State of Rhode Island Office of the Health Insurance Commissioner

Administrative Simplification Task Force

October 26, 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), Elena Nicolella (RIHCA), Hemant Hora (Point32Health), John Tassoni (SUMHLC), Krysten Blanchette (Care New England), Laurie-Marie Pisciotta (MHARI), Lisa Tomasso (HARI), Maria Zammitti (CharterCare), Melissa Campbell (RIHCA), Michelle Crimmins (Prime Therapeutics), Richard Glucksman (BCBSRI) Scott Sebastian (UnitedHealthcare), Shamus Durac (RIPIN), Stacey Paterno (RIMS), Victor Pinkes (BCBSRI), Sam Hallemeier (PCMA)

Not in Attendance

Al Charbonneau (RI Business Group on Health), Dr. Scott Spradlin (Aetna), Teresa Paiva Weed (HARI)

State of Rhode Island Office of the Health Insurance Commissioner Staff

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

1) **Welcome and Introductions**
   Cory King, Acting Health Insurance Commissioner, opened the meeting by welcoming all attendees and thanking them for their time. He then introduced Alyssa Metivier Fortin and Taylor Travers. Members of the Task Force introduced themselves and the organizations they represented. Cory provided an overview of the Task Force and defined the topic of prior authorization.

2) **Amendments to OHIC's Power and Duties Statute**
   Cory King outlined the amendments to OHIC's powers and duties statute that were brought forth in June 2023. A final report of recommendations is due to the general assembly in June of 2024. Additional requirements for OHIC to govern prior authorization include, the development of selective prior authorization criteria, the annual review of services requiring prior authorization, improved communication, transparency, and timely processing, improved continuity of care, and the encouragement of use of electronic prior authorization technology.

3) **2022 Administrative Simplification Task Force Accomplishments**

Alyssa Metivier-Fortin (OHIC) outlined the 2022 Administrative Simplification Task Force accomplishments which included a problem statement, in addition to payer, provider, and patient perspectives.

4) **Review of CTC-RI Report of Recommendations**

Taylor Travers (OHIC) introduced the set of recommended actions brought forth by the Care Transformation Collaborative of RI. Recommended actions include reducing the prior authorization volume, improving prior authorization data, the creating of ongoing statewide advisory committees, the evaluation of therapeutic substitutions at the pharmacy, the implementation of technologies that improve the prior authorization process, and the identification and reduction of 'PA-like' processes.

5) **Discussion Summary**

Cory King, Acting Health Insurance Commissioner addressed the importance of creating clear goals to reduce prior authorization and strategies to improve the processes of prior authorization.

Victor Pinkes (BCBSRI) asked if this work would be limited to primary care only.

Cory King (OHIC) addressed that the issue of prior authorization affects all aspects of the health care delivery system, and therefore the workgroup will focus on all entities. He outlined that the task force will guide discussions and recommendations.

Dr. Beth Lange (Pediatric Medicine) acknowledged that the 2022 task force workgroup was comprised of all entities and heard very meaningful remarks from all parties. Although CTC-RI is a primary care driven organization, prior authorization does affect all areas of the health care system and thus creates burden for all.

Hemant Hora (Point 32 Health) addressed that most facilities and entities are already engaging in discussions to reduce the burden of prior authorization. As it does affect all, it does make sense to reduce numbers across the board rather than focus on one individual facet. Hemant further addressed that it would need to be one coordinated effort to reduce prior authorizations by 20%, rather than all plans making separate decisions for code elimination.

Cory King (OHIC) addressed that the CTC-RI report outlined that plans should have flexibility to decide their individual changes, Although, uniformity and consistency would be ideal.

Dr. Barry Fabius (UnitedHealthcare) outlined that Project Promise will be enacted on November 1, 2023, which is a 20% reduction in volume of prior authorizations. The list of prior authorization codes being eliminated are available on the UHC provider website. Barry also provided a link to the website (available below) to all task force members to view the individual codes associated. He is hopeful for uniformity and consistency across plans. He does also sit on the board at CTC-RI and is excited to achieve the goal.

Prior authorization reduction equals nearly 20 percent of overall volume | UHCprovider.com

Stacey Paterno (RIMS) does see prior authorizations as a burden for all and not limited to primary care. Stacey acknowledged this effort should be done in a coordinated effort across all payers and products. Physicians are challenged by different rules for different products.

Dr. Barry Fabius (UnitedHealthcare) echoed that the reductions addressed at UnitedHealthcare are across all lines of business.

Elena Nicolella (RIHCA) addressed that all CTC-RI meeting presentations and minutes are publicly available and shared the link to all files in the chat.

https://public.3.basecamp.com/p/AZD8EeLKgptBVhMT2mP65AtZ/vault

Victor Pinkes (BCBSRI) addressed that Blue Cross eliminated prior authorizations and utilization management for all behavioral health services last year, excluding federal programs.

Richard Glucksman (BCBSRI) added thoughts about the trade off as you move into different types of payment arrangements and how that affects the impact of prior authorizations.

Cory King (OHIC) thanked all members for their comments thus far and thinks there should be a consistent approach across all disciplines, a consistent set of codes and some standardization across all plans and lines of business. He echoed the efforts of Blue Cross and added that some plans still do require prior authorization for behavioral health services. A way to measure data, and track progress towards the final goal is important.

Lisa Tomasso (HARI) acknowledged the work already being done by the insurers and questioned what the baseline might be for the 20% reduction given the new policies that are coming. The 20% should not be the ceiling but rather the floor.

Dr. Christopher Ottiano (NHPRI) acknowledged that the CTC discussions did talk about changes made in 2023 to be reflective as part of the 20% target reduction as NHP did make some changes as of 1/1/23. Secondly, from the standpoint of the function of the task force, different providers have different needs. Primary care providers issues may be pharmacy and commonly prescribed medications. For hospitals it would be in reviews for level of care. He addressed that an individualized approach would be beneficial, some meetings specifically for hospitals, some for specialty and some for primary care.

Michelle Crimmins (Prime Therapeutics) addressed that as a PBM, along with some insurers, with the accreditation through URAC and NCQA there are requirements to meet certain clinical standards when setting any utilization management programs which does already create some standardization across the industry, it further ensures they are meeting the requirements necessary instead of having any overly burdensome unproven utilization management requirements.

Hemant Hora (Point 32 Health) agreed with Dr. Ottiano (NHRPI) in the point that the task force should potentially have different sub workgroups focusing on the different providers, one for inpatient, one for pharmacy, etc. He also agreed with the statement that the reduction of volume by 20% is the floor not the ceiling. The bigger picture for reducing the administrative burden would be one bucket, the other bucket being gold-carding and the third bucket being the automation of prior authorization requests.

Cory King (OHIC) outlined that at the next meeting OHIC will come back to the task force with a proposal of how to sequence some of the topics. The amendments to the law effectuated but there was no appropriation for staff or consulting services. There is a need to address what we can accomplish through either voluntary agreements, or through using regulation to create some consistency in practices. To prioritize that if there are going to be standing work groups that comprise of physicians looking at these processes, how would they be staffed and how do we ensure that it's a well-run practice.

Elena Nicolella (RIHCA) addressed the importance of data collection and the types of information that were discussed in the CTC-RI sessions. Additionally, if data could start to be thought of in a way that would prepare the providers and insurers for the final Medicare rule of 2024 it would be very helpful. It is an interoperability rule that includes prior authorization recommendations that would affect both Medicare and Medicaid.

Cory King (OHIC) asked for any additional thoughts or opposing opinions and furthermore mentioned a contrary opinion that the state has a health care cost growth target that has never actually been met. Except during the pandemic that reduced prior authorization and one of the things that insurance companies use as a cost management tool is prior authorization. Therefore, a cost-management tool is really being taken off of the table and it would be interesting to track the data of prior authorization burdens and if it did it result in an increase in costs. Tradeoffs need to be addressed, some of the tools would be taken out of the insurance companies tool kit for cost management and that leaves only so many other mechanisms that can then be applied. He addressed the intersection of value-based contracts and downsized risk and that the incentive will not be there to generate volume.

Stacey Paterno (RIMS) added that while there is a cost saving tool being taken off the table, she believes there is a significant cost for all, and it will be eased for all, if the task force is successful.

Andrea Galgay (RIPCPC) mentioned that during last year's task force there were a lot of differing opinions. There was a lot of silence during discussions last year. She highlights the importance of speaking up now, rather than all being complicit in a set of recommendations until it goes further legislatively.

Hemant Hora (Point 32 Health) added that when all the prior authorizations requirements and policies are being evaluated there should be a constant evaluation of what should be taken off the table. He echoed Stacey's point that there are burdens on both sides, payers, and providers. He added that there are items that were brough to the market ten years ago that just have not been looked at closely enough to remove it now. Alternatively, there will be new technologies that come into the market that should be added to the list.

Cory King (OHIC) echoed Hemant's point that there will be removals and additions to the list of services requiring prior authorizations but adds that there needs to be a net reduction of overall volume.

Michelle Crimmins (Prime Therapeutics) addressed that as payers they do have processes in place to review services on the list annually to remove prior authorization requirements. Clinical best practices have changed and there is absolutely a need to revise those lists regularly. In

addition to being cautious to any cost increases she adds that there is also a safety aspect with removing any utilization management levers that payers have. With prior authorization there are times that members seek care at various pharmacies and clinicians and through those claims they can see if they have drugs that wouldn't interact together well that otherwise the provider wouldn't be able to see.

Cory King (OHIC) added that those points are part of the perspectives point of view laid out in previous task force meetings under the problem statement. He added that prior authorization will always have a role to play but there needs to be a coordination of consistency and efficiency across payers so that providers do not continue to see increased burnout and spend additional time and resources for administrative processes that could otherwise be spent on additional clinical staff.

Dr. Barry Fabius (UnitedHealthcare) echoed that these points echo the points of project promise, looking at physician time and cost in addition to payer time and cost and look at the value. This is how UnitedHealthcare is looking at the list and will continue to look at the list.

Cory King (OHIC) asked if UnitedHealthcare would be able to disclose any of the methodology used to assess the value of prior authorizations, in addition to any time and cost estimates.

Dr. Barry Fabius (UnitedHealthcare) advised that he will go back to UnitedHealthcare and ask if any of that is considered proprietary. He added that as cory outlined, it is essentially that, to look at the cost of the execution of the prior authorization on both the provider and payer. And the value in terms of what is the percentage of time that a service is denied, versus the percentage of time it is approved and didn't require prior authorization. The cost of the individual service is also important, there were a number of procedures that the cost of the item or service was significantly less than the cost of the time for the insurers and provider.

Hemant Hora (Point 32 Health) added that there are approaches to reducing prior authorization nationally, and that perhaps the UnitedHealthcare list that Barry shared earlier needs to be evaluated and align that with other insurer plans. Or perhaps there is a subset that can be derived for all.

Dr. Barry Fabius (UnitedHealthcare) added that he did share this information with EOHHS and that the information is publicly available and could perhaps be used as a foundation.

Cory King (OHIC) outlined the proposed meeting schedule and reviewed that the statute outlines there be a report of recommendations submitted to the general assembly by June 30, 2024. There is no requirement that the task force stop meeting in December, if there is more work to be done the work can be continued. There should be some agreement in action steps that can be taken either individually or through regulation. OHIC will review the UnitedHealthcare reductions that Barry brought forth and asked again if any data methodology could be shared that would be helpful but does recognize that it may not be available to share. Cory asked if members are optimistic to making progress during this year's task force.

Richard Glucksman (BCBSRI) added that he is very optimistic to make progress during this year's task force.

Hemant Hora (Point 32 Health) added that technology could be used to automate processes to add to the reduction of burden. Massachusetts has been looking at, at the state level having all the payers and providers on the same automated platforms.

Dr. Beth Lange (Pediatric Medicine) added that her optimism is due to Cory's last comment that if the task force is unable to make any meaningful progress in a collaborative way that it will result in more prescriptive language by the legislation. The inclusion in the process does add to buy-in to making this work.

Cory King (OHIC) is optimistic with the work done through the CTC-RI and legislature.

6) Public Comments

There were no public comments.