EXHIBIT E4

empower
HEALTHCARE SOLUTIONS

October 10th, 2024

Attn: Marty Garity
Director, Bureau of Legislative Research
1 Capitol Mall, Fifth Floor
Little Rock, AR 72201

Director Garity,

Act 575 of 2023 sets forth several requirements as it relates to the use of prior authorizations ("PA") by health insurance companies. Section 23-99-1127(a)(1) exempts Medicaid Provider-Led entities, also known as PASSEs, from the Act if the PASSE develops a program to reduce or eliminate PA's for a healthcare provider on or before January 1, 2025. Act 575 goes on to state that such a program must be 1) submitted to the Insurance Department and; 2) approved by Legislative Council.

Enclosed herewith is the program adopted by Empower Healthcare Solutions pursuant to Act 575. I would ask that it be presented to Legislative Council at its next available date.

By cover of separate letter, this policy is being provided to the Commissioner of Insurance.

Thank you for your assistance and feel free to contact me with any questions.

Sincerely,

Mitch Morris

Mitch Morris, CEO
Empower Healthcare Solutions

CC: Justin Allen, Wright Lindsey Jennings

Empower Healthcare Solutions	POLICIES AND PROCEDURES	
Policy Number: UM-200	**Category:** Utilization Management	**Page**
Title: Compliance with The Prior Authorization Transparency Act (Act 575 of 2023)	**Original Date of Issue:** January 1, 2025	
Keyword Search:	**Previous Date Approved:**	**Current Date Approved:**

Reviewed ☒	Revised ☐	New ☒	Approval Signatures: Approver Name:
Review Date:			
Revised Date:			
Compliance with The Prior Authorization Transparency Act (Act 575 of 2023)			
Functional Area(s) Involved in Review:			

I. PURPOSE

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

II. 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.

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III. 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."

Empower 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, Empower 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.

IV. PROCEDURE

Empower 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, Empower compares the current AR Medicaid requirements and limits to current authorization requirements. Empower considers removing Prior Authorization from codes with a high rate of approval across the provider network. The review team has multi-disciplinary representation including external community providers. Empower 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 Empower website and via email directly with the provider.

Prior Authorization requirements and procedures are maintained in readily accessible formats via the Empower PASSE website. These openly available resources include, among others, PA request forms, quick-reference guides, extension of benefit limits, and a PA Code Check search to quickly identify those codes and services which presently require prior authorization.

Empower 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
- Chemotherapy Procedures and Infusions
- Chemotherapy Drugs
    - PA not required when rendered by a hospital, hematologist, or oncologist.
- Diagnostic Imaging and Testing
- Dialysis
- Genetic Testing
- Pathology and Laboratory Services
- Certain Injectable Medications
    - Additional injectables covered for OB/GYN or Perinatologist.

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
   - Hospital Bed and Accessories
   - Patient Lifts
   - Compression Devices
   - Speech Generating Devices
   - Wheelchairs and Accessories
     - Excludes electric wheelchairs
   - 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
   - Behavioral Assistance (QBHP)
   - Psychoeducation
   - Crisis Stabilization Unit Admission
   - Psychiatric Evaluations
   - Psychiatric Medication Management for Behavioral Health or Medication Assisted Treatment for Substance Abuse
   - Pharmacological Counseling
   - Psychological or Neuro-psychological Cognitive Testing
   - Autism Evaluations

- Child and Youth Support Services
- 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, Empower 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.

V. REFERENCES

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

Empower Healthcare Solutions Prior Authorization List

VI. ATTACHMENTS

VII. RESPONSIBILITY FOR IMPLEMENTATION

Chief Medical Officer
Sr. Director of Provider Engagement
Sr. Director of Utilization Management

VIII. RESPONSIBILITY FOR MONITORING POLICY COMPLIANCE

Chief Medical Officer
Chief Operating Officer
Vice President of Operations
Sr. Director of Utilization Management
Sr. Director of Provider Engagement