Summit COMMUNITY CARE

October 11, 2024

Ms. Marty Garrity
Director
Bureau of Legislative Research

**Sent Via Electronic Mail**

RE: Act 575 Prior Authorization Transparency Act – Summit Community Care Program

Dear Ms. Garrity:

Pursuant to Act 575 (the "Prior Authorization Transparency Act") of the 2023 Regular Session, entities providing plans or services under the Medicaid Provider-Led Organized Care Act (PASSEs) are exempt from the requirements of the Act if the entity develops a program to reduce or eliminate prior authorizations for a healthcare provider on or before January 1, 2025 (Ark. Code. Ann. 23-99-1127).

The legislation further specifies that each PASSE's program developed in compliance with the Act is subject to approval by the Legislative Council on or before January 1, 2025. Pursuant to this letter, I would ask that the attached copy of Summit Community Care's program be submitted for Legislative Council approval as soon as possible.

If you have any questions, please do not hesitate to reach out to me.

Sincerely,

Jason Miller
Plan President

ENCL

| **Section (Primary Department)**<br>**Health Care Management (HCM); Compliance** | **SUBJECT (Document Title)**<br>**Compliance with The Prior Authorization Transparency Act (Act 575 of 2023)** |
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| **Effective Date** | **Date of Last Review** | **Date of Last Revision** | **Dept. Approval Date** |
|---|---|---|---|
| **Department Approval/Signature:** | | | |

**PURPOSE:**
To ensure compliance with The Prior Authorization Transparency Act (Act 575 of 2023).

**DEFINITIONS:**

**Care Coordination:** Activities involving a collaborative patient-centered engagement of the individual and their caregiver in service referral, follow up, and service navigation. The care coordination process includes assessing, collaborating on care planning, medication management, treatment plan follow-through, service coordination, monitoring the patient adherence, and reevaluating the patient for medically necessary care and service. These activities focus on ensuring the individual's healthcare and support service needs are met; through effective provider and patient communication, information sharing, follow up, care transitions, and assurance of timely access to care that promotes quality, cost-effective outcomes.

**PASSE:** The purpose of the Arkansas PASSE program, pursuant to Title XIX of the Social Security Act (The Act) and Arkansas Act 775, is to organize and manage the delivery of services for certain Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs. The federal statutory and regulatory requirements that govern the PASSE Program are described in 42 CFR § 438.

**Prior Authorization:** Prior authorization means the process by which a utilization review entity determines the medical necessity of an otherwise covered health care service before the health care service is rendered, including without limitation preadmission review, pretreatment review, utilization review, case management, fail first protocol, and step therapy. "Prior authorization" may include the requirement that a subscriber or health care provider notify the health insurer or utilization review entity of the subscriber's intent to receive a health care service before the health care service is provided.

**POLICY:**
Act 575 of 2023 (The Prior Authorization Transparency Act) establishes a mechanism "to exempt certain health providers that provide certain healthcare services from prior authorization requirements." Section 23-99-1127 provides a regulatory exemption for "an organization or entity directly or indirectly providing a plan or services to patients under the for Medicaid Provider-Led Organized Care Act or any other Medicaid-managed care program... if the program, without limiting the program's application to any other plan or program, develops a program to reduce or eliminate prior authorizations for a healthcare provider on or before January 1, 2025."

Summit also acknowledges that unnecessary PA requirements have the potential to further exacerbate concerns of administrative burden and wasteful practices that can contribute to a fragmented healthcare delivery system. In recognition of these facts, Summit takes several steps pursuant to Act 575 designed to reduce PAs for healthcare providers while

maintaining a balanced approach upholding key elements of the PASSE program. These initiatives support the intent of the PASSE exemption from the full regulatory scope of the Prior Authorization Transparency law, while reducing PA work volume and administrative tasks in a meaningful and appropriate manner.

**PROCEDURE:**

Summit reviews and updates its Prior Authorization list quarterly, at a minimum, to evaluate services where prior authorization is an unnecessary burden to the providers and unwarranted.

During this evaluation, Summit compares the current AR Medicaid requirements and limits to current authorization requirements. Summit considers removing Prior Authorization from codes with a high rate of approval across the provider network. The review team has multidisciplinary representation including external community providers. Summit notifies its provider network of any changes to prior authorization with a minimum of 90 days' notice. These changes are communicated to the network via provider alerts on the Summit website and via email directly with the provider.

Prior Authorization requirements and procedures are maintained in readily accessible formats via the Summit PASSE website. These openly available resources include, among others, PA request forms, quarterly prior authorization statistics, and a Prior Authorization Look-Up Tool (PLUTO) to quickly identify those codes and services which presently require prior authorization.

Summit currently considers specific CPT codes within the following broad service categories as gold carded, or exempt from prior authorization, for in-network participating providers:

1. Physical Health:
    - Primary Care Sick Visits
    - Well Child Visits
    - Second Opinions
    - Preventative Screenings
    - Urgent Care
    - Immunizations
    - Specialist Visits (i.e. orthopedics, endocrinology)
    - Pain Management and Nerve Blocks
    - Family Planning:
        - Prenatal Visits
        - Long-Acting Contraceptives
        - Infertility Visits
        - Delivery
    - Emergent and Non-Emergent Ambulance Transportation
    - Medical & Surgical Supplies
    - Allergy Testing
    - Diagnostic Imaging and Testing
    - Dialysis
    - Genetic Testing
    - Pathology and Laboratory Services

2. Physical Health – Therapy & Screenings:
   - Chiropractic
   - Hearing Screening
     - Audiology Testing
     - Hearing Aids for under 21
   - Radiation Therapy
   - Home Health
     - Nursing (RN/LPN)
     - Physical Therapy
     - Occupational Therapy
     - Wound Care
   - Evaluations
     - Speech and Language
     - Occupational Therapy
     - Physical Therapy
   - Therapy
     - Speech and Language
     - Occupational
     - Physical
   - Vision Screening
     - Glasses
     - Contacts
   - Adult Developmental Day Treatment
   - Early Intervention Day Treatment

3. Durable Medical Equipment:
   - Bedside Commode
   - Patient Lifts
   - Wheelchairs and Accessories
     - Excludes electric wheelchairs or power-operated vehicles
   - Incontinence Supplies
   - Nutritional Formulas for Tube Fed Members
   - Tracheostomy Supplies
   - Orthopedic Footwear
   - Orthotic Devices
   - Continuous Glucose Monitor Supplies
   - Prosthetic Devices

4. Behavioral Health:
   - Behavioral Health Counseling
   - Substance Abuse Counseling
   - Group Therapy
   - Marital Therapy
   - Family Therapy
   - Peer Support
   - Crisis Intervention and Stabilization

- Family Support Partners
- Psychoeducation
- Crisis Stabilization Unit Admission
- Psychiatric Evaluations
- Psychiatric Medication Management for Behavioral Health or Medication Assisted Treatment for Substance Abuse
- Pharmacological Counseling
- Treatment Planning

5. Emergency department visits never require Prior Authorization in observance of urgent need.

6. Observation in an inpatient hospital setting does not require authorization to facilitate less administrative burden on the provider for short stays and brief intervention.

Through these actions and initiatives, Summit maintains a framework of PA requirements that is generally less stringent than those administered by AR Medicaid. PA requirements that remain in effect are maintained specifically to balance the fiscal, clinical, and regulatory responsibilities established within the PASSE program.

**REFERENCES:**
The importance of the Medicaid managed-care exemption in Act 575 is further emphasized by key objectives defined in Act 775 of 2017 which authorized creation of the Provider-Led Arkansas Shared Savings Entity (PASSE) program.

*20-77-2702. Legislative intent and purpose.*
*(c) It is the intent of the General Assembly that the Medicaid provider-led organized care system created by the department shall:*

1. *Improve the experience of health care, including without limitation quality of care, access to care, and reliability of care, for enrollable Medicaid beneficiary populations*
2. *Enhance the performance of the broader healthcare system leading to improved overall population health*
3. *Slow or reverse spending growth for enrollable Medicaid beneficiary populations and for covered services while maintaining quality of care and access to care*
4. *Further the objectives of Arkansas payment reforms and the state's ongoing commitment to innovation*
5. *Discourage excessive use of services*
6. *Reduce waste, fraud, and abuse*
7. *Encourage the most efficient use of taxpayer funds*
8. *Operate under federal guidelines for patient rights*

A judicious Prior Authorization ("PA") review program is necessary to administer the PASSE program in a manner which maintains compliance with Act 775. PA procedures are designed and administered to support the statutory objectives to help "slow or reverse Medicaid spending growth," "discourage excessive use of services," "reduce instances of waste, fraud, and abuse," and "encourage the most efficient use of taxpayer funds."

| **Section (Primary Department)**<br>**Health Care Management (HCM); Compliance** | **SUBJECT (Document Title)**<br>**Compliance with The Prior Authorization Transparency Act (Act 575 of 2023)** |
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In addition to the regulatory considerations, there are additional elements of importance regarding support for utilization management and Care Coordination through prior authorization activities. PA preserves a critically important clinical information feedback loop in support of Care Coordination services provided to PASSE members by enabling Care Coordinators to support successful transitions in care, improve outcomes, and close gaps in care.

Through the PA process, PASSE Care Coordinators receive timely notification of certain outpatient services and inpatient admissions. This notification mechanism ensures that Care Coordinators maintain knowledge of the health status of the PASSE members they serve and provide care transition support before and after discharge. This type of clinical support furthers stated PASSE objectives to "improve the experience of health care," as well as "enhance the performance of the broader healthcare system."

Furthermore, the PASSE contract with the Arkansas Department of Human Services establishes certain Care Coordination performance requirements. One key PASSE contract standard requires Care Coordinators to follow up with enrolled members within seven (7) business days of an Emergency Room visit, discharge from a medical hospital, or discharge from an inpatient Psychiatric Unit. Full inpatient admissions require authorization within 24 hours, or 1 business day, of admission so that Care Coordination can be notified and assist with discharge planning and transition of care. Prior authorization or notification procedures are essential to maintain compliance with this PASSE contract performance standard.

Likewise, PASSEs require management and monitoring mechanisms to support the provision of fiscally responsible and appropriate care for Medicaid beneficiaries, helping to "slow or reverse spending growth." Appropriate management procedures, including PA where appropriate, help manage growth in Medicaid expenditures within the PASSE program by enabling additional clinical review of more intensive services before they are delivered to the patient. AR Medicaid defines certain benefit limitations in which service levels beyond the limits require review and approval for an extension of those benefits when medically necessary. For certain services targeted to the PASSE population (i.e. Home and Community Based and Counseling Services), Summit administers higher benefit limits extending the point at which a provider must request review for medically necessary extension of benefits.

Notwithstanding the prior considerations, this policy supports the intent of the PASSE exemption from the full regulatory scope of the Prior Authorization Transparency law, while reducing PA work volume and administrative tasks in a meaningful and appropriate manner.

Arkansas Act 575 of 2023: To Amend the Prior Authorization Transparency Act

Arkansas Act 775 of 2017: To Create the Medicaid Provider-Led Organized Care Act

https://provider.summitcommunitycare.com/arkansas-provider/prior-authorization-lookup

**RESPONSIBLE DEPARTMENTS:**

**Primary Department:** Health Care Management (HCM)

| **Section (Primary Department)**<br>**Health Care Management (HCM); Compliance** | **SUBJECT (Document Title)**<br>**Compliance with The Prior Authorization Transparency Act (Act 575 of 2023)** |
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**Secondary Department(s):** Compliance

**EXCEPTIONS:** **None**

**REVISION HISTORY:**

| Review Date | Changes |
|---|---|
| | • New |