claims with no payment evidence and work with the MCOs to resolve any substantiated findings to determine the root cause and solutions as part of our management of KanCare 3.0.

For Recommendation 2.1, KDHE has no control over final hospital claim submission; however, we will continue to work with the MCOs as they offer multiple training opportunities each year to focus on proper claims submission. We are also committed to continuing to work collaboratively with providers to ensure ongoing education and compliance.

Finding #3:

14 hospital days (4%) were not included in the "days covered."

Recommendations:

1.1 Reconcile Coverage Data: Verify hospital day coverage to ensure claims accurately reflect total eligible hospital days.

2.1 Audit Claims Regularly: Conduct routine audits to prevent missing or incomplete coverage data.

KDHE Response:

KDHE agrees with the finding that there is a discrepancy in the days covered. KDHE ensures the claims system allows editing to align the billed days with the days covered field, as payment is calculated based on this alignment.

For Recommendation 1.1, KDHE will look into ways to edit for these types of cases and may utilize our External Quality Review Organization (EQRO) contract to review some types of high dollar claims.

For Recommendation 2.1, KDHE confirms the claims team conducts an annual audit that includes each MCO as part of our standard oversight process. Our annual contract review varies by subject matter/contract requirements. Additionally, KDHE is enhancing our EQRO (External Quality Review Organization) as part of the management of KanCare 3.0 which will allow for additional targeted reviews if deemed necessary.

Finding #4:

MCO 2 and MCO 1 paid 100% and 99% of expected DRG on inpatient claims, while MCO 3 paid 77%.

Recommendation:

1.1 Engage with MCO 3: Initiate discussions to understand why payments are below the DRG and request corrective action in order to come into compliance with the DRG payment policy.

KDHE Response:

KDHE agrees with the finding that MCOs can pay different rates. MCOs are generally obligated to use the DRG reimbursement methodology for most inpatient hospital services, but the possibility of negotiated rates exists. Additionally, based on current MCO contracts with providers, this is allowable. KDHE acknowledges that MCO 3's rates may

differ from MCO 1 and 2 per the report's data, as reimbursement rates vary based on Managed Care Organization's (MCOs) individual contracts with hospital providers. While the state contract mandates the MCOs reimburse providers at no less than the Medicaid floor rate, it also provides MCOs with flexibility to negotiate and pay higher rates. This enables hospitals to negotiate more favorable reimbursement terms with some MCOs, while others may choose an amount closer to the standard Medicaid rate.

For Recommendation 1.1, KDHE does not audit or monitor for variations in DRG rates and has elected to maintain the current processes. Receiving higher reimbursement from certain MCOs can assist in the offset of lower rates from others. If all MCOs were required to pay only the Medicaid floor rate, hospitals could potentially face reduced financial incentive to contract with Medicaid, resulting in removing a key incentive for provider participation.

Furthermore, standardizing reimbursement rates across all MCOs would conflict with existing contractual provisions and state regulations, and limit hospitals' ability to negotiate rates above the Medicaid fee schedule. For these reasons, KDHE supports maintaining the current contracting structure, which balances fiscal responsibility with provider engagement and access to care.

Finding #5:

There was a 13% payment rate for non-crossover inpatient claims lacking prior insurance payments, lower than Medicare's 16% payment rate. MCOs pay an average of 1% on inpatient crossover claims.

Recommendations:

1.1 Clarify Prior Payment Tracking: Work with MCOs to refine tracking and ensure proper reimbursement for inpatient crossover claims.

2.1 Revisit Reimbursement Policies: Advocate for higher crossover reimbursement rates to ease financial strain on hospitals.

KDHE Response:

While KDHE agrees with the finding that MCOs paid an average rate of 1% on these claims, there is a reason. Per the Medicare Savings Programs (MSPs) outlined in the Social Security Act, States are only obligated to participate in cost sharing (member deductible, coinsurance). KDHE policy E2013-048 - Medicare Related Claims Pricing Algorithm states if Medicare paid more than Medicaid's allowed amount for the service, no additional reimbursement will be made. For the majority of the crossover claims the Medicare allowed amount is more than the Medicaid allowed - this results in no additional payment. Most of the claims will have a zero paid amount.

For Recommendation 1.1, the administration of KanCare 3.0 provides for the monitoring and tracking of claims. System logic is designed to compare allowable payments to other payments listed on claims or encounters.

For Recommendation 2.1, KDHE is following current federally required Third Party Liability (TPL) Medicaid policy and the advocacy requested is not in KDHE scope. This policy requires Medicaid to be the payor of last resort. The Provider Manual regarding the TPL Pricing Algorithm stipulates KMAP will reimburse for services also covered by other insurance only when the Medicaid payment rate exceeds the payment made by the primary insurer. In such cases, KMAP will pay only the amount necessary to satisfy the member's cost-sharing liability, up to the Medicaid allowable rate. For additional information on the federal requirements governing the processing of TPL claims, please refer to 42 CFR § 433.139 – *Payment of Claims*.

Historically, KMAP rarely issues payment on crossover claims, as the majority fall below the Medicaid reimbursement threshold. The MCOs are contractually obligated to adhere to the TPL policy. KDHE continues to monitor compliance through ongoing oversight.

Finding #6:

Incorrect data entry in prior payment fields and complex claim structures prevent global analysis in KMMS.

Recommendations:

1.1 Standardize Data Entry: Implement mandatory training and quality checks to improve prior payment accuracy.

2.1 Streamline Claims Processes: Revise claim organization in KMMS to enhance data retrieval and allow for comprehensive analysis.

KDHE Response:

KDHE agrees with this finding. KDHE acknowledges the complexity of the data within the KMMS system but would like to point out the possibility that inaccurate conclusions may result from analyses that exclude encounter voids, claim adjustments from analysis of a provider, or fail to fully account for MCO billing activity on behalf of members. In some situations, encounter data may need to be voided and replaced to file a correct claim copy, particularly when resolving issues with either KMMS or the MCOs.

For Recommendation 1.1, KDHE disagrees with this recommendation. What the analyst identified as "errors" were not data entry errors. The issue with the negative TPL amounts was an MCO system issue. Our current audit process identified the issue, and the system has been fixed. Because the majority of the claims are submitted electronically – this means the data entered on the claim was entered by the biller - we have no control over what they entered but we do have some checks in place to catch possible errors. We use our current auditing process to identify areas where training may be needed. We will continue to use any auditing process to help us identify improvement opportunities. Both the MCOs and KDHE currently utilize data checks that align with HIPAA guidelines and apply edit checks to ensure programmatic compliance. Expanding these checks beyond current requirements may result in a significant work effort and could potentially lead to an increase in claim rejections or denials.

For Recommendation 2.1, KDHE agrees with this recommendation. We will look at how we can strengthen existing processes and collaborate with the MCOs to help improve the accuracy and complexity of the data, especially in cases where claim resubmissions occur. While there is currently an indicator that identifies the most recent claim when resubmissions occurred, this is dependent on both the MCOs, and providers consistently following the void and replace process. When standard processes are not followed, the reliability of the claim indicators is compromised. This is further complicated by the requirement to process each claim as it is submitted. KDHE must still accept those submissions if they meet HIPAA guidelines. To address these challenges, for future reviews, KDHE would like to work directly with OIG to develop the most efficient method of analysis of the data.

Finding #7:

Payment rates for inpatient claims vary, with a combined 13% payment rate for claims without prior insurance payments.

Recommendations:

1.1 Develop Performance Metrics: Establish key performance indicators to track payment rates, denial trends, and coverage accuracy.

2.1 Foster Collaboration: Hold regular discussions with MCOs to resolve payment discrepancies and improve claim outcomes.

KDHE Response:

KDHE agrees with the finding that MCOs can pay different rates.

For Recommendation 1.1, KDHE actively monitors and validates that MCOs comply with the requirement to pay at minimum the Medicaid floor rate. KDHE will review our key performance indicators that track payment rates, denial trends and coverage accuracy to seek improvements.

For Recommendation 2.1, KDHE notes that we currently collaborate with MCOs on payment discrepancies. It is important to note that, per policy, Medicaid is the payer of last resort. As outlined in our response to Finding 4's recommendation, MCOs are required to pay the Medicaid floor rate, which is established and approved by the Legislature for covered services provided. However, hospitals and other providers are permitted to negotiate higher rates with the MCOs.

Finding #8:

Unsecure UM Communication via Fax

Fax-based UM communication for PAs is outdated, causing security risks, miscommunication, lost or incomplete content transmitted, and overall delays in the PA process. House Bill 2283 (2023) addresses these issues, advocating for more transparent electronic alternatives.

Industry leaders, including Saint Luke's Health System CEO Robert L. Olm-Shipman, support shifting to electronic processes for faster approvals and appeals, improving care delivery. Similarly, MACPAC highlights the excessive time and resources spent on manual prior authorization methods, with physicians averaging 43 requests per week and 12 hours spent processing them, according to an American Medical Association physician survey.

Interviews with Kansas hospitals suggest intentional delays in UR by MCOs. A ProPublica report revealed a $13M lawsuit settlement against Carelon, formerly AIM Specialty Health, for practices obstructing coverage approvals, including limiting fax pages to deny documentation.

To address inefficiencies, CMS issued a final rule (Jan. 17, 2024) requiring Medicaid Managed Care payers to adopt an API for PAs by 2027, streamlining approvals and reducing administrative burdens.

Recommendations:

1.1 Hospitals must have all paper-based fax machines or multifunction printers (MFPs) in a secure location that can only be accessed by authorized individuals. These paper-based devices can be a breach risk if the device is not in a secured location and limited to authorized access only.

2.1 Update all paper-based devices to a digital fax solution. These digital solutions exchange content electronically and deliver it directly to its intended recipient. Recipients can access the content at their computer, within an application or secured network folder. This allows the content to remain private and only can be viewed by authorized users. Digital fax solutions also normally adapt to electronic medical records (EMRs) for ease of uploading or delivering protected health information (PHI) from within an application. Removing the administrative burden of handling paper documents, scanning, and processing paperwork. Digital fax also aids in minimizing the risk of lost or misplaced fax content.

KDHE Response:

KDHE agrees with this finding. While providers do sign the Provider Agreement that states they must read the Hospital Manual before providing services and must follow all HIPAA regulations, the KMAP Provider Agreement itself could more explicitly address HIPAA compliance. KDHE intends to update the KMAP Provider Agreement to help strengthen the HIPPA language and ensure a more secure process for fax transmissions. KDHE has a plan to implement the APIs required by CMS Final Rule 0057 with our current interoperability vendor. This is part of our roadmap of system changes.

For Recommendation 1.1, although the State does not have authority to mandate changes to hospital operations or equipment, KDHE can collaborate with MCOs to update their MCO provider enrollment agreements. These updates may encourage hospitals to either relocate fax machines to secure areas or transition to electronic fax submissions. The State will monitor and work with MCOs to ensure that contracts with hospitals include

strong language supporting secure and timely fax-based utilization management (UM) communication for prior authorizations. To help safeguard PHI, KDHE will review and evaluate these contracts for inefficiencies and work to address any gaps, then remediating by applying the CMS Final Rule.

For Recommendation 2.1, KDHE acknowledges the importance of hospitals utilizing a digital fax solution. All three MCOs currently have the capability to receive prior authorization requests electronically through their provider portals, which is their preferred method. While Sunflower and Aetna continue to accept faxed requests, United Healthcare no longer allows this form of submission. Due to the availability of receiving prior authorizations electronically through the MCO's provider portal, any effort to implement this recommendation should be initiated and coordinated between the MCOs and the hospitals. KDHE can work with the MCOs to raise awareness of this issue and recommend stronger contract language between the MCOs and hospitals.

KDHE understands the issue of unsecure paper-based or multifunction printers not only affects Medicaid, but other insurance companies as well. KDHE is committed to strengthening HIPAA compliance efforts for the benefit of all patients, regardless of insurance coverage.

Finding #9:

Hospital-Issued Notices of Noncoverage (HINN)

Hospitals may provide HINNs to Medicaid beneficiaries before admission, at admission, or during an inpatient stay. HINNs are provided when the hospital determines that the beneficiary's items or services are not covered. However, HINNs are not used to inform beneficiaries who are receiving observation services in outpatient status, or to communicate they are not on inpatient status while in the hospital.

K.A.R. 30-5-59(e)(4) states that each participating provider shall *not charge any Medicaid/MediKan program consumer for noncovered services unless the provider has informed the consumer, in advance and in writing, that the consumer is responsible for noncovered services;*

Recommendations:

1.1 Medicaid beneficiaries should receive notice similar to the Medicare Outpatient Observation Notice (MOON). MOON informs Medicare beneficiaries who are receiving observation services as outpatients that they are not inpatients and explains the implications of outpatient status on Medicare cost-sharing and coverage for post-hospitalization SNF services.

2.1 The Medicaid notice, like the MOON, should be provided within 36 hours of observation services initiation or upon release, whichever is sooner.

KDHE Response:

KDHE does not agree with this finding.

For Recommendation 1.1, A MOON or something similar is delivered by a hospital. The MOON is required by statute to be delivered by hospitals to Medicare beneficiaries. KDHE currently does not have a way to inform Medicaid beneficiaries who are receiving observation services as outpatients that explains the implications of outpatient status and the coverage for post-hospitalization SNF services. While a MOON is not currently used in Medicaid, the current Explanation of Benefits (EOBs) is used by the MCOs meet the requirements suggested within the KanCare contract. Within an Issue Brief issued by your office on 5/27/25 your recommendation was as follows: "Update contract or Kansas statute to require MCOs (UnitedHealth Care, Healthy Blue, and Sunflower) to provide electronic EOB notifications on a per-claim or monthly basis. The contents of the EOB should consist of:

A list of services provided and billed to the health plan:

- The name of the provider furnishing the service.
- The date on which the service was furnished.
- Clear contact for recipient services.
- Instructions for reporting suspected fraud.

All three KDHE MCOs (Healthy Blue, Sunflower, and United Healthcare) offer EOB access to members through their member portals on their websites. Their EOBs include the following items that detail claim service payment or denials, and meet the requirements within our contract:

- Dates of services.
- Procedure codes.
- Amount billed; amount allowed, & amount paid.
- Patient liability.
- Provider that submitted the claim.
- MCO contact instructions.

Additionally, both Healthy Blue and United Healthcare have a paper copy available to members. Healthy Blue also lists suspected fraud instructions. We could request that Sunflower and United Healthcare add this as well. We agree that electronic delivery is by far the most cost-effective way to deliver this information to members and is already figured into the MCOs capitated payments. By offering through the member portals, KDHE is meeting the electronic delivery. If KDHE were to require paper notices be sent to all members, that would increase costs to the program and funding would be required to support paper versus electronic delivery.

For Recommendation 2.1, KDHE reiterates that a MOON or a HIIN would be provided by the hospital. Medicaid does not provide any kind of notice to a member prior to or while in the hospital for an observation stay. KDHE understands the value of this type of notification, however, feel that we do not have the staffing or budget to be able to accomplish this task. Medicaid member EOBs are available in MCO member portals once claims have been processed.

Finding #10:
Finding – Conflicts of Interest with KanCare MCO

Two related conflict-of-interest scenarios were identified involving UnitedHealthcare, a KanCare MCO:

- Clinical Criteria Screening Tool Ownership: UnitedHealthcare owns and utilizes its own proprietary clinical decision support tool to evaluate prior authorization (PA) requests. These tools apply a series of decision rules using diagnosis, symptoms, medical history, and lab results to determine medical necessity. By controlling the tool's logic, design, and algorithms, the MCO has the ability to influence approval rates, reduce medical expenditures, and enhance internal performance metrics without independent validation.
- Claim Review Vendor Affiliation: Hospitals reported utilizing claim review services offered by Optum and Change Healthcare—subsidiaries of UnitedHealthcare. These vendors apply Correct Coding Initiative (CCI) edits to verify compliance with Kansas Medical Assistance Program (KMAP) standards. The ownership arrangement enables vertical integration between payer and review functions, introducing a self-monitoring dynamic that can compromise neutrality in claims validation.

These circumstances stem from limited restrictions in vendor selection and ownership disclosure requirements within the KanCare program. Current policies do not explicitly prohibit MCOs from owning decision-making tools or claim review vendors, nor do they mandate external audits of affiliated systems.

Recommendations:

1.1 Prohibit Ownership of Clinical Screening Tools
KanCare MCOs should be restricted from using or owning proprietary PA decision tools. Prior authorization determinations must rely on independently validated clinical criteria to ensure fairness, transparency, and consistency across payers and providers.

2.1 Require Third-Party Claim Review Vendors
The state should mandate the use of independent, unaffiliated claim review entities for all MCOs. This safeguards objectivity in coding validation and ensures compliance with KMAP standards without influence from the MCO's financial interests.

3.1 Enhance Disclosure Requirements
MCOs must disclose ownership ties to any vendors involved in clinical or billing operations, with mandatory reporting on algorithmic logic and outcomes for both PA decisions and coding edits.

4.1 Strengthen State Oversight
KDHE and other oversight bodies should conduct regular audits of PA tools and claim review platforms, especially those linked to MCOs. These audits should verify fairness, review denial patterns, and assess coding error suppression.

5.1 Revise Procurement and Contracting Standards

Future KanCare contracts should include explicit language prohibiting vertical integration that compromises impartiality in medical necessity determinations or claim validation.

KDHE Response:

KDHE agrees with this finding. We acknowledge the use of Interqual, which is United Healthcare's proprietary clinical criteria screening tool, along with claim review services, also offered by Optum and Change Healthcare, presents a perceived conflict of interest. The health care industry is changing quickly with health plans now acquiring billing, health screening and other such companies creating new dynamics not only for Medicaid but all payors. CMS does have conflict of interest provisions that state Medicaid programs must follow, but to date United acquiring billing and other health care companies and continuing to use those products is not a conflict per the current standards. KDHE also recognizes these tools are used by all three contracted MCOs in Kansas which creates additional dynamics if KDHE were to try and restrict United use but allow other MCOs to use such tools. These tools are widely used and accepted by healthcare providers across the nation to make medical decisions and validate claims.

For Recommendation 1.1, KDHE agrees that restricting the KanCare MCO, United Healthcare from using their proprietary tool, or owning any proprietary PA decision tool, would likely ensure fairness, transparency, and consistency across payers and providers. Kansas will evaluate options in its capacity to limit the use of such a proprietary tool. United Healthcare is a large health corporation with many subsidiaries across the United States. It would be difficult to convince United Healthcare to agree contractually with our recommendations and KDHE currently does not have any statutory or CMS regulation to require United to accept such restrictions.

As for Recommendation 2.1, KDHE agrees with using independent, unaffiliated claim review entities. This practice can help safeguard objectivity in coding validation, ensure compliance with KMAP standards, and allow the state to operate without the influence of the MCOs financial interests. MCOs are required to follow KDHE specific policies and Medicaid National Correct Coding Initiative (NCCI) structured by CMS when utilizing their own tools. United Healthcare is a large company that acquired Change Healthcare (their subsidiary). This has afforded United Healthcare a large portion of the national market in claims and coding. It would be difficult to convince United Healthcare to agree to moving away from the use of this vendor.

For Recommendation 3.1, KDHE agrees MCOs should disclose ownership ties to any vendors or subsidiaries involved in clinical or billing operation with mandatory reporting on algorithmic logic and outcomes for both PA decisions and coding edits. Currently the MCOs have full responsibility and oversight of their own claims. KDHE will be notified by the providers of claim denials that should normally be covered by Medicaid. If said reporting is supplied to KDHE, we would need full time employees (FTE) hired to audit the given reports.

As for Recommendation 4.1, KDHE agrees that PA tools and claim review platforms, especially those linked to MCOs should have more oversight and regular auditing. As mentioned in recommendation 3.1, the MCOs have full responsibility and oversight of their own claims. KDHE would need FTEs hired to have the capacity of auditing said reports.

For Recommendation 5.1, KDHE agrees that future KanCare procurement contract standards should include explicit language that the state will have tight auditing and oversight standards to safeguard objectivity in claims review and PA standards. Also, an expectation of the contractor to show in the RFP response how they will safeguard impartiality in medical necessity determinations or claim validation.

Finding #11:

Multiple methods of communication used in hospitals to submit prior authorizations and appeals has contributed to the administrative burden of the hospital UM teams.

Testimonial evidence revealed that hospitals are often left uncertain as to what method is supposed to be used for sending or receiving information to or from the MCOs. The various methods of communication for UM teams are provider portals, phone calls, fax, or mail. Various communication methods paired with the lack of one designated method of communication has contributed to the administrative burden of hospital UM teams.

Recommendations:

1.1 Standardize the method of communication between hospitals and MCOs for sending or receiving information to or from the MCO.

KDHE Response:

KDHE agrees with this finding. KDHE recognizes the approach of MCOs utilizing the same communication platform could offer potential efficiencies and standardization.

For Recommendation 1.1, while the recommendation is certainly ideal, implementation would be highly complex due to each MCO currently operating on their own proprietary platform. This requirement may increase administrative overhead for the MCOs, which would be captured in future capitation rates. KDHE would need to conduct a cost benefit analysis to determine whether this provides a return on investment or other alternatives that would improve current state.

In addition to costs, KDHE has concerns regarding the potential risks associated with sharing a single platform across all MCOs. Specifically, there is a heightened risk that member information could be misrouted or disclosed to the incorrect MCO. Advancements in technology likely mitigate some of these risks, any shared system would require rigorous safeguards to protect member privacy and ensure data accuracy. Given the volume of users across multiple entities and locations, the potential for user error remains a concern.

In alignment with CMS, KDHE plans to implement the CMS Final Rule 0057 (linked below), which aims to promote-more efficient and transparent prior authorization processes

through technological advancements and standardized information exchanges via API's (Application Programming Interfaces). CMS intends for these changes to improve the patient experience and enhance access to care. By finalizing several new requirements for prior authorization processes, CMS seeks to reduce the administrative burden on patients, providers, and payers.

To streamline the prior authorization process, CMS is requiring impacted payers to implement and maintain a Prior Authorization API. In the proposed rule (linked below for reference), CMS refers to this as the "Prior Authorization Requirements, Documentation, and Decision API (PARDD API). On January 1, 2027 (or the actual compliance date), payers will be required to make available data about all active prior authorizations, regardless of how long they have been active, and any requests that have had a status update within the previous 1 year period (that is since January 1, 2026, if a payer implements on these changes on that day).

https://www.cms.gov/files/document/fact-sheet-cms-interoperability-and-prior-authorization-final-rule-cms-0057-f.pdf

https://www.federalregister.gov/documents/2024/02/08/2024-00895/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-advancing-interoperability

Finding #12:

MCOs frequently do not honor to the scheduled time for P2P calls

MCOs frequently do not honor the scheduled time for P2P calls, resulting in the working physician taking the call instead of the treating physician. This lack of familiarity with the patient's condition often renders the P2P to be less effective. Furthermore, when the treating physician is unavailable on the day of the scheduled P2P, the working physician may be specialized in a different area of care (specialty) than the treating physician, further leading to unjust denials. As a result, physicians conduct extensive monitoring and effort to justify the medical necessity of the patient's status or requested services.

As mentioned in testimonial evidence, each MCO has their own availability for P2Ps.

- **MCO 1** – has a dedicated P2P team of doctors that are available Monday through Friday from 7:00 a.m. to 7:00 p.m.
- **MCO 2** – did not provide a specific time that they are available for P2Ps.
- **MCO 3** – P2Ps generally occur during business hours, Monday through Friday, 8 a.m. to 5 p.m. If the provider is unavailable, medical directors may accommodate by leaving voicemails or rescheduling.

The variation in P2P availability can also contribute to the treating physician being unavailable on the day of the scheduled P2P if their normal work schedule is outside the MCO's P2P team hours.

Recommendations:

Hospitals can improve the effectiveness of P2P calls, reduce physician fatigue, and ensure fairer decision-making regarding patient care by implementing the following:

1.1 Standardized Scheduling Protocol – Establish a standardized scheduling protocol that mandates MCOs to adhere to the agreed-upon P2P call times. This could include penalties for missed scheduled calls to ensure compliance.

2.1 Advance Notice Requirement – Require MCOs to provide advance notice of any changes to the P2P schedule. This would allow the treating physician to be available or to arrange for another suitable physician familiar with the patient's case.

3.1 Dedicated P2P Coordinators – Appoint dedicated P2P coordinators within hospitals to manage and oversee the scheduling and conduct of P2P calls. This could help ensure that the appropriate physician is always available for the call.

4.1 Use of Telemedicine Platforms – Implement telemedicine platforms that provide real-time notifications and reminders to both MCOs and physicians about scheduled P2P calls. This can help in minimizing scheduling conflicts.

5.1 Policy Advocacy – Advocate for policy changes at the state level to mandate stricter regulations on MCO scheduling practices. This could include legislation that enforces timely and effective P2P calls.

KDHE Response:

KDHE agrees with the finding. KDHE acknowledges that implementing a standardized scheduling protocol would enhance efficiency and coordination.

For Recommendation 1.1, KDHE believes there is a level of complexity to implementing these recommendations. To effectively evaluate the recommendations and determine appropriate next steps, the state would like to assess additional MCO data on missed P2P calls that were scheduled. In KanCare 3.0, new contract language has been included that requires a like-trained physician to conduct P2P calls. These applicable contract changes will be evaluated in the data as well. This data will enable KDHE to assess the scope of the issue and inform a data-driven approach. KDHE would then evaluate the data and form a workgroup consisting of KDHE and MCO clinical teams to address identified barriers with P2P scheduling and calls to form a more efficient P2P implementation strategy.

For Recommendations 2.1, 3.1, If such implementation strategy is established, accompanying rules and regulations (such as an advance notice requirement) may be adopted as part of the implementation process. Should an advance notice requirement be formalized, the state believes there would be no need for dedicated Peer-to-Peer (P2P) coordinators. Decisions regarding staffing or process changes would remain at the discretion of each hospital, in consultation with MCOs and their Medical Directors.

For Recommendation 4.1, on the use of telemedicine platforms, KDHE does not believe that their use is necessary in this context. P2P calls are scheduled directly on the MCO

Medical Director's calendar, and the call is initiated by the MCO to the facility physician. In most cases, the facility physician is aware of the nature of the call. While there may be instances, particularly in larger hospital systems, where the call is received by a third-party physician representing the facility, telemedicine would add another complex layer of communication, that in KDHE's opinion, does not substantiate the need for this communication platform for P2P interactions.

For Recommendation 5.1, KDHE does not plan to pursue policy advocacy. P2P calls are sometimes unavoidable, because clinical staff at provider facilities are often operating under high-demand schedules, and where interruptions are common.

Finding #13:

MCOs frequently deny hospital claims for readmissions within 30 days, even if the new admission is unrelated. Labeling these denials as "administrative denials" allows them to reject claims and avoid payment.

Hospitals report that MCOs frequently deny requests for LTACH placements, steering patients toward lower-cost PAC options instead. These denials often lead to preventable hospital readmissions, which the MCOs then refuse to cover—frustrating providers. Additionally, MCOs frequently reject readmission claims within 30 days of discharge, even if the subsequent admission is unrelated. This causes the hospital to lose money when claims associated with readmissions are denied. The delays in PAC PAs also reduce hospital bed availability, leading to longer wait times for ER patients and hospital transfers.

Hospitals further report that MCOs blame them for failed discharge plans when readmissions occur, even when PAC PA requests for medically necessary facilities were denied. Some MCOs rely on proprietary criteria, such as InterQual, but refuse to share these standards with hospitals. As expressed through their testimonies, the hospitals experienced inconsistent claim approvals. If the hospital submitted PA requests with identical diagnoses and length of stay, the identical requests would receive different PAC determinations.

This inconsistency suggests there is a lack of structured internal criteria for evaluating PA requests. Ultimately, patients are not receiving appropriate PAC for recovery. Instead, many are sent home with insufficient care, increasing the likelihood of readmission. The MCOs demonstrate prioritizing cost containment by approving PAC at minimal levels while leveraging KMAP policy loopholes to deny hospital readmissions within 30 days of the previous admission.

Recommendation:

1.1 Update KMAP, FFS Provider Manual, Hospital Services, Section 8410 to include language that removes the loophole which MCOs appear to be using to deny hospital payments for readmissions when PAC PA requests for medically necessary facilities were denied inappropriately by the MCO (underlined below):

Kansas Medical Assistance Program (KMAP), FFS Provider Manual, Hospital Services, Section 8410

Readmissions may be subject to utilization review. Utilization review of readmissions will occur for members who are readmitted as an inpatient to a general hospital between 1 and 15 days of discharge. Readmission guidelines for days 2-15 of a hospital stay do not apply if Medicaid is not the primary payer of the initial inpatient stay claim.

Shall be reviewed to determine if the readmission was the result of an inappropriate discharge from the initial admission based on one of the following criteria:

- *A medical readmission for a continuation or recurrence for the initial admission or closely related condition (e.g. readmission for diabetes following an initial admission for diabetes).*
- *A medical complication related to an acute medical complication related to a care during the initial admission (e.g. patient discharged with urinary catheter readmitted for treatment of a urinary tract infection).*
- *An unplanned readmission for a surgical procedure to address a continuation or a recurrence of a problem causing the initial admission (e.g. readmitted for appendectomy following a primary admission for abdominal pain and fever).*
- *An unplanned readmission for a surgical procedure to address a complication resulting from care from the primary admission (e.g. readmission for drainage of a post-operative wound abscess following an initial admission for a bowel resection).*
- *The unplanned readmission is the result of a need that could have reasonably been prevented by the provision of appropriate care consistent with accepted standards prior to discharge or during the post-discharge follow-up period.*
- *An issue caused by a premature discharge from the same facility.*
- *Readmission is medically unnecessary.*

KDHE Response:

KDHE agrees with this finding. KDHE appreciates the concern expressed regarding patients potentially not receiving appropriate post-acute care (PAC) necessary for optimal recovery. Based on the data reviewed, this may not solely lay on the MCO. Yet, KDHE recognizes that if a MCO is reviewing at 16-30 days post-discharge, there is violation of state regulatory language and that will be reviewed.

For Recommendation 1.1, KDHE is concerned the recommendation may suggest covering all hospital readmissions without sufficient regard for potential quality issues that often contribute to those readmissions. It is important that readmissions be reviewed on a case-by-case basis as there are a variety of reasons why readmission may occur. Some reasons may be related to quality or care issues that need to be addressed, as it is not appropriate that Medicaid expenditures would increase due to these issues not being overseen.

Eliminating scrutiny in such cases may inadvertently allow systemic quality concerns to go unaddressed. Unfortunately, the State has no other way of encouraging hospitals to address quality surrounding hospital discharges except to not cover diagnostically related readmissions. KDHE will discuss further internally regarding this recommendation.

KDHE will do further research regarding the assertion that delays in PAC prior authorizations are the primary driver of post-acute care (PAC) bed unavailability. KDHE understanding from the MIG reports, the information suggests many PAC facilities decline to admit complex Medicaid patients (which is the population involved in much of the chronic readmission work) due to the financial mismatch between reimbursement rates and the true cost of care. As a result, these admissions often represent a financial loss for the facilities, which understandably influences admission decisions. It is important to recognize that challenges related to PAC prior authorization and the timing of decisions are not the sole responsibility of the MCOs. These issues typically involve a triad of entities: the discharging hospital, the PAC provider, and the MCO. Each plays a role in the process, and resolution requires coordinated effort and accountability among all three parties. Ultimately, to support improvements in the PAC process, including solutions to PAC PA delays, KDHE will consider collaborating with MCOs to tracking challenging situations, monitor related processes, and facilitate real-time resolution of difficult PAC placements.

In addition, and recognizing hospital's financial losses with these processes, KDHE submitted a budget enhancement request that was sent to the legislature for a partial hospitalization fund for patients who no longer met medical necessity but had no viable discharge option. The request did not get included as a budget enhancement as it was appealed in November and was not approved to move forward in the budget process last year.

Finding #14:

The language in K.A.R. § 129-1-1(oo)(1) lacks clarity and specificity, creating opportunities for misinterpretation and misuse.

KAR 129-1-1 Definitions were amended by Kansas Register Volume 43, No. 50; effective 12/27/2024. A review of the definition was conducted to determine if insurance providers could potentially exploit vague or flexible wording in the definition. The amended definition language is provided below:

K.A.R. § 129-1-1(oo)(1) *"Medical necessity" means that a health intervention is an otherwise covered category of service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:*

(A) Authority. The health intervention is recommended by the treating physician and is determined to be necessary by the secretary or the secretary's designee.

(B) Purpose. The health intervention has the purpose of treating a medical condition.

(C) Scope. The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) Evidence. The health intervention is known to be effective in improving health outcomes.

(i) For new interventions, effectiveness shall be determined by scientific evidence as described in paragraph (oo)(3).

(ii) For existing interventions, effectiveness shall be determined by scientific evidence as described in paragraph (oo)(4).

(E) Value. The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. Cost-effective shall not necessarily be construed to mean lowest-priced. An intervention may be medically indicated and yet not be a covered service or benefit or meet the definition of medical necessity in this subsection. Interventions that do not meet this regulation's definition of medical necessity may be covered at the discretion of the secretary or the secretary's designee. An intervention shall be considered cost-effective if the benefits and harms relative to the costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the condition of the individual patient shall be determinative.

K.A.R. § 129-1-1(oo)(2) *The following definitions shall apply to these terms only as they are used in this subsection:*

(A) "Effective," when used to describe an intervention, means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(B) "Health intervention" means an item or covered service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For the definition of medical necessity in this subsection, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which the health intervention is being applied.

(C) "Health outcomes" means treatment results that affect health status as measured by the length or quality of a person's life.

(D) "Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

(E) "New intervention" means an intervention that is not yet in widespread use for the medical condition and patient indications under consideration.

(F) "Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. However, if controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be considered to be suggestive, but shall not by themselves be considered to demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be

explained either by the natural history of the medical condition or by potential experimental biases.

(G) "Secretary's designee" means a person or persons designated by the secretary to assist in the medical necessity decision-making process.

(H) "Treat" means to prevent, diagnose, detect, or palliate a medical condition.

(I) "Treating physician" means a physician who has personally evaluated the patient.

***(3)** Each new intervention for which clinical trials have not been conducted because of epidemiological reasons, including rare or new diseases or orphan populations, shall be evaluated on the **basis of professional standards of care or expert opinion** as described in paragraph (oo) (4).*

***(4)** The scientific evidence for each existing intervention shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, **professional standards of care shall be considered.** If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Coverage of existing interventions shall not be denied solely on the basis that there is an absence of conclusive scientific evidence. Existing interventions may be deemed to meet the definition of medical necessity in this subsection in the absence of scientific evidence if there is a strong consensus of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of those standards, **convincing expert opinion**.*

Our review concluded that insurance providers could potentially exploit the vague or flexible wording in the definition of "medical necessity" above in several ways. These loopholes could lead to delays, denials, or restrictions on care, impacting patients who rely on timely and necessary treatments.

Identified potential loopholes are:

- Subjective Approval Process – Since approval depends on a physician's recommendation and the judgment of an authority, insurers could impose stricter criteria or override physician recommendations, leading to denials.
- Cost-Effectiveness Clause – The requirement that an intervention be "cost-effective" compared to alternatives allows insurers to favor cheaper treatments, even if less effective, by arguing they still provide some benefit.
- Vagueness in Scientific Evidence – While controlled trials are preferred, insurers could selectively interpret research, dismiss observational studies, or demand higher standards of proof to deny coverage.
- Exclusion of Certain Treatments – Even if an intervention meets the criteria for necessity, the definition allows exclusions from coverage, meaning insurers could deny payment based on policy restrictions rather than patient need.

- Discretionary Coverage – The definition states that some medically indicated treatments might still not be covered, leaving room for insurers to deny services they deem too expensive or unnecessary, even if experts agree they are beneficial.
- Limited Consideration for Individual Cases – While individual patient needs are supposed to be considered in cost-effectiveness decisions, insurers might apply broad policies without fully evaluating unique circumstances.

Further K.A.R. § 129-1-1(oo)(3-4) references professional standards of care without providing a clear definition or guidance on their application. This absence of well-defined terminology undermines the consistent application of the regulation and increases the risk of abuse. Additionally, paragraph ***(4)*** relies on expert opinion as a determining factor, but the phrasing suggests that such opinions are only valid if they are deemed persuasive in the context of defining medical necessity. This approach may compromise the objectivity and reliability of expert assessments.

Recommendations:

1.1 Update the statutory language to include a clear definition for 'professional standards of care' to eliminate the application of this regulation to be abused.

2.1 Update the statement and remove the word 'convincing' in paragraph (4) of this current statute when used in *convincing expert opinion*, removing the implication that the expert opinion is only valid when it is successfully persuasive in consideration of the definition medical necessity.

KDHE Response:

KDHE disagrees with this finding. KDHE would like to clarify that while KAR 129-1-1 ("Definitions") was amended in December, the definition of *medical necessity* was not modified during that update.

KDHE understands the assertion that the current approval process for medical necessity is subjective. There is a level of subjectivity involved in service decisions of claims. KDHE regulates the MCOs' subjectivity by requiring use of our medical necessity regulation (which contains safeguards for the agency), our PRTF medical necessity criteria, our policies for services/DME, and our authorization criteria for medications. The MCOs are required to utilize State resources first, then may use clinical policies of their own where needed. In the managed care model, the State has delegated the authority to determine medical necessity to the managed care organizations (MCOs), as per their contractual agreement with the State. These contracts explicitly require that MCOs apply the provisions of KAR 129-1-1 when making medical necessity determinations. Specifically, KAR 129-1-1(oo)(1)(A) mandates that the treating physician and the State agency's Secretary (or the Secretary's designee) agree that a proposed health intervention is medically necessary for it to be approved. When there is disagreement between both parties, the MCO may override the physician's recommendation and deny the request.

All denials are subject to an appeal. KDHE monitors the volume and subject matter of denials that are appealed and reviews every State Fair Hearing case related to denials.

Importantly, the State must agree with the MCO's decision before it will defend that denial in a State Fair Hearing. The MCOs are required to support each adverse denial decision ~~of~~ by referencing all resources they used in the notices. That documentation is part of the documentation for every State Fair Hearing. Annually, KDHE will also audit the MCO's decision process by reviewing all documentation and every step that led to a State Fair Hearing.

KDHE also disagrees with the assertion that the cost-effectiveness clause skews the approval or denial of claims. KAR 129-1-1(oo)(1) requires that all five criteria outlined in subparagraphs (A) through (E) must be met for a treatment to be deemed medically necessary. An argument that a cheaper treatment will be more cost-effective is appropriate only if all required medical necessity criteria are met. Given the complexity and variability of scientific evidence, MCOs do not base their determinations exclusively on clinical studies. Instead, they follow KAR 129-1-1's medical necessity definition and use State-approved clinical guidelines. Clinical studies may be referenced for particularly complex, rare, or specialized services, treatments, or durable medical equipment (DME).

KDHE acknowledges that certain excluded services may not align with individual patient needs. However, under federal guidance from the Centers for Medicare and Medicaid Services (CMS), certain exclusions are permissible. For instance, Medicaid restricts coverage for adult dental services, even when such services may be medically necessary.

KDHE also clarifies that while some services may appear discretionary, CMS permits Medicaid programs to cover non-traditional services under the "In Lieu of Services" (ILOS) authority—those provided services are on the CMS-approved ILOS list. Additionally, under KAR 129-1-1(oo)(1)(E), coverage discretion is afforded to the Medicaid program's Secretary or the Secretary's designee (i.e., the MCO), allowing interventions that do not meet the strict definition of medical necessity, when appropriate. Therefore, KDHE disagrees that individual cases receive limited consideration. With State approval, MCOs have flexibility to cover services that fall outside the standard regulatory definition of medical necessity. The monitoring of the KanCare 3.0 contract allows for additional validation of the application of these practices among the three MCOs.

For Recommendation 1.1, KDHE disagrees. The Department that these are overseen by the Medicaid program's Medical Director (a licensed physician) and the Deputy Director of Clinical Services (a licensed nurse). It is not necessary to define these standards within regulation, as they can be addressed contractually with the MCOs for clearer and more adaptable guidance. KDHE agrees that the State can more clearly define professional standards of care in its contract with the MCOs. This will ensure the MCOs' medical necessity decisions meet the professional standards of care required for the Medicaid program and for maintenance of State licensure.

For Recommendation 2.1, KDHE disagrees. KDHE supports the language in paragraph (4) regarding the use of *expert opinion* in the absence of consistent and up-to-date professional standards of care. While this situation is expected to be rare, it is essential that *expert opinion* remain an option. In such cases, the Medicaid program's Medical Director would consult with the MCOs' Chief Medical Directors to reach appropriate

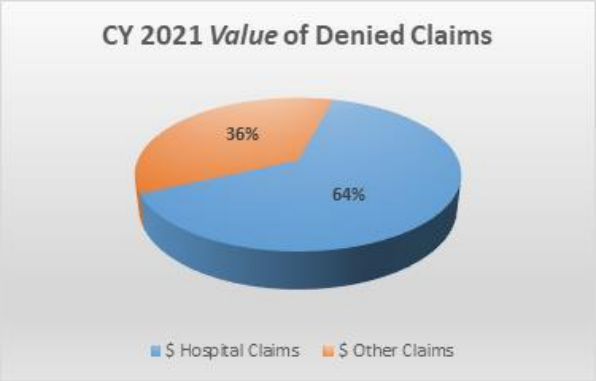
determinations. KDHE supports retaining the term *"convincing expert opinion"* in the regulation, as placing the term "*convincing*" in front of expert opinion narrows its application and makes the use of *expert opinion* more precise.

Finding #15:

Significant trends for Hospital Claims from the KanCare Summary of Claims Adjudication Statistics

CY 2021: The *number* of denied claims for Hospital services averaged only 7% of all denied claims. However, the *value* of denied Hospital claims disproportionately averaged 64% of all denials.

- MCO 1: The value of all services denied was $1,427,654,908. Hospital claim denials accounted for $921,732,748 (65%).
- MCO 2: The value of all services denied was $876,443,203. Hospital claim denials accounted for $633,157,066 (72%).
- MCO 3: The value of all services denied was $1,258,015,913. Hospital claim denials accounted for $696,988,584 (55%).

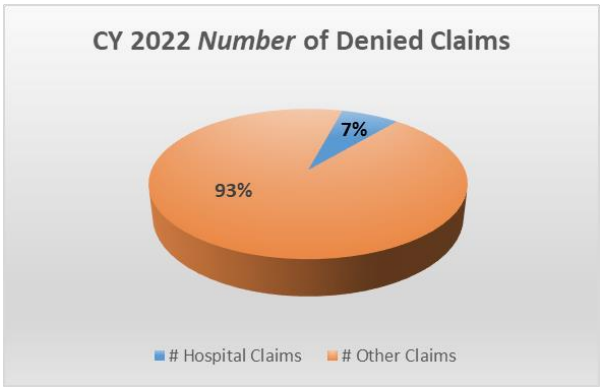


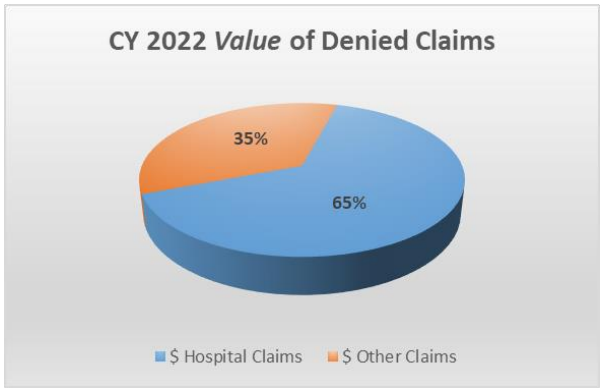
CY 2022: The *number* of denied claims for Hospital services averaged only 7% of all denied claims. However, the *value* of denied Hospital claims disproportionately averaged 65% of all denials.

- MCO 1: The value of all services denied was $1,658,564,120. Hospital claim denials accounted for $1,022,239,851 (62%).
- MCO 2: The value of all services denied was $926,806,509. Hospital claim denials accounted for $659,333,189 (71%).

- MCO 3: The value of all services denied was $1,477,490,969. Hospital claim denials accounted for $899,546,297 (61%).

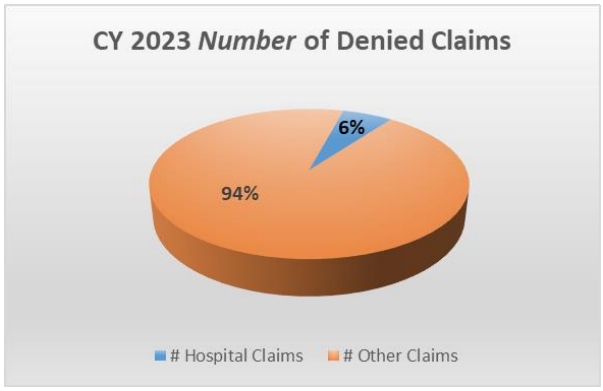
CY 2023: The *number* of denied claims for Hospital services averaged only 6% of all

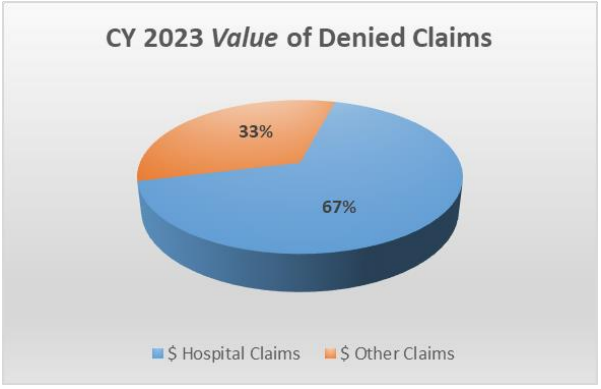




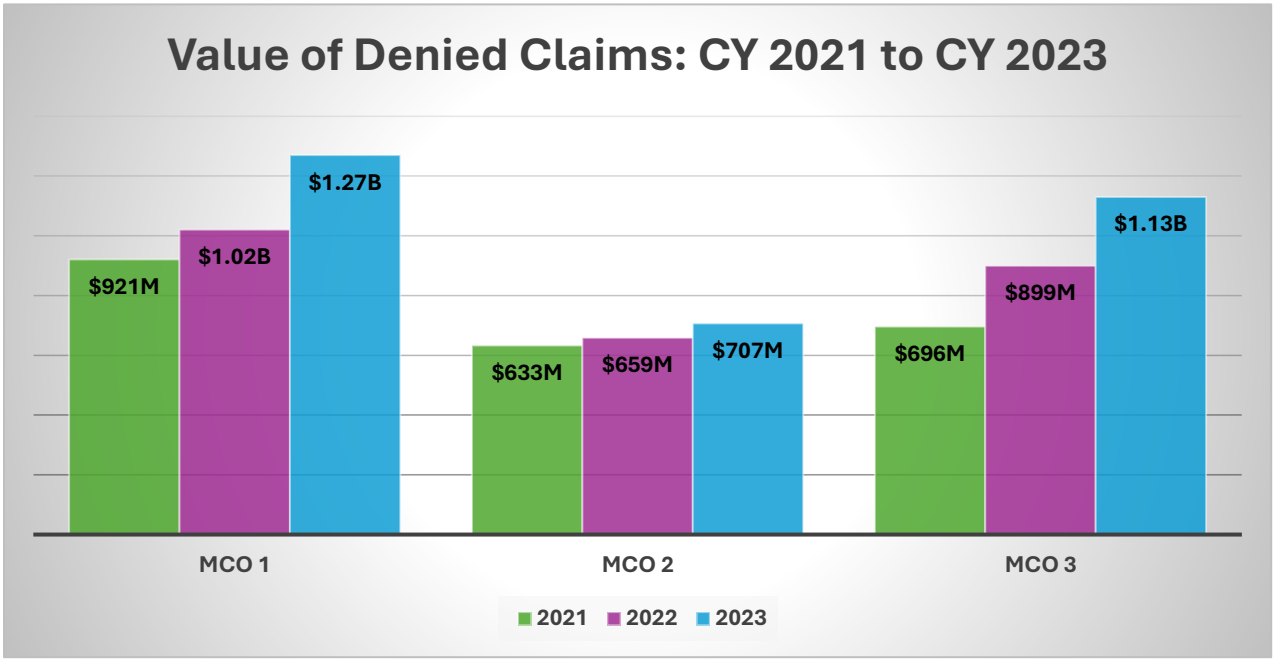
denied claims. However, the *value* of denied Hospital claims disproportionately averaged 67% of all denials.

- MCO 1: The value of all services denied was $1,833,302,065. Hospital claim denials accounted for $1,276,162,988 (70%).
- MCO 2: The value of all services denied was $1,019,967,786. Hospital claim denials accounted for $707,664,730 (69%).
- MCO 3: The value of all services denied was $1,838,971,701. Hospital claim denials accounted for $1,135,230,556 (62%).





The analysis conducted concludes a steady increase of Hospital denied claim values across all three MCOs over a three-year period.



Recommendations:

1.1. Investigate Root Causes of High Denied Claim Values: Perform a detailed analysis of why Hospital Inpatient and Outpatient services contribute disproportionately to total denied claim values, even though their claim count remains low (5%–9%).

1.2. Identify common reasons for denials (e.g., coding errors, incomplete documentation, policy changes) and target these for corrective action. A reduction in denial rates as hospitals address documentation errors and payer-specific inconsistencies, leads to fewer denied claims overall.

1.3. Enhance Claims Submission Processes: Provide training for providers on proper documentation, coding practices, and compliance with payer-specific requirements to reduce claim denial rates. Consider implementing automated claim-check systems that flag potential errors before submission.

1.4. Engage with Payers: Open communication with MCOs to clarify denial patterns and resolve systemic issues causing higher denial rates for Hospital Inpatient and Outpatient claims. Negotiate for clearer and more consistent denial criteria. Better collaboration with payers may foster mutual understanding and alignment on claim criteria, minimizing systemic denials and strengthening provider-payer relationships.

1.5. Monitor and Benchmark Performance: Establish a continuous monitoring system to track denied claim trends by year, payer, and service type. Benchmark against industry standards to identify potential inefficiencies or best practices for improvement. Continuous monitoring and benchmarking will support sustained

improvement, enabling data-driven adjustments and long-term enhancements in denied claim management.

1.6. Strengthen Appeals Processes: Focus resources on appealing high-value denied claims, especially those for Hospital Inpatient and Outpatient services, as they constitute a significant portion of total denied claim values. Optimize internal workflows to speed up the appeal resolution process. Improved financial outcomes are expected as lower denial rates and enhanced appeals processes contribute to higher recovery of denied claim values, strengthening the financial position of providers and organizations.

1.7. Allocate Resources Strategically: With total denied claim values increasing year-over-year, allocate more resources to areas where denials are most frequent and costly. Target interventions at specific payers or service categories contributing the most to denied claim values. Targeted interventions for high-value claims may stabilize or reduce the disproportionate impact of denied claims, which currently accounts for up to 70% of Hospital Inpatient and Outpatient services. Increased efficiency in claim processing through streamlined submission and automated error-checking systems could accelerate approvals and reduce delays.

1.8. Predictive Analytics for Future Trends: Use the data from CY2021–2023 to develop predictive models for future denied claim trends. Identify potential problem areas early and take preemptive measures to reduce denials. Predictive analytics can facilitate early detection of denial trends, allowing organizations to proactively mitigate emerging issues.

KDHE Response:

KDHE agrees with the finding that there was a steady increase of Hospital denied claim values across all three MCOs over a three-year period. This is to be expected with medical costs rising. KDHE appreciates the recommendations related to investigating and monitoring denied claims.

For Recommendation 1.1 and 1.2, the KDHE focus is to ensure claims are processed in accordance with policy with State and Federal guidelines. We agree there is value in analyzing denied claims in the suggested manner, but that would require additional staff and specialized training. While KDHE could address the specialized training within existing resources, there are not FTEs available to take on the additional workload. Additional FTEs would require legislative approval. In the absence, of internal capacity, KDHE does have a Health Improvement Partner, the Kansas Foundation for Medical Care (KFMC), that reviews and reports on high-dollar claims. KDHE will explore an extension of our current contract with KFMC to include the analysis of high dollar denied claims and will determine of costs could be covered within existing appropriation.

For Recommendation 1.3, KDHE has assigned the responsibility for training of providers to the MCOs. KDHE approves all training materials. In the future KDHE will work to enhance the training materials and will scrutinize current documents for areas to improve. If

providers require additional training to ensure accurate and proper claims submission, KDHE can encourage and guide the MCOs to provide that support.

For Recommendation 1.4, KDHE agrees open and transparent communication with MCOs regarding denial criteria is essential to strengthening provider-payer relationships. This will help address recurring issues at their source, potentially leading to a significant reduction in claim denials. By proactively negotiating and clarifying these criteria, the State has an opportunity to influence policy rather than merely respond to outcomes. Reducing unnecessary denials will also minimize care disruptions for members.

For Recommendation 1.5, KDHE monitors and benchmarks as specified in KanCare 3.0. Enhanced monitoring and benchmarking would require additional FTEs and legislative approval for such.

For Recommendation 1.6, KDHE recognizes the importance of a robust appeals process and agrees denied claims should be appealed when appropriate. However, the State is not positioned to lead or prioritize claim appeals as the State is not the entity receiving appeals, the hospitals receiving the denials of payment are. Hospitals have informed us that they often set thresholds for the dollar amount of denied claims and choose to only appeal some. In other cases, the hospitals may write off certain denials as administrative burdens or because of legal costs. Understanding this process, KDHE does not see a benefit in allocating resources toward the appeals process for high-dollar claims. That said, we do acknowledge the appeal resolution process could benefit from improvements, and KDHE will work to collaborate with the MCOs to enhance this.

For Recommendation 1.7, KDHE agrees with allocating resources strategically but with a small claims team (6 FTE's) at KDHE, this request must be examined in the overall schema of Medicaid claims processing. Additional resources would likely be needed but further analysis is required.

For Recommendation 1.8, KDHE does not agree with this recommendation. We will refrain from using data from calendar years 2021–2023 to develop predictive models for denied claims. The data from this period is skewed due to extended member retention driven by COVID-19-related protocols, resulting in inflated monthly figures. We will revisit this approach once enrollment and claim trends stabilize and are no longer impacted by the residual effects of the pandemic.

Finding #16:

All appeal and reconsideration data metrics within 1115 Waiver reports provided by KDHE contained 'resolved' data only.

The "KanCare Section 1115 demonstration" refers to the State of Kansas' Medicaid program, known as KanCare, which operates under a federal waiver granted by Section 1115 of the Social Security Act, allowing Kansas to implement a unique managed care system with greater flexibility in how they deliver healthcare to Medicaid recipients compared to standard Medicaid guidelines; essentially, it's a pilot program that lets Kansas test new approaches to managing their Medicaid program.

Kansas must periodically submit renewal applications to the Centers for Medicare and Medicaid Services (CMS) to continue operating under the Section 1115 waiver. As part of the demonstration, Kansas is required to track and report data on the effectiveness of their program to CMS.

Excluded 'unresolved' appeal and reconsideration data within the 1115 Waiver reports removes the wholistic view of the ratio of the total appeals or reconsiderations compared to the resolved appeals or reconsiderations.

Recommendation:

1.1 Restructure to the reporting metrics to include total number of appeals and reconsiderations. Reporting the wholistic view of the ratio of the total appeals or reconsiderations compared to the resolved appeals or reconsiderations.

KDHE Response:

KDHE disagrees with the finding. KDHE recognizes the importance of tracking and reporting metrics related to appeals and reconsiderations, as well as those resolved.

For Recommendation 1.1, KDHE disagrees that its grievance and appeal reporting metrics for the MCOs needs to be restructured. KDHE clarified that the State requires the MCOs to report all grievances and appeals received. Reporting requirements include the resolutions for all appeals and grievances received. Resolutions for grievances include whether the issue was substantiated or unsubstantiated. Resolutions for appeals include whether the original denial decision was upheld or reversed following appeal review. The ratio of total appeals and reconsiderations to those resolved is consistently 1:1.

Per federal regulations, managed care members submit grievances and appeals to the MCO in which they are enrolled. KDHE requires the MCOs to submit detailed monthly reports of all resolved appeals and reconsiderations. A reconsideration or appeal is considered resolved once it has been received by the MCO, reviewed by the appropriate MCO review team, the MCO has a determination, and the MCO has issued a notice of that determination to the member. The MCOs are not required to report the resolutions of each reconsideration and appeal until the MCO makes a determination, establishes a date of resolution, and issues the notice of resolution within 30 calendar days of the determination. The State requires a detailed level of categorization and explanations in the MCO's monthly report so KDHE can pinpoint increases in volumes and types of service or payment issues involved in the reconsiderations and appeals. This level of detail also shows differences between the MCOs. KDHE also requires the MCOs to provide monthly data that allows the State to see how many reconsiderations and appeal decisions the MCOs have reversed due to an internal error by the MCO, reversed after corrections by the member/provider, or upheld. KDHE reviews each MCO's compliance with contractual requirements each month. KDHE and we will continue to monitor this data.

Finding #17:

Inconsistencies in MCO Provider Manuals

While the provider manuals provide structured guidelines and processes for prospective, concurrent, and retrospective reviews, the testimonial evidence from hospital interviews highlighted significant gaps and discrepancies in the implementation and experience of the processes stated in each of the MCO's provider manuals.

Recommendations:

1.1 Provider manuals and MCO practices should be reevaluated and improved to align better with hospitals' needs and realities for Kansas Medicaid beneficiaries.

2.1 Ensure the requirements are being met with internal audits and tracking for coverage of services and for a provider manual are as follows:

Kansas Medicaid Managed Care Request for Proposal, KanCare 2.0, BID Event Number: EVT0005464

Pg. 22 – 5.2.1 Enrollment, G. CONTRACTOR(S) Responsibilities

3. Coverage of services, including inpatient hospital care, will be the responsibility of the CONTRACTOR(S) as of the beginning of the month enrollment becomes effective. All other (ancillary) charges, not reimbursed by the inpatient hospital payments, are the responsibility of the CONTRACTOR(S). Non-inpatient (ancillary) charges are the responsibility of the CONTRACTOR(S) if the Admission date occurs before assignment. If an Admission date occurs during the assignment to the CONTRACTOR(S), that CONTRACTOR(S) is responsible for the cost of the entire Admission regardless of assignment or eligibility.

Pg. 93 – 5.6.1. Requirements for a Provider Manual

A. Develop and submit to the State for approval, a Provider Manual that:

1. *Contains dated CONTRACTOR(S) policy and procedure information, including, in part, credentialing criteria, UM policies and procedures, billing and payment procedures, Provider and Member Grievance and Appeal processes, and network management requirements.*
2. *Is distributed electronically to all Participating Providers following approval of the State no later than thirty (30) calendar days following the CONTRACT effective date, and then to Participating Providers and Non-Participating Providers upon request thereafter.*
3. *Is updated regularly and distributed electronically in whole or in part to Participating Providers at least thirty (30) calendar days in advance of any policy or procedure change substantive revisions to the Provider Manual must be submitted to the State for approval. Changes must be posted on the CONTRACTOR(S) website and notify Providers via bulletins.*
4. *Is posted as an electronic version of the Provider Manual to the CONTRACTOR(S)' web site with hard copies made available upon request.*

5. *Is consistent with State Medicaid Provider Manuals (KMAP) in regards to services covered and who can provide the services.*

KDHE Response:

KDHE agrees with this finding. KDHE acknowledges that there have been reports of instances in which the MCOs may not always follow the criteria within their provider manuals. When KDHE receives reports of these instances, we work with the MCOs to correct their procedures.

For Recommendation 1.1, KDHE recognizes the importance of regularly evaluating and improving Provider Manuals and MCO practices. The manuals are reviewed annually by KDHE and are evaluated to ensure they contain any new or updated information. KDHE will add the lens of the hospitals' needs and the realities of Kansas Medicaid beneficiaries in their reviews. KDHE will strategically connect with the Kansas Hospital Association (KHA) annually to obtain feedback on each MCO's Provider Manual content. Additionally, updates to the manuals may be requested at any time throughout the year by KDHE. Once a change has been approved, the respective MCO is responsible for notifying providers of the updates. The revised manuals are then published on the MCO's website and made accessible to the public. The Provider Manual applies to both individual providers and healthcare facilities. The contract also outlines the specific content requirements for each manual. KDHE will perform ongoing assessments to align the Provider and KMAP manuals.

For Recommendation 2.1, KDHE will continue to work with providers to identity occurrences of the MCOs not following the practices and guidelines stated within their provider manuals. KDHE will reinforce to providers that they may contact the KDHE MCO Manager staff at any time to report these instances or that they may request assistance with these type of issues by emailing KDHE.MCOInquires@ks.gov.

On behalf of our entire Medicaid team, we again thank you for your continued partnership, professionalism, and shared commitment to maintaining the highest quality standards in the Kansas Medicaid program.

Sincerely,

Christine Osterlund
Deputy Secretary of Agency Integration and State Medicaid Director
Kansas Department of Health and Environment
Christine.Osterlund@ks.gov

Appendix B – Applicable Laws and Regulations

***Auditor Note*:** *This compilation reflects statutes and regulations as of October 2024. Laws and regulations may have changed since then, and specific implementation details may be found in managed care organization contracts, state plan amendments, and federal waiver terms and conditions.*

Federal Statutes (U.S. Code)

Title 42 - The Public Health and Welfare

- **42 U.S.C. § 1396** - Medicaid program authorization
- **42 U.S.C. § 1396a** - State plans for medical assistance (requirements for state Medicaid plans)
- **42 U.S.C. § 1396b** - Payment to states (federal matching funds and requirements)
- **42 U.S.C. § 1396n** - Waivers of state plan requirements (1915(b) managed care waivers)
- **42 U.S.C. § 1396u-2** - Provisions relating to managed care (managed care organization requirements)
- **42 U.S.C. § 1396d** - Medical assistance definitions (covered services and provider qualifications)
- **42 U.S.C. § 1396r-4** - Adjustment in payment for inpatient hospital services furnished by disproportionate share hospitals

Federal Regulations (Code of Federal Regulations)

Title 42 - Public Health, Part 400-499 (Centers for Medicare & Medicaid Services)

Managed Care Regulations

- **42 C.F.R. § 438** - Managed Care (comprehensive managed care requirements)
    - **42 C.F.R. § 438.6** - Contract requirements
    - **42 C.F.R. § 438.14** - Requirements that apply to MCO, PIHP, PAHP, PCCM, and PCCM entity contracts [MCO – Managed Care Organization, PIHP – Prepaid Inpatient Health Plan, PAHP – Prepaid Ambulatory Health Plan, PCCM – Primary Care Case Management]
    - **42 C.F.R. § 438.56** - Disenrollment requirements and limitations

- **42 C.F.R. § 438.206** - Availability of services
- **42 C.F.R. § 438.207** - Assurances of adequate capacity and services
- **42 C.F.R. § 438.214** - Provider selection
- **42 C.F.R. § 438.230** - Coordination and continuity of care

Payment and Reimbursement

- **42 C.F.R. § 447** - Payments for services
  - **42 C.F.R. § 447.250-447.299** - Upper payment limits
  - **42 C.F.R. § 447.321** - Institutional providers
- **42 C.F.R. § 440** - Services: Conditions and limitations
- **42 C.F.R. § 441** - Services: Requirements and limits applicable to specific services

Hospital-Specific Regulations

- **42 C.F.R. § 482** - Conditions of participation for hospitals
- **42 C.F.R. § 413** - Principles of reasonable cost reimbursement
- **42 C.F.R. § 455** - Program integrity: Medicaid

Disproportionate Share Hospital (DSH) Payments

- **42 C.F.R. § 447.294** - Disproportionate share hospital payments
- **42 C.F.R. § 447.296** - Extent of uncompensated care costs
- **42 C.F.R. § 447.298** - State disproportionate share hospital allotments

Kansas State Statutes

Kansas Statutes Annotated (K.S.A.)

- **K.S.A. § 39-7,121** - Kansas medical assistance program; administration
- **K.S.A. § 39-7,122** - State plan for medical assistance
- **K.S.A. § 39-7,123** - Powers and duties of secretary of health and environment
- **K.S.A. § 39-7,124** - Medical assistance benefits
- **K.S.A. § 39-7,125** - Provider agreements

- **K.S.A. § 39-7,126** - Reimbursement rates and methods
- **K.S.A. § 39-1801 et seq.** - Kansas health care provider insurance availability act
- **K.S.A. § 40-19c01 et seq.** - Managed care organization regulation

Kansas Medicaid Appeals

- K.S.A. 77-501 through 77-566 - Kansas Administrative Procedure Act (KAPA)

KanCare-Specific Statutes

- **K.S.A. § 39-7,140** - KanCare program implementation
- **K.S.A. § 39-7,141** - KanCare advisory council
- **K.S.A. § 39-7,142** - Managed care organization contracts
- **K.S.A. § 39-7,143** - Quality assurance and performance measurement

Kansas Administrative Regulations (K.A.R.)

Title 30 - Social and Rehabilitation Services

- **K.A.R. § 30-5-1** through **30-5-191** - Medical assistance regulations
- **K.A.R. § 30-5-52** - Hospital services coverage
- **K.A.R. § 30-5-53** - Hospital reimbursement methodology
- **K.A.R. § 30-5-54** - Inpatient hospital services
- **K.A.R. § 30-5-55** - Outpatient hospital services
- **K.A.R. § 30-5-56** - Emergency services
- **K.A.R. § 30-5-125** - Provider agreements and enrollment
- **K.A.R. § 30-5-126** - Claims processing and payment
- **K.A.R. § 30-5-127** - Prior authorization requirements

KanCare Managed Care Regulations

- **K.A.R. § 30-5-175** through **30-5-191** - KanCare managed care organization requirements
- **K.A.R. § 30-5-175** - Definitions for managed care
- **K.A.R. § 30-5-176** - MCO contract requirements
- **K.A.R. § 30-5-177** - Provider network adequacy
- **K.A.R. § 30-5-178** - Member enrollment and disenrollment
- **K.A.R. § 30-5-179** - Service authorization and utilization review
- **K.A.R. § 30-5-180** - Quality assurance and improvement
- **K.A.R. § 30-5-181** - Grievance and appeal procedures
- **K.A.R. § 30-5-182** - Financial and reporting requirements

Hospital-Specific Regulations

- **K.A.R. § 30-5-183** - Hospital payment methodologies under managed care
- **K.A.R. § 30-5-184** - Disproportionate share hospital payments
- **K.A.R. § 30-5-185** - Graduate medical education payments
- **K.A.R. § 30-5-186** - Critical access hospital provisions
- **K.A.R. § 30-5-187** - Supplemental hospital payments

Additional Federal Requirements

Centers for Medicare & Medicaid Services (CMS) Guidance

- CMS Managed Care Final Rule (42 C.F.R. § 438) - Updated requirements effective 2016-2018
- State Medicaid Director Letters (SMD) regarding managed care payment requirements
- Medicaid and CHIP Payment and Access Commission (MACPAC) recommendations

Section 1115 Demonstration Waiver Authority

- **42 U.S.C. § 1315** - Demonstration projects (authority for KanCare waiver)

- Special Terms and Conditions of Kansas's Section 1115 Demonstration Waiver

Cross-References

Federal-State Coordination Requirements

- State plan amendments must comply with federal requirements under 42 U.S.C. § 1396a

- Managed care organization contracts must meet federal standards under 42 C.F.R. § 438

- Hospital reimbursement rates must comply with federal upper payment limit requirements

- Quality reporting requirements under both federal and state law

Provider Network and Access Requirements

- Network adequacy standards under both federal (42 C.F.R. § 438.207) and state law (K.A.R. § 30-5-177)

- Essential community provider requirements

- Geographic access standards for hospital services

Appendix C – Acronyms

ADHD	Attention-Deficit/Hyperactivity Disorder
AI	Artificial Intelligence
AMA	American Medical Association
API	Application Programming Interface
APM	Alternative Payment Model
C.F.R.	Code of Federal Regulation
CC	complications and comorbidities
CCBHC	certified community-based health centers
CHIP	Children's Health Insurance Program
CMO	Chief Medical Officer
CMS	Centers for Medicare & Medicaid Services
CPD	Claim Payment Dispute
CY	calendar year
DRG	diagnosis-related groups
DSH	disproportionate share hospital
DSRIP	Delivery System Reform Incentive Payment
EITPR	External Independent Third-Party Review
EMR	electronic medical records
EQR	external quality review
EQRO	External quality review organizations
ER	emergency room
FDA	U.S. Food and Drug Administration
FFS	Fee-For-Service
FMAP	Federal Medical Assistance Percentage
FQHC	federally qualified health centers
FY	Fiscal Year
GAO	Government Accountability Office
GME	graduate medical education
HCAIP	Health Care Access Improvement Program
HHS	U.S. Department of Health and Human Services
HHS/OIG	U.S. Department of Health and Human Services-Office of the Inspector General
HINN	Hospital-Issued Notices of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act
ICU	intensive care unit
IRR	Interrater Reliability
K.A.R.	Kansas Administrative Regulations
KanCare	Kansas Medicaid
KAPA	Kansas Administrative Procedure Act

KDHE	Kansas Department of Health and Environment
KDHE-DHCF	KDHE's Division of Healthcare Finance
KDOI	Kansas Department of Insurance
KFF	Kaiser Family Foundation
KFMC	Kansas Foundation for Medical Care
KHA	Kansas Hospital Association
KMAP	Kansas Medical Assistance Program
KMMS	Kansas Modular Medicaid System
K.S.A.	Kansas Statutes Annotated
LOC	level-of-care
LOS	length of stay
LPTC/BCCH	Large Public Teaching Hospital/Border City Children's Hospital
LTACH	long-term acute-care hospital
LTSS	Long-Term Support Services
MACPAC	Medicaid and CHIP Payment and Access Commission
MCC	major complications and comorbidities
MCG	Milliman Care Guidelines
MCO	Managed Care Organizations
MCPAR	Managed Care Program Annual Report
MOON	Medicare Outpatient Observation Notice
NCQA	National Committee for Quality Assurance
NOA	Notice of Admission
OAH	Office of Administrative Fair Hearings
OIG	Office of Inspector General
OUD	opioid use disorder
P2P	peer-to-peer
PA	Prior Authorization
PAC	post-acute care
PI	Program Integrity
PMPM	per member per month
POC	point of contact
PPS	prospective payment system
RAC	Recovery Audit Contractor
SFH	State Fair Hearing
SGF	State General Fund
SME	Subject Matter Experts
SNCP	Safety Net Care Pool
SNF	skilled nursing facility
SPA	State Plan Amendments
SSA	Social Security Act

SURS	Surveillance and Utilization Review Subsystem
TPL	Third-Party Liability
U.S.	United States
UC	Uncompensated Care
UM	utilization management
UPL	Upper Payment Limit
UR	Utilization Review
URAC	Utilization Review Accreditation Commission
VP	Vice President

Appendix D – KHA Letter to Kansas Medicaid Director

Kansas Hospital ASSOCIATION

June 13, 2022

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

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

Dear Director Fertig,

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

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

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

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

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

ENSURING TIMELY RESPONSE

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

CLOSING ACCOUNTABILITY GAPS

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

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

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

INSTITUTING STANDARDIZATION

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

OUTLINING APPEALS PROCESS

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

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

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

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

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

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

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

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

Sincerely,

Shannan Flach

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