Prior Authorization Reform: Early Lessons Learned While Pursuing Gold Card and Prior Authorization Legislation

1. **Prior Authorization Reform is a team sport**
    a. Look for other provider groups in your state that experienced similar escalation of administrative burden around Prior Authorization
    b. States that have passed Gold Card Legislation or Prior Authorization Reform laws commonly had large groups of providers, their associations, and lobbyists working together
        i. Possible provider groups could include Occupational Therapists, Speech Therapists, Physicians, Chiropractors, Behavioral Health providers, Hospital Associations

    Supportive talking points:
    - *Ohio legislation had 30+ groups included*
    - *Arkansas legislation included all healthcare providers*
    - *Louisiana law included all healthcare providers, including hospitals*
    - *A consortium of larger groups have had greater success with passing legislation*
    - *Provider groups that included physician associations had greater success with passing legislation*
    - *With large provider groups pushing for this type of legislation, the sooner that physical therapists can join the initiative, the greater the likelihood of having therapy specific provisions included*.

2. **Qualification for a Gold Card should be determined by looking at the success rate of prior authorizations during a look back period.**
    a. Start with an 80% success rate to allow for the greatest success for providers

    Supportive talking points;
    - *Louisiana legislation left this open-ended. Resulting threshold from a payer was 95%*.
    - *Michigan legislation mandates a 95% threshold*.
    - *Arkansas legislation mandates a 90% threshold*.
    - *West Virginia legislation mandates a 90% threshold*.
    - *Large provider groups commonly report PA denial rates of 2-3%*.

3. **Qualification for a Gold Card should be evaluated on a yearly basis**
    a. Yearly evaluations allow providers an opportunity to qualify who may not have met the threshold on previous reviews. A yearly frequency allows for adequate provider opportunity, without being overly burdensome to payers or providers

Supportive talking points

- *West Virginia law does allow re-review at 6 months.*
- *Louisiana law requires 30 days notice before a provider can have their Gold Card revoked.*
- *Arkansas law does evaluations yearly.*
- *Michigan law does evaluations yearly.*

4. **Determination of the Gold Card exemption should be calculated by the payer and granted automatically, without providers having to apply for the exemption**
    a. Determination of Gold Card achievement should be during a pre-determined look back period with clear deadlines when a provider is notified of Gold Card status
    b. Provisions for an appeal of this determination should be included as well.
        i. This should include an internal as well as external appeals process

Supportive talking points

- *The Affordable Care Act has external appeal language that could be referenced.*
    - *https://www.cms.gov/marketplace/resources/regulations-guidance#External_Appeals*
- *West Virginia requires the payer to initiate a Gold Card determination once a provider qualifies.*
- *Providers do not have the analytic infrastructure to support determination of, and application for a Gold Card.*
- *Arkansas law requires automatic, annual evaluation by the payer after June 30th of each year.*

5. **Initial Gold Card status should be automatically granted to all providers at the onset of the law**
    a. At the onset of the program, Gold Card status should be granted to all current providers
    b. After an initial look back period, payers can do claims analysis to determine if a provider's Gold Card status should be revoked

Supportive talking points

- *Granting a Gold Card to all providers at the initiation of the law ensures that payers are fully engaged to implement the program. Payers have a long history of delaying claims and programs to serve their interests.*
- *Louisiana law left initiation of the Gold Card program open ended for payers, resulting in a disjointed rollout that does not equally include all providers.*
- *Arkansas law granted a Gold Card to all providers that had to be revoked by the payers after an initial lookback period.*

6. **Gold Card determination should be calculated by examining therapy care by dates of service**
    a. Many Gold Card laws discuss granting exemptions of a prior authorization for a particular service, as determined by a CPT code. This works for many providers but is not practical for therapy providers.
    b. Qualification of a Gold Card for therapists should be determined by looking at dates of service authorized vs dates of service requested.

    Supportive talking points
    - *When therapy providers are working with a consortium of provider types to pass Gold Card legislation, the unique billing paradigm for therapy providers must be considered.*
    - *Granting a Gold Card by individual CPT codes would be micromanagement and interference on the delivery of care on the part of payers, as well as difficult to incorporate in to many existing capitation or visit payment caps.*

7. **Gold Card legislation should begin with a wide net, encompassing as many state-governed plans as possible**
    a. Creating symmetry between plans at the state level reduces provider burden and enables maximum protection for providers.
    b. ERISA(self-insured/self-funded) governed plans will be exempt from state law.

    Supportive talking points
    - *Application of legislation to state Medicaid plans should be evaluated on a state-by-state basis, ensuring legislation does not force Medicaid plans to start new prior authorization processes. Managed Medicaid plans would need to be included in this evaluation.*
    - *Louisiana, Arkansas, and West Virginia law cover state-governed fully insured plans only.*
    - *Proposed legislation in Georgia includes commercial and Medicaid plans.*
    - *The breadth of plans that Gold Card legislation applies to is often narrowed down during the negotiation process of the legislation.*

8. **Gold Card legislation should include language that addresses pre-payment audits for providers that have achieved a Gold Card.**
    a. Pre-payment audits are simply another form of prior authorization, but now with additional risk taken on by the provider.
    b. Only in instances of suspected fraud or negligence should a 100% pre-pay audit be performed.
    c. If a provider successfully passes 90% of any post-payment audit, any future audits should be done post-payment.

Supportive talking points

- *As programs mature in states that have implemented PA/Gold Card reform legislation, some payers have responded with an increase in pre-payment audits.*
- *Pre-payment audits are a reasonable mechanism that payers should have to ensure medical necessity of services, but these should not be used in a punitive manner. Pre-pay audits should only be performed when a provider has a high failure rate on post-payment audits.*
- *Only if a provider has been fraudulent or shows that they are not documenting medically necessary services should they have the burden of a 100% pre-pay audit.*

9. **Prior Authorization Reform legislation should incorporate therapy standards for a base number of visits before a provider takes on the burden of seeking authorization**
    a. The average plan of care for physical therapy is 12-13 visits. Prior authorization should not be required prior to this threshold.

Supportive talking points

- *Maine legislation eliminated prior authorization before the 12th visit.*
- *Requiring prior authorization before the 12th visit is a waste of provider and payer resources and restricts necessary care.*
- *Prior authorization should only be required when a provider is exceeding normative treatment guidelines.*

10. **Prior Authorization Reform legislation should provide for electronic submission for authorization that is determined in a timely fashion.**
    a. Ensure language of legislation defines expedited vs standard PA requests as well as provisions that concurrent requests.
    b. CMS rules for MA plans as well as Federally-Facilitated Exchange plans require an expedited request in 72 hours and standard request in 7 days.
    c. Requests for a continuation of an existing therapy plan of care (concurrent request) should be treated as an expedited request.
    d. Appeal of the authorization determination should be conducted by a similarly licensed professional.

Supportive talking points

- *The AOPT/PPS payment consortium side-by-side provides additional principles important in PA reform legislation.*
- CMS Interoperability and Prior Authorization Final Rule addresses PA decision timeframes.
  https://www.cms.gov/newsroom/fact-sheets/cms-interoperability-and-prior-authorization-final-rule-cms-0057-f