OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Administrative Simplification Task Force
Report to the Rhode Island Health Insurance Commissioner
February 13, 2023

Introduction

Rhode Island's Office of the Health Insurance Commissioner (OHIC) reconvened the Administrative Simplification Task Force on September 13, 2022, to seek input from organizational representatives who understand the operational and policy complexities of the prior authorization process. Prior authorization is the prospective assessment of a health care service prior to that service being rendered.

Invitations were sent on July 8, 2022, to representatives of insurers, review agencies, providers (including organizations and individuals representing physical health, mental health, and substance abuse) and consumers advocacy groups.

Background

OHIC's purpose in this Administrative Simplification Task Force was to gain a better understanding of the existing prior authorization environment. The Task Force's charge was to gather input and recommendations on prior authorization requirements and processes.

Meeting Dates and Participants

The Administrative Simplification Task Force convened on September 13 and held four additional meetings on September 27, October 18, November 15, and December 13. The following table lists the Task Force membership and the attendance at each meeting.

Table 1: Task Force Membership and Organizational Affiliation

Name	Affiliation	9/13	9/27	10/18	11/15	12/13
Dr. Scott Spradlin	Aetna					
Dr. Jill O'Brien	Lifespan	X	X	X		X
Stacey Paterno	RIMS		X	X		X
Shamus Durac	RIPIN	X	X		X	
Laurie-Marie Pisciotta	MHARI			X	X	X
Dr. Christopher Ottiano	NHPRI		X	X	X	

Name	Affiliation	9/13	9/27	10/18	11/15	12/13
Richard Glucksman	BCBSRI	X	X		X	X
Andrea Galgay, RIPCPC COO	RI Primary Care Physicians Corp.	X	X	X	X	X
Donna M. Dardompre RN, MPH	Point32Health	X				
Teresa Pavia Weed	HARI	X	X	X	X	
Scott Sebastian	UnitedHealthcare	X		X		X
Krysten Blanchette	Care New England	X	X	X	X	X
Christopher Dooley	CharterCARE					
John Tassoni	SUMHLC					
Dr. Peter Hollmann	Brown Medicine	X	X			X
Al Charbonneau	RI Business Group on Health		X	X	X	
Dr. Beth Lange	Pediatric Medicine Provider	X	X	X	X	X
Melissa Campbell/Elena Nicolella	RIHCA	X	X		X	X
Caitlin Kennedy	Coastal Medical	X		X	X	

In addition to the appointed members of the Administrative Simplification Task Force, some insurers/UR agents elected to have additional representatives participate as members of the public. These regular public attendees include:

1. Elizabeth McClaine & Heather Beauvais, NHPRI
2. Rena Sheehan, BCBSRI
3. Tara Pizzi, Care New England
4. Nicole Searles and Lisa Tomasso, HARI
5. Matthew Ness, Yvette Lefebvre and Dr. Eric Gratias, Cigna/eviCore
6. Deb Hurwitz, CTC-RI
7. Sheila Riley, Prospect CharterCARE
8. Sam Hallemeier, PCMA
9. Johnny Garcia, Prime Therapeutics
10. Terrance Martesian, AHIP
11. Erin Boles Welsh, Point32Health

The meeting structure consisted of the following:

1. Orientation – September 13, 2022
2. Discussion of Task Force Principles and Problem Statement – September 27, 2022
3. Presentation: eviCore healthcare – October 18, 2022

4. Draft Problem Statement and Straw Model Proposal – November 15, 2022
5. Final Discussion on Draft Report and Problem Statement/Straw Model Proposal - December 13, 2022

Orientation

The first meeting on September 13, 2022, was an orientation for the 2022 Administrative Simplification Task Force. Cory King, the Chief of Staff, currently Acting Health Insurance Commissioner, opened the meeting by welcoming and thanking Task Force members for participating and emphasized the importance of their upcoming participation.

He then initiated the remaining meeting agenda items:

1. Task Force Introductions
   OHIC staff introduced themselves and then asked each Task Force participant to introduce themselves, their titles, and the organization that they are representing.

2. History of Administrative Simplification and Task Force's role
   OHIC reviewed the history, purpose and statutory charge of Administrative Simplification Task Force and gave examples of previous topics that past Task Forces were charged with. Examples of previous Administrative Simplification Task Force topics include external appeals requirements, retroactive terminations, coding and billing, benefit determination, external appeals, medical management, and consumer cost sharing to be included in plan design.

3. 2022 Topic – Prior Authorization requirements and processes
   OHIC explained why this topic was selected for further development:
   - OHIC noted that legislation was brought forth during the latest session that would have required OHIC to govern prior authorization.
   - Additionally, there have been discussions with provider groups on this topic and the pain points of the prior authorization process.
   - OHIC currently receives quarterly reports from all certified utilization review agents that perform non-administrative benefit determination. The reports include the following broad categories for medical/surgical, mental health and substance use: hospital inpatient, emergency, other hospital outpatient services, lab/diagnostic/testing/imaging, pharmaceutical, durable medical equipment, physician services, other professional services, and dental. The review agents submit their data that includes prospective, retrospective, concurrent, appeals, and out of network approved and denied. OHIC is currently working on enhancements for the portal where the data is housed in order to put the information in an easily accessible format to determine trends and outliers.

OHIC highlighted the goals and objectives for this year's Task Force as follows:

- Discuss and understand prior authorization requirements and processes for payers and providers;
- Define the barriers that prior authorization can create for providers, payers, and consumers;
- Discuss and agree on a problem statement;
- Based on discussions, make recommendations to the Commissioner

Discussion of Task Force Principles and Problem Statement

The purpose of the second session held on September 27th was to discuss the workforce principles and draft a problem statement for the Task Force along with a presentation by Care New England on notification and authorization.

At this meeting, OHIC stated that it was not taking a specific position on the matter but coming into these meetings without bias and looking for recommendations to streamline the administration of health care services around prior authorization. During this meeting, OHIC discussed a jointly published consensus statement, developed by the American Medical Association, "Consensus Statement on Improving Prior Authorization Process[1]". This article stimulated discussion between the Task Force members on the pros and cons of a process called "gold carding" as well as other methods to improve the processes.

Krysten Blanchette from Care New England presented to the Task Force on notification and authorization. The presentation highlighted the problems that occur with prior authorization, such as payer requirements, missing clinical documentation and time and accountability. Several areas of concern were identified based on the study completed by Care New England. Examples include time, insurance verification, incorrect (or mismatched) or missing CPT's, rescheduling, procedure changes in the OR, and medical necessity requirements that may vary across payers and products. Care New England identified the continued barriers that prior authorization processes create such as staffing resources. Due to the complexities of the processes for staff to submit notification or obtain authorization, there is an investment in hours and engagement to train and hire staff. This could take months for a staff person to be up to par with performing both efficiently and accurately. Regardless of all of efficiencies that could be made, the payer policies remain inconsistent across and yet specific within the markets.

Presentation – eviCore Healthcare

The purpose of the third meeting, held October 18th, was to discuss the prior authorization process from the review agent/payer perspective. Dr. Eric Gratias from eviCore/Cigna discussed why prior authorization exists. The original versions for prior authorization were

[1] https://edhub.ama-assn.org/data/multimedia/10.1001ama.2018.0080supp1.pdf

to target high-cost therapies. It has since evolved from affordability to quality of health care services being provided. A blind spot identified by Dr. Gratias is within medical knowledge, as it is ever changing and can be extremely challenging for providers to keep up with, therefore, prior authorization is necessary and provides a protection for patients. Dr. Gratias indicated that the need for prior authorization is only going to increase because of continued innovation within the medical sphere. While eviCore is aware of the administrative burden prior authorization may cause, the organization has developed technology tools to automate and improve information flow. The goal is to close the gap between the provider, review agent, and patient.

This presentation facilitated a thoughtful discussion from the Task Force members on educating providers and evidenced-based information. The Task Force recognizes the importance prior authorization can have, but there are also numerous pain points such as delay in care, quality, and confusion on the patient's end. Anecdotal examples were brought up during this meeting that a provider can do everything according to the prior authorization, but a service can still be denied. As prior authorization as a whole is a large and broad topic, the suggestion by Dr. Gratias was that maybe during future meetings, the Task Force prioritizes and breaks it down into more groupings to determine ways of improvement.

Draft Problem Statement and Straw Model Proposal

During the fourth meeting, held on November 15th, Caitlin Kennedy from Coastal Medical presented on pharmaceutical prior authorization data. The program was established in 1997 with one pharmacist. Today, Coastal Medical has 7 clinical pharmacists, 1 pharmacy resident, and 12 pharmacy technicians. In 2018 Coastal Medical began to study how to quantify the volume of prior authorizations and created a structured data field and a template. Coastal Medical completed a time study that on average it takes 45 minutes per prior authorization. The study consisted of reviewing 12,000 prior authorization requests, which Coastal Medical stated is an underestimate of the number of requests received.

OHIC then discussed the elements within the draft problem statement. These elements were drafted for the Task Force members to discuss and to include what has been addressed in previous meetings from payers and providers as well as incorporate the patient experience. The first draft of the problem statement read as follows:

- Payers view prior authorization as a utilization management tool to promote evidence-based care, reduce wasteful spending, and promote patient safety.
- Providers view prior authorization as causing increased administrative burden, increased operating costs, and potentially jeopardizing patient safety.

- Patients' experience of care can be materially and adversely impacted when the application of prior authorization creates real, or perceived, barriers and delays in accessing care.

These elements brought forth further discussion between the payers, providers, and consumer advocates around affordability and whether or not it is relevant for the patients' experience. Based on this discussion, it is clear that a consumer has an interest in affordability and patient safety, but when a consumer is in active course of treatment and they have a prior authorization request that is denied, the consumer is likely not thinking about what their premium is or cost share in that moment.

Finally, the meeting closed with OHIC providing a draft two-part proposal for the Task Force. Part A which focused on medical services, not including pharmacy or devices, proposed removing prior authorization for all medical services that have an average approval rate of 95% or higher and an average cost of $25,000 or less. The reason OHIC used the term average is the Task Force may want to review a multi-year period when thinking about this construct. The question OHIC had for the Task Force members were:

- Would Part A of the proposal reduce the administrative burdens faced by providers while preserving latitude for payers to maintain evidence-based prior authorization requirements?
- Would the task force like to propose changes to the parameters of Part A?
- Would the task force like to propose alternatives to Part A?

There was brief discussion as to whether the 95% approval rate would derive from the insurer or provider. OHIC explained that this proposal was drafted so that the Task Force members can have the ability to make any changes and/or negate it entirely and come up with something different. In review of Part B of the straw model proposal, OHIC notes that access to behavioral health services is a major concern, and that as part of OHIC's power and duties, OHIC is charged with addressing behavioral health matters, particularly directing insurers towards policies that address the behavioral health needs of the public. Part B proposed discontinuing prior authorization for all in-network behavioral health services with the following questions to the Task Force members:

- Would Part B of the proposal reduce the administrative burdens faced by providers?
- Would the task force like to propose alternatives to Part B?

The Task Force members discussed the rationale for having a threshold for medical versus behavioral health. OHIC drafted this straw model at the request of Former Commissioner Patrick Tigue in order to go big and encourage the Task Force members creativity throughout this process.

Final Discussion on Draft Report and Problem Statement/Straw Model Proposal

The last meeting was held on December 13th in the hopes to finalize the problem statement, discuss the straw model proposal and review the draft outline of the report. OHIC made some changes based on the November meeting discussion and added framing language to capture that prior authorization is a practice that is ingrained in the industry and is a useful function, in terms of determining what is medically necessary and ensuing there is science behind the care that is being rendered. The problem statement framing language stated "Prior authorization is a form of utilization management that has an important role to play in the provision of medically necessary care under health benefit plans. However, health care providers and those speaking from the patient perspective, have articulated reasonable concerns with the application of prior authorization and the resulting burdens placed on those involved in the provision of patient care". No changes were made to this framing language by the Task Force members. OHIC then identified the changes to the problem statement elements and stated that based on comments from the previous meeting, no changes were made to the problem statement component that described the patients' experience. The payer and provider components of the problem statement were modified thus:

- Payers view prior authorization as a utilization management tool to promote evidence-based care, reduce wasteful spending, and promote patient safety and affordability for health care purchasers.
- Providers view prior authorization as causing increased administrative burden, increased operating costs, and potentially jeopardizing patient safety. Providers have identified prior authorization as a contributor to clinician burnout.

These changes offer further evidence that the Task Force members had very different perspectives on the topic and were unable to come to an agreement on any substantive changes. The problem statement in its final form read as follows:

- Prior authorization is a form of utilization management that has an important role to play in the provision of medically necessary care under health benefit plans. However, health care providers and those speaking from the patient perspective, have articulated reasonable concerns with the application of prior authorization and the resulting burdens placed on those involved in the provision of patient care.
    - Payers view prior authorization as a utilization management tool to promote evidence-based care, reduce wasteful spending, and promote patient safety and affordability for health care purchasers.
    - Providers view prior authorization as causing increased administrative burden, increased operating costs, and potentially jeopardizing patient

safety. Providers have identified prior authorization as a contributor to clinician burnout.

- Patients' experience of care can be materially and adversely impacted when the application of prior authorization creates real, or perceived, barriers and delays in accessing care.

Lastly, to conclude the final meeting, Task Force Members again addressed the Straw Model Proposal that was introduced at the last meeting for a final discussion. The Straw Model Proposal was crafted as such for services that have an approval rate above a certain threshold and are below a dollar value threshold, in order to take services off the list that require prior authorization. OHIC invited the Task Force members to comment via email, however, did not receive any comments on the proposal. OHIC reiterated that the office will not be proposing legislation based on these meetings or on the topic of prior authorization. The Task Force members discussed how the Straw Model Proposal does not identify any parameters regarding measurement and analysis which OHIC stated that aspect is for the Task Force members to resolve through discussion. A concern that arose among the Task Force members is where to find administrative simplification across payers for prior authorization processes. From the provider perspective, the status quo would remain the same because the provider would still need to react to each payer's prior authorization process. The challenge for OHIC is that its authority lies strictly with fully insured commercial payers in the state, which does not include Medicaid, Medicare, or self-insured business. This point brought up a discussion about having a more expansive, state-wide approach to the prior authorization processes and requirements in Rhode Island.

At the close of the last session, OHIC thanked the group for their collaboration in this year's Administrative Simplification Task Force and noted that OHIC will begin drafting the final report to submit to the Commissioner.

Recommendation

At the final Task Force meeting on December 13th, there was discussion and a recommendation suggested by OHIC that the Care Transformation Collaborative of Rhode Island board review the report and consider whether there are opportunities in Rhode Island to collaborate and to work with OHIC and Medicaid as well as other organizations to continue these discussions. The CTC referral proposal was supported by both payers and health care providers.

Conclusion

OHIC believes that the 2022 Administrative Simplification Task Force process was effective at problem definition, but also difficult for the Task Force members to come to a consensus on the solutions to specific, and systemic issues that stem from the practice of prior authorization. Unfortunately, the Task Force members were unable to come to an

agreement on how to reduce the burden that prior authorization requirements and processes have presented to health care providers and patients. The Task Force members had many discussions regarding the pain points on the provider, payer, and consumer side. As a result, OHIC hopes that this report and the Center for Medicaid and Medicare Services (CMS) recent announcement on its new rule meant to streamline prior authorization by requiring certain payers to implement an electronic prior authorization process and respond to requests more quickly, will continue to allow for simplification in prior authorization processes and requirements.