State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
November 15, 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: Krysten Blanchette (Care NE), Dr. Beth Lange (Pediatric Medicine), Melissa Campbell (RIHCA), Andrea Galgay (RIPCPC), Teresa Pavia Weed (HARI), Dr. Christopher Ottiano (NHPRI), Al Charbonneau (RI Business Group on Health), Caitlin Kennedy (Coastal Medical), Laurie-Marie Pisciotta (MHARI), Shamus Durac (RIPIN), Richard Glucksman (BCBSRI)

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

Not in Attendance
Dr. Peter Hollman (Brown Medicine), Scott Sebastian (United), Dr. Scott Spradlin (Aetna), Erin Boles Welsh (Tufts/Point32Health), Christopher Dooley (Charter Care), John Tassoni (SUMHLC), Stacey Paterno (RIMS), Elena Nicolella (RIHCA), Dr. Jill O'Brien (Lifespan)

Guests
Tara Pizzi (Care NE), Matthew Ness (Cigna/eviCore), Sheldon Schneirt (eviCore/Cigna) Deb Hurwitz (CTC-RI), Elizabeth McClaine (NHPRI), Sam Hallemeier (PCMA), Johnny Garcia (Prime Therapeutics), Sheila Riley (Prospect Chartercare), Rena Sheehan (BCBSRI)

1. **Welcome and Introductions**
    - Alyssa Metivier-Fortin introduced herself, along with Cory King and Courtney Miner at OHIC. The Task Force members in attendance introduced themselves as well as guest attending the meeting.
2. **Coastal Medical Presentation: Pharmaceutical Prior Authorization Data**
   Caitlin Kennedy (Coastal) – Director of Pharmacy
    - Please refer to Coastal's presentation posted here
    - In 1997 the pharmacy program was established with one pharmacist, fast forward to 2014 the pharmacy techs were first integrated in Coastal Medical. Caitlin Kennedy started in 2017 with Coastal Medical at that time the team was 6 pharmacy technicians and here we are in 2022 we have 7 clinical pharmacists, a pharmacy resident and 12 pharmacy technicians that make up the pharmacy team.
    - 2018 Coastal began to look at how to quantify the volume of PA. Created a structured data field and a template, our data team runs a weekly report.
    - August 2018 through September of 2022 just templated it is an

underestimate. The data is incomplete. The technician goes through and reviews the report. Unknown category – needs to be looked at, but about 90% success rate with PA. We have done a time study, on average takes 45 minutes per PA, around 12,000 PA. Time consuming, some of them are easy.

- Wanted to show the evolution and the history. Coastal has created a system to help with the massive PA. A team of 12 pharmacy technicians. 45 minutes per PA, in the course of 4 years they have done around 12,000 which is an underestimate. We have taken an interest in this and started gathering longitudinal data. 90% success rate, it takes an army to do that.
- Questions?
    - Dr. Beth Lange (Pediatric Medicine) – Coastal Pediatrician – last year or two of this data. Underestimate is a true fact. The number of employees that have to be hired in order to do an administrative process.
    - Sam Hallemeier (PCMA) – Of those PA, how many are looking at drug to drug interaction?
        - Caitlin Kennedy (Coastal) – I am not sure, it would come as a hard stop at the pharmacy. It definitely falls into the not needed category. Not sure what the actual number is.
    - Laurie Marie Pisciotta (MHARI) – 45 minutes per PA, is that from your perspective as a pharmacist. How long does the patient wait?
        - Caitlin Kennedy (Coastal) – Good question. We start the process within 48 hours. 2-day window, some can be approved instantly. 36-48 hours waiting for the medication.
    - Johnny Garcia (Prime) – On the last side, are most of these rejections through the adjudication process? So you get that instantaneously when you adjudicate through the claim?
        - Caitlin Kennedy (Coastal) – I will say the dispensing pharmacy would, then they have to send us the notification and that comes through our document management team that processes most of the fax requests that come through to us. We may get them pretty quickly and sometimes we don’t get them at all.
    - Rena Sheehan (BCBSRI) – Part of it was to attest during the PA, do you have them built in or workflows?
        - Caitlin Kennedy (Coastal) – Yes, it is in the clinical documentation that providers have with patients. I don’t think we have any hard stops or pop ups. In terms of best practice and audits, to say this is appropriate documentation to justify that it was prescribed.
    - Shamus Durac (RIPIN) – It looks like you have had 800 denials over the 4 years, 25 actually went to appeal. First question is that

a capacity issue? Is there another outcome and what was the outcome?

- Caitlin Kennedy (Coastal) – The outcomes for the other ones were eventually changed to a formulary alternative. If we go to appeal, there is a true clinical reason, go through the process or I hate to say this, but we did this for you, here is your next option, just for patients to be okay. Most appeals do it as a next step, vs. a true reason for us to be doing it. We have started that PA, and it comes with please wait for additional questions, by the time we have a chance to, or we automatically get a denial, we did not get the questions to respond to in the first place, so it can be a communication/notification issue.

3. Problem Statement

- Cory introduced the draft problem statement elements. In previous meetings we talked about crafting the problem statement. Something that was simple and open for feedback and refinement or total rejection by the Taskforce. We wanted to articulate what we have heard from the payors, providers, and try to include something that captured the patient experience.
- Providers view PA as causing increased administrative burden and increasing operating cost and as potentially jeopardizing patient safety. How does the patient interact with this system? Patient's experience can be materially and adversely impacted when the application of PA creates real, or perceived, barriers and delays in accessing care.
- Open up to the discussion of the task force, is this fair? What would you add or take out?
    - Dr. Beth Lange (Pediatric Medicine) – I am very impressed. The last couple of meetings we have heard various sides of the issue. The only addition I would make to the provider view; I would write PA is an accelerant or major contributor to clinical burnout.
    - Rich Glucksman (BCBSRI) – I wouldn't change anything on the payor or provider side. On the patient experience, affordability is relevant. There is a reference to wasteful spending. We certainly hear, most people employers are struggling with increased premiums as well as out of pocket costs for their employees. To the extent that PA addresses cost, it could control premiums and has some out of pocket savings.
    - Matthew Ness (Cigna/eviCore) – Really good point. If there is a test or procedure that is medically unnecessary has a cost to the patient as well.
    - Al Charbonneau (RI Business Group on Health) – The rise in premiums driven in part by pharmaceutical expenses. I sent over an article- mock interview of patients in 7 states, one state was RI, 20% of the time, when the patient advocated for a particular drug, the physician changed their mind, even though the physician didn't agree. Anything that we come up with has to accommodate that.

- Shamus Durac (RIPIN) – First off, I totally agree that there is a perspective on affordability for PA more generally. I do want to separate that out from the patient experience. We are thinking of two different things. I think sometimes when folks are denied a PA feels their care is worse than it would have been otherwise. The consumer experience of all of this could potentially be affected by that.
- Cory King (OHIC) –Maybe we add a fourth bullet. Obviously, consumers have an interest in affordability and patient safety. I think I agree with you Shamus, when the patient is in active course of treatment and they have a PA that is denied, they are not thinking about what their premium is, or cost share. We will craft a 4th bullet that tries to incorporate what you've said and bring it to the next meeting to hash out.
- Rena Sheehan (BCBSRI) – I was just wondering given the patient experience of care and that it can be negatively impacted, it seems like the statement is saying 100% of the time there is no benefit to the patient. We have heard some examples of it being beneficial to the patient. Maybe it is not the intention, but it does read that there is no positive impact to the patient.
- Cory King (OHIC) – We can integrate some language for you all to review to bring some more balance. We tried to capture what the worst-case scenario is. There can be some enhancement
- Sheldon Schneirt (Cigna/eviCore) – I am new here and I'm a gastroenterologist. I want to echo the last statement, for example we have a very active (eviCore) consumer engagement. When someone requests a radiology procedure at a hospital, and there is a freestanding quality clinic across the street. Our consumer engagement would call and let them know that their co-pay will be $500 at the hospital or $75 across the street to get your cat-scan. That is a positive patient experience, not a negative. More frequently than not, they say thank you and go ahead and do that procedure. A hospital costs twice as much for a colonoscopy than at a freestanding surgical center.
- Cory King (OHIC) – We will add some of the things we have discussed. Thank you.

4. Straw Model Proposal

- Cory discussed the two-part proposal for the Task Force to motivate discussion.
    - Part A, which focuses on medical services, not on pharmacy or devices. Remove PA for all medical services that have an average approval rate of 95% of higher and an average cost of $25,000 or less. The reason we use the term average is you may want to look at a multi-year period. The questions we have for you, would Part A reduce the administrative burden? Would the task force propose any changes or alternatives?
    - An early observation is that the provider has to spend an average

time on the phone, we can't necessary change operationally how much time a provider spends on the phone per PA request, but we can try to change the frequency with which the phone is picked up (fax, email, etc) and trim the size of the list. We thought that this proposal would reduce the size of the list. OHIC does not have regulations drafted around this.

- Andrea Galgay (RIPCPC) – I have a clarifying question. The insurer would come across and look at the averages or if the provider would have a 95% approval rate, there would be different lists for different providers.
- Cory King (OHIC) – That is a parameter for the model that you all can discuss.
- Krysten Blanchette (Care NE) – If it is done by the provider it would be impossible to manage. I was thinking like CPT level. How do we decide what the 95% approval rate is? Would it come from the payors?
- Cory King (OHIC) – Yes, and the payors do report. If a policy like this would be implemented, OHIC would have to have a way to identify what the services are. We might have to change our reporting structure.
- Teresa Pavia Weed (HARI) – Just a question, is the concept like 95% approval rating over the past year and evaluated annually.
- Cory King (OHIC) – I envision like a moving average, a two- or three-year window. This is just a straw model proposal; it is totally up to you all.
- Laurie Marie Pisciotta (MHARI) – I am very excited about Part B of your proposal. But for Part A, does services include prescription medications, where do they fit in?
- Cory King (OHIC) – We could discuss a similar model for that, I just wanted to focus this on medical services for now, imaging, diagnostic, etc. Question to the payers is whether this is going to blow up costs, is it going to prevent you from evidence-based PA practices?
- Rena Sheehan (BCBSRI) – Part of clarifying questions, so a way it is written is on the service, is there a need for any provisions on outlier providers? So again, purely thinking about the patient and the patient safety aspect of this. If there is a service that has an overall 95% approval rate, but there are 10 providers that are consistently not following the guidelines, how do you account for it?
- Cory King (OHIC) – We could potentially account for that. I would love for you all to identify the gaps in this construct. We could do it on a book of business type of level. I know there is variation in quality of care that is provided to the patients, that is a problem.
- Rich Glucksman (BCBSRI) – I think that is a really good point, the initial reaction is to try and dive in, what is right percentage and dollar threshold. The conversation has made it clear, thinking through what is there and why. The conversation has shed light on process changes that could happen and are happening. There are different levers that the office has to move the system in a way that creates less friction.
- Cory King (OHIC) – Even though this proposal is just on medical, if we were to pretend, I'd like to hear about the pharmacy side, given there

would be a different dollar threshold.

- Sam Hallemeier (PCMA) – The drug-to-drug interaction, got rid of PA, all of the drug interactions go away. There is no safety check on that side.
- Caitlin Kennedy (Coastal) – I think that could be done on the dispensing side. What happens now, pharmacists don't see that information. It is a technician that knows to do the overrides. There also needs to be workflow and software changes on the dispensing end. This isn't PA, don't send to your doctor.
- Johnny Garcia (Prime) –For a dollar limit, it would be hard to say. Specialty drugs are so expensive, have to keep that in mind, the average cost for is $100,000 a year for a specialty drug.
- Caitlin Kennedy (Coastal) – Is there a way to allow our community partners to work at the top of their license, rather than saying I am being held to this standard because this isn't covered or this is, vs. I know clinically and therapeutically that this is an appropriate change, and if it is not, then it's a discussion with your provider and patient.
- Johnny Garcia (Prime) – I think from the pharmacy side, pushing the technology. That is what CMS is trying to do.
- Matt Ness (Cigna/eviCore) – Just going back to the medical side. Two points, I read it a little bit differently. The way I look at it is, we have a 95% threshold, it means 5% of unnecessary care can take place. I am looking at it from a patient safety perspective. I don't want to be in the 5% or my family. There is definitely an agreement that the pharmacy side is further ahead as far as implementing electronic PA. Maybe some low hanging fruit to make it less of an administrative burden, increase turnaround times. Get rid of the fax machines, incentivize providers to not use the fax machine. If there is some way to incentivize providers to use more electronic means.
- Cory King (OHIC) – I respect all of the comments. When I look at this from the OHIC regulatory perspective, not that we are talking about regulations, these are market enterprise-wide processes, that go beyond the scope of OHIC's particular authority. Every payor is different and has its own strengths and weaknesses. We have one more meeting of this body left and it is fair to say we are not coming to a consensus, which means that this will get hashed out in the legislature next year. I am happy to commit more time to process improvements and use of technology, from the regulatory perspective having simple and understandable rules in place that determine the guardrails in which actors behave seems to more efficient than talking about all of the process improvements and throwing out the fax machines, though I respect that, I don't think we should be using fax machines in 2022.
- Shamus Durac (RIPIN) – I 100% agree with the comment around the fax machines. One thing I want to come back to is the straw proposal, is the idea that, first off, I don't think yes, we want 100% of services to be medically appropriate and necessary. I do not think the patient experience is that PA does that anyway, I feel like they are probably some services that go through the PA process that wouldn't be unnecessary, just a as much for the patient experience that are denied for the PA process that are considered necessary.

- Teresa Pavia Weed (HARI) – From the hospital perspective, it is a timeliness issue. The SNFs discharge, it isn't going to help us. Timeliness is an important part. I think this is a great proposal.
- Cory King (OHIC) – We will discuss this internally. If people want to provide written comment on this proposal.
- Rich Glucksman (BCBSRI) – How do you view the office and the tools, I just want to come back to the idea of going big and picking something easy, just because it is easy, doesn't make it the right way to approach it. We are really responsive and do see OHIC as having effective tools, such as market conduct exams, you are an effective lever in getting plans to look at these things in a tight way. So I think coming at it, from another perspective, that there is an effectiveness on the process of the office
- Cory King (OHIC) – I wasn't saying we are ineffective. When it comes to crafting a process, something that is simpler to enforce, without a mishmash of things is preferable. We have over 1 million in Rhode Island and less than 200,000 are enrolled in products that OHIC has jurisdiction over. There is so much more out there, Medicaid, Medicare and the self-funded groups.
- Rich Glucksman (BCBSRI) – Just to react to that, if I could, that's exactly why the process may be more important, the fully-insured taking that approach and other products doing something different.
- Cory King (OHIC) – Reviewing Part B of the straw model proposal, access to behavioral health services is a big issue. Part of OHICs powers and duties addressing behavioral health, particularly directing insurers to towards policies to improve the overall health of the public. This proposal again, is part of Commissioner Tigue's proposal to throw something big and cut the list, discontinue prior authorization for all in-network BH services. The questions are a little bit different on this one, would the proposal reduce the administrative burden faced by providers and would the task force like to propose alternatives?
- Sam Hallemeier (PCMA) – Is drugs part of this?
- Cory King (OHIC) – No prescription drugs, but for the purpose of discussion sure.
- Al Charbonneau (RI Business Group on Health) – I just want to remind everyone, that the Truven report that was commissioned by EOHHS said two things, that BH cost is the highest in the country, prescribing and hospital admission. We should be careful here in turning the spicket on.
- Rena Sheehan (BCBSRI) – I had a question. What is the rationale for having a threshold for medical vs. BH?
- Cory King (OHIC) – To go big. I want to motivate you all to creativity. What if we did this? I want to get your opinions.
- Teresa Pavia Weed (HARI) – I serve on the Governor's Council of Overdose, this issue of PA and discharge from the ER, keeps coming up. I am not on the ground enough to know what the obstacles are. I'd like to get back in writing to find out, because it has come up a number of times.
- Laurie Marie Pisciotta (MHARI) – We have a crisis because there is a shortage of providers and lack of outpatient services. The Mental Health

Association conducted an outpatient BH provider survey in 2021, one of the things we learned, just like medical professionals, BH professionals spend a lot of time and money doing the paperwork for PA. That leads to provider burnout and drives up their expenses, which makes it difficult to stay in business and harder for patients to stay in care. The last thing you want to do is get cut off from your therapist or a program you are because of your insurance.

- Rich Glucksman (BCBSRI) – I will just add, for BCBSRI, we have taken off utilization management, PA concurrent, retro for BH. A couple of reactions, we did that when COVID hit, it is hard to share with you what has been the impact of it. We are still trying to figure out what the impacts are. If you take off PA, what else can you do to be thoughtful about care management? For us having done that, to still hear that there are issues in the community, who are you doing that for? Outside of RI plans, Medicaid? Who is causing the pain points?
- Johnny Garcia (Prime) – We need to be careful, if you remove from Medicaid, Medicare, you create a difference in healthcare for populations. So, for commercial patients you are going to get better care because you don't have PA. It is going to cause some issues. You can't remove for one market and not the other.
- Rena Sheehan (BCBSRI) – We are looking at a super scarce resource, we know we don't have enough beds. How do we ensure that the patients who really need it, are getting the care they need? How do we manage a scarce resource? There aren't enough beds, inpatient, residential, IOP, partial.
- Dr. Beth Lange (Pediatric Medicine) – This is where OHIC's BH statement will be helpful because just like heart disease, diabetes, obesity, the need for acute beds is preventive. It is a workforce issue; we don't have enough physicians. I look forward to what OHIC has been working on so hard.
- The meeting concluded and there were no public comments.