KANSAS CHAPTER
American Academy of Pediatrics
INCORPORATED IN KANSAS

TESTIMONY IN SUPPORT OF HB 2283

February 20, 2023

Chair Sutton and Members of the House Insurance Committee:

The Kansas Chapter, American Academy of Pediatrics (KAAP) represents more than 450 practicing pediatricians in the state. The KAAP has the fundamental goal that all children and adolescents in Kansas can grow up safe and strong. It is with this goal in mind that we would like to share our **support for HB 2283** which will improve the prior authorization process to be more patient centered, decrease barriers to timely authorization, and decrease waste in healthcare by making the process less cumbersome for health care professionals. Physician expertise and judgment based on an individual patient's unique clinical situation should not be obstructed by those outside the doctor-patient relationship. Insurance companies should not be allowed to practice medicine without a license.

At a time when healthcare costs continue to increase exponentially, insurance companies continue to experience record profits. There is no recourse for inappropriate denials, in fact it seems as if insurance companies are counting on denials not being appealed. Initially intended to control costs, it has become an undue administrative burden for patients, physicians, healthcare staff, pharmacies, and hospitals, diverting valuable resources away from direct patient care. The current process to obtain prior authorization is antiquated, inefficient, and essentially handcuffs the physician, interfering with the doctor-patient relationship. These actions and inefficiencies result in delayed medical care and affect patient health outcomes on a daily basis.

The AMA led a coalition of medical societies and associations to develop "The Prior Authorization and Utilization Management Reform Principles," identifying the most common patient and physician and provider concerns. A multi-stakeholder group including patients, physicians, hospitals, and pharmacists developed principles on utilization management programs to reduce the negative impact they have on patients, physicians, health providers, and the health care system. Adherence to these principles will improve patient care by ensuring patients have timely access to treatment and reduce administrative costs to the health care system. The principles are summarized below and categorized into clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions. HB 2283 incorporates several of these principles which are bolded below.

Utilization management programs, whether for a service, device, or drug, should:

1. Be based on evidenced based, and current clinical criteria, and NEVER cost alone. This **information should be public and readily available to patients and the prescribing/ordering physician or health care professional.**
2. Allow for flexibility, including the timely overriding of step therapy requirements and appeal of prior authorization denials.

3. **Offer an appeal system that allows a prescribing/ordering physician or provider direct access to an equally qualified and specialized colleague** for the discussion of medical necessity issues.
4. Offer a minimum of 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. Medical treatments or prescription regimens should not be interrupted as overrides, formulary exceptions, etc. are addressed.
5. **Cover without restrictions for the duration of the benefit year, any medical service, device, or drug coverage that is removed from a plan's formulary or is subject to new coverage restrictions after a beneficiary has enrolled.** Patients often decide on a health plan based on their medical and financial needs. Unanticipated changes by the insurance plan should not negatively impact patient care.
6. Continue approval for the duration of the prescribed/ordered course of treatment to encourage adherence to treatment. Recurring prior authorization requests can lead to gaps in care delivery and negative patient outcomes.
7. Not require patients to repeat step therapy protocols or retry therapies failed under other benefit plans before qualifying for coverage of a current effective therapy. It is unacceptable for patients to be required to abandon effective treatment and be made to repeat therapy that has been proven ineffective.
8. **Disclose publicly, in an easily searchable electronic format, patient-specific utilization management requirements, including prior authorization, step therapy, and formulary restrictions with patient cost-sharing information for individual drugs, devices, medical services.** Utilization review entities should clearly communicate to prescribing/ordering physicians and providers what supporting documentation is needed to complete every prior authorization and step therapy override request.
9. **Provide and display, accurate, patient-specific, and current formularies that include prior authorization and step therapy requirements in electronic health records for e-prescribing systems.** This is critical to ensure that physicians and providers have the required information at the point of care. Otherwise, treatment may be delayed or abandoned, placing additional administrative burdens on prescribing physicians and providers as well as pharmacies and pharmacists.
10. Be required to share data and statistics regarding prior authorization approval and denial rates available on their website in a readily accessible format. These data should inform efforts to improve and hold utilization management programs accountable.
11. Provide detailed explanations for prior authorization or step therapy override denials, including an indication of any missing information. All denials should include the clinical rationale for the adverse determination, provide the plan's covered alternative treatment and detail the provider's appeal rights.
12. **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 service benefits. Facsimile, proprietary payer web-based portals, telephone discussions, nonstandard electronic forms are ineffective and inefficient.**
13. **Commit to coverage obtained through the prior authorization process.** No criteria outside the prior authorization review process should be used to deny payment.

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14. Honor coverage for authorized care provided within 45 business days from the date authorization was received, as some treatments are authorized significantly in advance of the treatment date. **They should NOT revoke, limit, condition or restrict coverage that has been approved and should allow a sufficient period of time for patients to access the prescribed care.**
15. **Make coverage determinations in a timely manner in order to ensure prompt access to care.** Determination and notification should be provided within 48 hours of obtaining all necessary information.
    a. For urgent care, determination should be made within 24 hours.
    b. For emergent care, prior authorization should never be required.
16. Provide a timely and fair appeals process when prior authorization is denied. All appeal decision should be made by a physician or provider who is of the same specialty, subspecialty as the prescribing/order physician or provider and should not have been involved in the initial denial.
    a. Expedited appeal communication within 24 hours
    b. All other appeals within 10 calendar days
17. Never require prior authorization for emergency care
18. Standardize criteria across the utilization industry to reduce administrative burden.
19. Restrict utilization management programs to "outlier" physicians and providers whose prescribing or ordering patterns differ significantly from their peers after adjusting for patient specific factors. Physicians and providers with a history of appropriate resource utilization and high prior authorization approval rates should not be punished with this higher administrative burden.
20. Offer at least one physician-driven alternative, less costly option to serve the same functions for as prior authorizations for physicians, providers, clinics, such as "gold-card" or "preferred provider" **programs or attestation of appropriate use of criteria, clinical decision support systems or clinical pathways.**
21. Allow exemption for physician or providers contracted with a health plan to participate in financial risk-sharing payment plan. They are already incentive to contain unnecessary costs, thus prior authorization is unnecessary.

Thank you for the opportunity to share our strong support of HB 2283. This will promote patients over profits. Modernization and streamlining the prior authorization process is long overdue and all steps should be taken to mitigate impeding patient care. We welcome any questions you might have and are happy to serve as your resource on all pediatric related issues.

Respectfully submitted,

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Chair, Public Policy Committee
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Attachment: The Prior Authorization and Utilization Management Reform Principles