State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
September 27, 2022 – 8:00am – 9:30am
State of Rhode Island Department of Labor and Training
1511 Pontiac Avenue, Building 73-1
Cranston, RI 02920-4407

Meeting Summary

Attendance
Members: Dr. Jill O'Brien (Lifespan), Shamus Durac (RIPIN), Richard Glucksman (BCBSRI), Krysten Blanchette (Care NE), Dr. Peter Hollmann (Brown Medicine), Dr. Beth Lange (Pediatric Medicine), Melissa Campbell (RIHCA), Andrea Galgay (RIPCPC), Stacey Paterno (RIMS), Teresa Pavia Weed (HARI), Teresa Pavia Weed (HARI), Dr. Christopher Ottiano (NHPRI), Elena Nicolella (RIHCA), Al Charbonneau (RI Business Group on Health)

State of Rhode Island Office of the Health Insurance Commissioner Staff
Cory King, Alyssa Metivier-Fortin, Courtney Miner

Not in Attendance
Dr. Scott Spradlin (Aetna), Laurie-Marie Pisciotta (MHARI), John Tassoni (SUMHLC), Christopher Dooley (Charter CARE), Caitlin Kennedy (Coastal Medical), Donna Dardompre (Tufts/Point32Health), Scott Sebastian (United)

Guests
Tara Pizzi (Care NE), Nicole Searles (HARI), Matthew Ness (Cigna/eviCore), Yvette Lefebvre (Cigna/eviCore), Lisa Tomasso (HARI), Deb Hurwitz (CTC-RI), Elizabeth McClaine (NHPRI), Sheila Riley (Prospect Chartercare), Sam Hallemeier (PCMA), Johnny Garcia (Prime Therapeutics), Lisa Tomasso (HARI)

1. **Welcome and Introductions**
    - Cory King introduced himself, along with Alyssa Metivier and Courtney Miner at OHIC. The Task Force members in attendance introduced themselves as well as guests attending the meeting.
2. **Discussion of Workgroup Principles and Problem Statement**
    - Cory discussed the problem statement and agenda. Also, he brought up the meeting minutes from the first meeting which was on 9/13/2022. Cory summarized some of the major points from the first meeting:
        i. Deb Hurwitz (CTC) brought up that the AMA developed a consensus statement on approving the prior authorization process. In Cory's view the AMA consensus statement was a balanced

document and the five areas would be helpful for us to organize our draft problem statement or purpose to take the recommendations & apply them to our local market. Cory summarized the points of several Taskforce members as follows:

ii. Dr. Hollmann made the comment that he thinks the group could make a problem statement and narrow it down.
iii. Matthew Ness stated how technology is important.
iv. Shamus Durac (RIPIN) brought in the consumer perspective and impact prior authorization has.
v. Dr. Lange asked if we just narrow the list of services that require prior authorization?

- Cory stated that OHIC is not taking a position, coming into this without bias and is looking for recommendations to streamline the administration of health care services. OHIC has heard well-articulated points from both sides (payor and provider community).
- Rich Glucksman (BCBSRI) asked if the meeting minutes from 9/13/2022 be modified to reflect that less than 10% of drugs require prior authorization.
- Cory brought up the Consensus Statement on Improving Prior Authorization Process that was developed by the American Medical Association along with a number of other groups. The document was not provided prior to the meeting. Cory brought up the first point in the consensus statement, Selective Application of Prior Authorization. Cory asked if this would be an area the Task Force would want to develop recommendations?
- Dr. Hollmann (Brown Medicine) stated that most of the principles are good ideas.
- Dr. Beth Lange (Pediatric Medicine) – mentioned the concept of gold carding. If there is a gold card provision given to a physician who meets certain criteria, because they have been granted immunity, it can be challenging based on the specialty (ortho. vs pediatric medicine).
- Cory – Have you studied this (payors)? How would you operationalize it?
- Rich Glucksman (BCSRI) – stated that BCBSRI is not doing it right now due to technology challenges.
- Sam Hallemeier (PCMA) some of our companies did have gold carding but the programs were canceled due to cost.
    i. Cory asked Sam Hallemeier if an analysis was done?
    ii. Sam Hallemeier (PCMA) said no
- Matthew Ness (eviCore/Cigna) – It is a complex issue. Gold carding has been used in 12 to 13 states and all have failed. Texas passed a law on gold carding, it turned out to be a disaster and difficult to issue the final rules. One issue in Texas was the 90% threshold. Allowing 10% of services/drugs to be administered that were not medically necessary.

eviCore/Cigna did a study on radiology.

- Liz McClaine (NHPRI) – stated that NHPRI doesn't gold card. NHPRI did tiny experiments on not requiring PA on some services.
- Johnny Garcia (Prime) – stated that we need to separate medical vs. pharmactuaical, therapeutic duplication PA for RX.
- Dr. Hollmann (Brown Medicine) – The group can provide examples of almost anything good or bad. Health plans, PBMs, etc., he wants to see the study and validate the sources. We need to see evidence of this. Throwing anecdotal snippets is not productive. We have to look at the big picture.
- Dr. Beth Lange (Pediatric Medicine) – stated that it is challenging time to look at PA. PA was waived during the pandemic. People we afraid to go to the hospital. Any spike in medical care could be due to the backlog and hoping to get in before the PA. It is hard to say. Having the data would be very helpful to see.
- Jill Obrien (Lifespan) – Medicare implemented PA then gold carded. I wonder if Medicare has done any research on that. What the utilization was (does it work, does it not? Is it helpful?) I haven't done that research
- Cory – A homework assignment, if industry representatives have studies (that would meet certain scientific criteria) send to us to pull information. Need to have a balance of evidence.
- Teresa Pavia-Weed (HARI) – stated that there is a lack of evidence one way or another. There isn't have enough data yet to substainate. West Virginia has gold carding, and Connecticut had a bill that was introduced but did not pass. She said she will double-check, the articles she read stated that they don't have the data (TX or WV)
- Cory – The gold carding conversation has to continue. Turning to value-based contracting - how does this interface with gold carding? Are the financial incentives in VBPs strong enough?
- Dr. Hollmann (Brown Medicine) – Even it was just PCPs a group might still decide they want PA for cost or safety. You wouldn't necessarily gold card a certain provider, it would be the whole group. Many patients are treated outside of the group. Chartercare takes on UR, there is some utility for utilization review. They have it for a reason and it costs money.
- Sheila Riley (Prospect Chartercare) – 80% of patient services are outside of our network.
- Elena Nicolella (RIHCA) – The foundational question is the problem statement. The solutions that we have been talking about for the last 10 minutes. It is assumed that there is a problem on both sides (providers and plans).
- Cory –Let's try to discuss a problem statement. The issue is, the body wouldn't even designate co-chairs. Are they going to agree to a problem statement? I have heard forceful arguments on both sides. PA is a burden to providers; it takes their time and the freedom to exercise their physician

responsibility. The Payors are concerned about cost and patient safety. We are not going to abolish PA or medical management. So what changes can we agree to in this forum that will be meaningful to providers and still serve the broader objectives of everyone.

- Jill O'Brien (Lifespan) – consistency in process for prior authorization and this list (services that require PA). There needs to be a consistent process for identifying what needs PA and how to get it.
- Cory – What we are hearing is a lack of consistency in health plan processes and what is on the list (services that require PA). Various modalities that providers use to request PA (fax, phone, email). Payors all have different processes.
- Liz McClaine (NHPRI) – stated that there is a difference between the lines of business and the payor might try to be consistent across their own lines of business when it comes to PA.
- Cory – we can agree that there is lack of consistency and lack of agreement in terms of the list
- Stacy Paterno (RIMS) – Agree. How are the insurers trying to fix patient safety? There are times that patient care is comprised due to PA. The document (AMA consensus statement) was used for the legislation that was almost passed last session, used to guide that work. This document is looking at it from everyone's different perspective. It is not fair to a patient that a doctor's office has to go to five different processes. We have to improve that. There must be ways we can do this.
- Dr. Beth Lange (Pediatric Medicine) – Often times the PA bumps out due to administrative area (birthday, etc). Having a streamlined form that is very clear. It truly is the physician or provider who is filling out the paperwork.
- Cory – the paperwork that you have to fill out varies by product line. OHIC only regulates a certain portion of the market. OHIC may or may not adopt regulations based on this working group. Does not solve the problem of fragmentation of processes across payers and lines of business.
- Teresa Pavia-Weed (HARI) – Ohio did a survey, it wasn't scientific. It broke down into two categories, medical vs. administrative. Seems to me we could break this into simple categories. Identify the problem, is it administrative or something much more significant.
- Dr. Hollman (Brown Medicine) – The main problem is that when things work the way they are intended- a minor burden. We need better statistics and how to improve the process. Spending half an hour on hold because the prior authorization didn't go through, that's where the issue is. We need to figure out ways that the failures can be minimized.
- Dr. Ottiano (NHPRI) – A lot of this stems from time limits and communications. Some of these issues, there are 24-hour turnaround times (Medicaid). Whether it's the logistics of regulatory timeframes (fax, phone, etc) not sure if that goes too far into the weeds.

- Cory – We are here to determine if there are public policies that can be designed to address the problem. I am not going to be able to eliminate the phone calls or even reduce the time spent on the phone. However, we could try to reduce the frequency of making phone calls, which means evaluating the services that require PA and reducing the size of the PA list.
- Yvette Lefebvre (eviCore/Cigna) – We are all agreeing maybe more than we sound like. Point number 5 in the AMA statement automation to improve transparency and efficiency. The patient should be able to see where they are in the PA process.
- Matthew Ness (eviCore/Cigna) – We all can agree that we need a more efficient process, further automate the process, get to yes faster. I think that is the fix. I know there is a bill in congress (focused on Medicare Advantage plans) electronic PA, that is a potential fix for all of this.
- Rich Glucksman (BCBSRI) – He validates brining us all together to collaborate. There is an opportunity to educate people on how to use BCBSRI systems. Something on the table for OHIC bringing Medicaid/EOHHS in.
- Cory – I think we are a little closer to identifying the problem. There are normal day to day business functions that health plans should do to make the provider experience better. Then there is public policy, which is a blunt instrument.

3. **Discussion of services that require Prior Authorization**
    - OHIC provided the lists of services that require PA as represented to the office in this year's form review process but did not discuss this list with the Task Force members.
4. **Care New England Presentation: Notification and Authorization**

    Krysten Blanchette (Care NE)

    - I am in finance which is a little different from everyone here. A comment from earlier about sitting on the phone for 30 minutes, that is happening every single day. The forms are different forms inside the plan for a product (fax, phone call, online). It is difficult for providers to have to know CPT codes and many changes.
    - Please refer to CNE's presentation posted here.
    - Cory asked if there were any questions on the presentation.
    - Elena Nicolella (RIHCA) asked if Krysten could elaborate on missing CPT code problem and what that looks like
    - Krysten Blanchette (Care NE) – stated a lot of providers write the procedure and not the CPT code. The staff has to determine what the CPT code is.
    - Dr. Lange (Pediatric Medicine) – I will write CT of the left knee and not write the diagnostic code, as there are probably 40 different codes, it is challenging. It is not in our training. Impactful comments. Processes are great, can we decrease the number of times, lets make the list smaller.

- Stacey Paterno (RIMS) – The CPT code issue is very complicated. It is interesting that providers have to teach themselves what an insurer put into place. A lot of the burden lies with the provider and office. Is there a way to quantify this to a dollar figure, what the actual dollar amount is?
- Krysten Blanchette (Care NE) – stated that for this meeting, she removed a lot of payor specific information from the presentation.
- Cory – stated in terms of this question of having a list of services that require PA. How much cost are we building into the system to avoid cost? (i.e., FTEs, payor cost, cost avoidance from the existence of the practice. Patient safety and delayed care access).
- Stacey Paterno (RIMS) – or just to get paid from a provider perspective? This seems like it is delaying it
- Krysten Blanchette (Care NE) – taking a hit by hiring an outside vendor; still getting paid the same amount – if we avoid denials
- Al Charbonneau (RI Business Group on Health) – stated that CPT codes have been around for 30 – 40 years. The focus should be on the practices that are not doing it right. There is a problem on the insurer side and problems on the practice side.
- Krysten Blanchette (Care NE) – Yes, CPT codes have been around a long time, the amount per test and how often they change is different. CPT codes can change yearly or quarterly. The requirements can change, such as following CMS and then not following CMS.
- Dr. Beth Lange (Pediatric Medicine) – There are so many different codes, I don't know which one is the best one. It is collegial relationship to determine the appropriate code.
- Andrea Galgay (RIPCPC) – it is not that the providers don't know the code, it could be an instance where the patient presents a different problem and the prior authorization was already submitted under the initial code.
- Matthew Ness (eviCore/Cigna) – It is a balancing act – why do payors do UR? Medical knowledge changes every 73 days it is impossible to keep up. There is a reason why UR takes place because there is a lot of inappropriate care.
- Elena Nicolella (RIHCA) – if the payors view PA as also a quality improvement or learning tool. There feels like there is opportunity, if there are certain procedures that are no longer evidence based.
- Dr. Ottiano (NHPRI) – Some of our vendors are doing better – New Century Health (NCH) chemo and cancer treatment. NCH has teams of oncologist keeping up with the standards and linking them to the provider locally for the prescription. Finding it very helpful.
- Cory – I think this has been a very robust discussion. Thank you for the presentation, Krysten. Alyssa and I need to go back in order to move this Taskforce along. We are going to try to draft the principles and elements of the problem statements. It is incumbent of us to put something up for your discussion. Your role is to submit recommendations and if you can't reach a

consensus, to outline the issues. Using public policy to reduce the number of times the phone has to be picked up and reducing the list could be in play. All of the work the payors are doing for automation.

2. **Coastal Medical Presentation: Pharmaceutical Prior Authorization Data**
    a. Unable to attend and present on September 27, 2022.
3. **Discussion**
4. **Public Comment**
    a. There were no public comments.