State of Rhode Island Office of the Health Insurance Commissioner

Administrative Simplification Task Force

November 16, 2023 – 8:00am – 9:00am

Virtual Meeting Summary

Attendance

Andrea Galgay (RIPCPC), Caitlyn Kennedy (Coastal Medical), Christopher Dooley (CharterCARE), Dr. Barry Fabius (UnitedHealthcare), Dr. Beth Lange (Pediatric Medicine), Dr. Christopher Ottiano (NHPRI), Dr. Peter Hollmann (Brown Medicine), Elena Nicolella (RIHCA), Hemant Hora (Point32Health), Howard Dulude (HARI), John Tassoni (SUMHLC), Kara Lefebvre (CharterCARE), Karen Labbe (BCBSRI) Laurie-Marie Pisciotta (MHARI), Mark Lorson (NHPRI), Melissa Campbell (RIHCA), Michelle Crimmins (Prime Therapeutics), Richard Glucksman (BCBSRI), Sam Hallemeier (PCMA), Scott Sebastian (UnitedHealthcare), Shamus Durac (RIPIN), Stacey Paterno (RIMS), Teresa Paiva Weed (HARI), Victor Pinkes (BCBSRI)

Not in Attendance

Al Charbonneau (RI Business Group on Health), Dr. Scott Spradlin (Aetna), Maria Zammitti (CharterCARE)

State of Rhode Island Office of the Health Insurance Commissioner Staff

Acting Commissioner Cory King, Alyssa Metivier-Fortin, Courtney Miner, Taylor Travers

Guests

Deb Hurwitz (CTC-RI), Erin Boles Welsh (Point32Health), Mark Gallagher (UnitedHealth), Tara Pizzi (Care New England)

1. **Welcome and Introductions**

Cory King, Acting Health Insurance Commissioner opened the meeting by welcoming all attendees and thanking them for their time. He reviewed the material from the first meeting on October 26th and outlined again the amendments to OHIC's powers and duties, in addition to the review of the CTC-RI report of recommendations.

2. **Review of UnitedHealthcare Commercial Prior Authorization Code Reduction List**

Cory King (OHIC) outlined that the focus of today's meeting was to review UnitedHealthcare's prior authorizations reductions list that was previously circulated to all task force members. He reiterated the goal of creating some multi-payer alignment, and the ability to measure baseline data to track progress towards the 20% overall reduction. He also mentioned the removal of prior authorizations on behavioral health/substance use disorders at BCBSRI. He asked members of the task force to review the UnitedHealthcare reductions list and identify some potential areas for alignment. Additionally, from the provider perspective he asked for feedback on potential pain points.

Taylor Travers (OHIC) outlined the broad categories identified on the UnitedHealthcare prior authorizations reductions list. These categories included DME/orthotics/prosthetics, hysterectomy, spine surgery, genetic testing, breast reconstruction (non-mastectomy), site of service, cardiology, radiology, unclassified, and outpatient therapies (including physical and occupational). For a total of 461 codes eliminated from UnitedHealthcare's prior authorization list. Taylor also provided a sample of the list for review.

Dr. Barry Fabius (UnitedHealthcare) commented that this list was not limited to the commercial plans but rather across all lines of business. He further added that it may not be just primary care providers involved but as an example orthopedic specialists may also be involved. When looking at the overall calculation of prior authorization required services, it did meet the 20% criteria for reduction.

Alyssa Metivier-Fortin (OHIC) added that the specific codes and numbers that Taylor outlined was taken from the commercial list provided by UnitedHealthcare. She added that some of the other lines of business may not have the same codes as the commercial list. The categories may be similar, but this list shown is specific to the commercial lines only.

Taylor Travers (OHIC) explained the crosswalk sample of DME codes, and the alignment across different insurance plans. For the specific codes outlined, E1802, E1805, E1825, and E1840 most plans were in alignment and did not require prior authorization. Taylor further noted that BCBSRI does require prior authorization for codes E1802, E1805, and E1825.

Hemant Hora (Point32Health) added that he did a crosswalk as well, and out of the total 461 codes, they were able to look at 218. For the genetic testing codes, they do contract with a vendor, and they are still waiting for those results. For the remaining codes, Point32Health only requires prior authorization on 12 out of those 218. He added that Tufts has prior authorizations required for 43 outpatient therapies.

Cory King (OHIC) added that it would be interesting if other carriers could do a similar analysis.

Hemant Hora (Point32Health) asked if the UnitedHealthcare reduction was nationwide.

Dr. Barry Fabius (UnitedHealthcare) commented that it was a national initiative, and this is only representative of a starting point. He did reiterate that UnitedHealthcare may have some codes that require prior authorization that Point32Health does not and vice versa. Other categories may need to be reviewed to achieve the 20% reduction.

Hemant Hora (Point32Health) noted that if 461 codes was a 20% reduction, then there were probably around 2,000 codes all together.

Dr. Barry Fabius (UnitedHealthcare) added that he did not have the specifics at his disposal, but that figure did seem correct.

Dr. Peter Hollmann (Brown Medicine) added that it may be beneficial to look at the data in a spreadsheet and do further data analysis. He added that the approval and denial rates of codes would be helpful. He further added that Rhode Island is exempt from site of service codes, so no reduction would be seen in that category. He further added that the C codes are payment codes for facilities that are getting paid on the outpatient prospective payment system so they should not be

on the prior authorization list. He concluded that additional data would be beneficial, adding that if the overall volume is not known it is hard to measure the impact.

Hemant Hora (Point32Health) acknowledged that from 106 site of service codes removed by UHC, Point32Health had only 2. Out of the 67 radiology and cardiology codes combined, Point32Health had again only 2.

Dr. Peter Hollmann (Brown Medicine) added that some of the payers may not even use the C codes.

Karen Labbe (BCBSRI) added that for the outpatient therapies including physical and occupational therapies, BCBSRI will be removing the prior authorization requirement effective 1/1/2024. Those codes equate to about 9,000 referrals annually.

Cory King (OHIC) added that there is a difference between prior authorizations and referrals, and to date the task force has concentrated on prior authorizations but referrals are also a pain point for physicians but necessary from the insurance perspective. Before establishing the necessary data, he asked how the task force might go about establishing a list of services and the associated volume to have a data driven discussion. He added that UnitedHealthcare has provided a starting date, but that it is not representative of all plans.

Dr. Peter Hollmann (Brown Medicine) added that it would be helpful to look at the individual codes, approval number and denial numbers with an overall percentage. An analyst would be able to add what it is across all the different plans and conduct comparative analysis. He added that the work done so far is very illuminating to what the issues are.

Cory King (OHIC) acknowledged the limitations of data available to OHIC.

Dr. Peter Hollmann (Brown Medicine) added that during the CTC-RI meetings a majority of the plans stated they would be willing to provide this data.

Elena Nicolella (RIHCA) asked if there was any benefit to looking at a less specific code approach but rather the why behind some of the prior authorization requirements.

Hemant Hora (Point 32 Health) added that Blue Cross of Massachusetts will be removing prior authorization requirements from home care services, and asked if BCBSRI will be aligning with those same measures.

Dr. Barry Fabius (UnitedHealthcare) added that you do not want to use just a numerical cut off, but also look at the safety and cost of the service. For example, if 90% is being used as the threshold, and 92% of heart transplants are being approved, it should not be removed as a prior authorization as it can be a huge cost and safety issue when done inappropriately.

Cory King (OHIC) added that in tandem, with an approval threshold, you would want to also have a threshold for average cost or cost of procedure as well.

Victor Pinkes (BCBSRI) responded to Hemant's question regarding alignment with Blue Cross of Mass, BCBSRI will be heading in that same direction and probably by 1/1/2024. He added that prior authorizations for behavioral health have been removed since 2018, they now only require notification of admission and discharge. With regards to what Dr. Fabius said about safety- it is an issue for behavioral health, because a certain percentage of behavioral health and substance use

disorder does goes out of network. If concurrent reviews are not being done it can present a little bit of a problem because you're not sure that they're getting evidence-based care.

Dr. Peter Hollmann (Brown Medicine) regarding Elena's question added there are many reasons why items may go on and off the prior authorization list. New services may go on the list and then be taken off as they age. He added that physical therapy has gone on and off the list. Looking at national data, there can be a rapid growth in a certain CPT code.

Elena Nicolella (RIHCA) thanked Dr. Peter Hollmann for the rationale and further asked if understanding and addressing the 'why' behind it may also be productive.

Cory King (OHIC) commented that the why is an important piece but questioned if OHIC had the bandwidth to address. He asked if there can be an identification of certain pain points for providers that can be taken off the list to relieve burden but still allow health plans to have flexibility to conduct prior authorizations.

Teresa Paiva Weed (HARI) thanked everyone for their participation. She further asked what the impact would be on eliminating prior authorization on denials and if there would be a retrospective look. She added that just because you don't require a prior authorization doesn't mean you are required to pay the claim, and asked if any of the insurers are changing their policies.

Victor Pinkes (BCBSRI) commented that substance use disorder and behavioral health are large drivers of medical expense but does not think it has increased utilization. The changes in their prior authorization process pertaining to these categories has allowed additional collaboration with various entities to try and avoid emergency department visits for behavioral health and improve transitions of care. He further stated that there are configuration issues that need to be taken care of, but it has been successful for BCBSRI and patients. To Hemant's point there is a need to match things done in medicine and surgery with behavioral health due to federal law.

Cory King (OHIC) addressed the concern of behavioral health parity laws, could the concern be eliminated by removing the non-quantitative treatment limitation. He is interested in creating some alignment, and perhaps having Rhode Island's payers eliminate prior authorization, and perhaps even utilization review in total from behavioral health.

Dr. Barry Fabius (UnitedHealthcare) added that there is a significant difference in utilization once you move into the Medicaid space. In a way, behavioral health and substance use are the leading causes of emergency and inpatient utilization in all the ae data.

Cory King (OHIC) asked how the existence of a prior authorization modulates that relationship.

Dr. Barry Fabius (UnitedHealthcare) responded that he would have to go back and examine this in more detail to give a fair answer. There is a platinum program that Optum runs, and certain facilities already go without prior authorization. It does not rise to this level of elimination of utilization review, but it is a big step in that direction.

Cory King (OHIC) would appreciate if Optum would look at this and review whether this would be feasible to align with BCBSRI. He added that OHIC's authority does not extend to Medicaid, so it would not apply to the Medicaid space.

3. Data Measurement of Prior Authorization Services for Reduction

Cory King (OHIC) asked how feasible it may be to get additional data on prior authorizations, and it would be very helpful to have a data driven conversation. He emphasized the need to come up with a mechanism to collect and track data over time.

Taylor Travers (OHIC) outlined the baseline data needed to determine reduction of prior authorization services. This data includes prior authorizations per insured member, prior authorizations approved vs prior authorizations approved with modifications, and the method of reporting the service codes that require prior authorization.

Victor Pinkes (BCBSRI) added if there were a certain template dispersed to all to provide that information it would be beneficial for all.

Stacey Paterno (RIMS) added that the way all entities receive and disperse information is different, and in the spirit of uniformity that would be helpful.

Cory King (OHIC) commented that after today's meeting, he can discuss with payer's what type of unified data template is feasible.

Dr. Peter Hollmann (Brown Medicine) added that the absolute number might be different for all regarding the 20% total reduction figures, but trends may be similar. He added that for primary care providers, imaging and prescription drugs would be at the top of the list. He further noted the topic of referrals being an administrative burden for primary care providers.

Richard Glucksman (BCBSRI) added that for the prior authorization part, he would like an opportunity to look at the list of services and flag it for potential burden reduction.

Cory King (OHIC) does recognize the work that some payers have done in the past, and that some credit should be given for that work towards the reduction in volume. First, the denominator and numerator does need to be defined.

Hemant Hora (Point32Health) added that the denominator would be affected by what would be considered as the time period being reviewed.

Richard Glucksman (BCBSRI) asked if this would be defining of specific items or defining a certain process.

Hemant Hora (Point32Health) added that there should be a certain process in place, however it may not be a one size fits all. He further added the ability of adding gold-carding as another approach in addition to elimination of certain services.

Cory King (OHIC) added that the topic of gold-carding would be discussed at the next task force meeting.

Christopher Dooley (CharterCARE) asked if the task force would also be looking for specialist's input.

Cory King (OHIC) commented that he is looking to relieve the administrative burden from primary care providers, but specialists and facilities input is equally important to the task force work. He

added that next steps are talking about how to capture the data needed to reduce the prior authorization volume. Planning for the next meeting, the task force will look at selective prior authorization uses like gold-carding. He is interested in the notion of creating an ongoing process that allows providers and insurers to have an open discussion around the use of prior authorization.

Hemant Hora (Point32Health) concluded that a way to reduce burden would be to use the portals available to send in requests. If the fax machine is down, that can create a big backlog. He also mentioned the use of EMR access.

Tara Pizzi (Care New England) asked Hemant if Tufts had a plan for the Rhode Island Together Community plan to be put on the portal as it is not currently available and is now being done by fax.

Hemant Hora (Point32Health) added that it will be moved to the portal, he is not yet aware of the set date but added that it will be available soon.

Cory King (OHIC) outlined the future meeting dates being November 30th, and December 14th. He also added that slide decks and summaries from both meetings will be sent out.

4. Public Comment

There were no public comments.