State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
December 14, 2023 – 8:00am – 9:00am

Virtual Meeting Summary

Attendance
Andrea Galgay (RIPCPC), Caitlin Kennedy (Coastal Medical), Dr. Barry Fabius (UnitedHealthcare), Dr. Peter Hollmann (Brown Medicine), Dr. Victor Pinkes (BCBSRI) Elena Nicolella (RIHCA), Hemant Hora (Point32Health), Howard Dulude (HARI), Kara Lefebvre (CharterCARE), Karen Labbe (BCBSRI) Laurie-Marie Pisciotta (MHARI), Michelle Crimmins (Prime Therapeutics), Richard Glucksman (BCBSRI), Stacey Paterno (RIMS)

Not in Attendance
Al Charbonneau (RI Business Group on Health), Christopher Dooley (CharterCARE), Dr. Beth Lange (Pediatric Medicine), Dr. Christopher Ottiano (NHPRI), Dr. Scott Spradlin (Aetna), John Tassoni (SUMHLC), Maria Zammitti (CharterCARE), Mark Lorson (NHPRI), Melissa Campbell (RIHCA), Sam Hallemeier (PCMA), Scott Sebastian (UnitedHealthcare), Shamus Durac (RIPIN), Teresa Paiva Weed (HARI)

State of Rhode Island Office of the Health Insurance Commissioner Staff
Acting Commissioner Cory King, Alyssa Metivier-Fortin, Courtney Miner, Molly McCloskey, 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 provided a brief overview of past meetings and outlined the meeting objective of reviewing the remaining Statutes and CTC-RI recommendations not previously covered in detail.

2. **OHIC's Powers and Duties Statute**
   Cory (OHIC) outlined that the concept of selective prior authorization methods, such as gold carding had been talked about at previous meetings. He outlined each provision starting with article vii: Improve communication channels between health plans, health care providers, and patients by requiring transparency and accessibility of prior authorization requirements, criteria, rationale, and program changes for providers, patients, and enrollees. In addition to supporting timely submission by providers of the complete information necessary to make determinations as early as possible and the timely notification of prior authorization determinations to impacted providers, patients, and enrollees by posting to provider accessible websites. He asked each participant to share what their organization may be doing, what issues they may be facing and provide recommendations for what items should be pursued.

   Dr. Peter Hollmann (Brown Medicine) acknowledged that there are a variety of issues that come in to play regarding communication. The goal would be to make the process as clear as possible and define the expectations to meet the prior authorization request. The criteria should be immediately available, and ideally within the process of making the request rather than having to navigate to additional screens or platforms. He provided an example of formularies being

available on a particular health plan website, but there are so many different products that it is almost impossible to tell from the membership card which formulary applies. There are as many as 30 different plans, and it is not as straightforward as commercial, Medicaid or Medicare. He has heard from Pharmacists that they are able to go to the third-party website, covermymeds.com and input the member ID which provides them with the correct formulary. He also mentioned a potential difficulty of logging in to such provider websites, compared to the availability of pre authenticating.

Howard Dulude (HARI) mentioned the staffing issues that hospitals and health plans may be experiencing and how that might potentially impact these items.

Cory King (OHIC) invited health plan representatives to comment on their current vacancy rates.

Hemant Hora (Point32Health) added that there are always people leaving, and joining but they have been lucky, and their vacancy rate is low. He also mentioned that [Point32Health] is somewhere in the 98% range for compliance with turnaround time for both medical and pharmacy services. Citing that there are very few that are beyond the ideal timeframe. Regarding standard appeals and expedited appeals, they are typically completed within 72 hours, equaling to a 95% compliance rate on turnaround time. It is in the members best interest to submit as a standard appeal request as it gives the insurer more time to get all the necessary information needed to make the determination. This timeframe also allows for the insurer to talk to the providers, if necessary. With expedited appeals, they are typically completed within 72 hours, but usually within 48 hours.

Karen Labbe (BCBSRI) added that for BCBSRI, they are running at about a 99% in terms of vacancy. With prior authorization, they have a portal where the providers can submit a request and if it meets the criteria, they get an automatic approval, so it is done instantaneously. As for appeals, they are meeting the necessary timeframes which is typically within 72 hours. She also added that years ago BCBSRI committed to providing an authorization upon a patients discharge for skilled level of care, including nursing homes within 3 hours, they would be following through on that commitment through 2024.

Dr. Barry Fabius (UnitedHealthcare) added that UnitedHealthcare also has similar timeframes, and they are in the 98-99 percentile consistently. He also added that as Rhode Island is a generic first state, 90% of the orders are for generic drugs and therefore do not require prior authorization. Of the remaining 10%, they are also in the turnaround timeframe of 98-99%.

Dr. Peter Hollmann (Brown Medicine) stated that the process needs to be simple and easy to figure out so that everyone can do their job on time. He added that he does not think that the plans are failing to meet their statutory or regulatory requirements but the criteria does need to be defined from the start for provider ease of use. Some instances, where systems are built in place the process can be fairly easy and can click right through, However, that is not the case for all.

Laure Marie Pisciotta (MHARI) noted that she is representing mental health consumers, and she would encourage all insurers to follow BCBSRI's approach in eliminating the need for prior authorization for outpatient behavioral health services. She added that timely access to care, saves lives, improves patient outcomes, and saves money in the long term.

Cory King (OHIC) added that he is also interested in the idea of the elimination of prior authorization for behavioral health services, as BCBSRI has done.

Stacey Paterno (RIMS) noted that there seems to be many different paths to get to the same endpoint. She suggests the idea of a 'customer experience map' of some sort. Adding that while not intended, due to the number of products and insurers providers must deal with, the path to the same answer can be 30 times different.

Cory King (OHIC) agreed to Stacey's point but asked how they functionally get there. Do they promulgate loose recommendations for insurance companies to change their internal processes or is it something more specific that they would promulgate through administrative rule making that sets forth a rule of action to make set process.

Andrea Galgay (RIPCPC) asked if referrals were being excluded from this language, because where prior authorization has some clinical relevance, the repetitiveness of a standing referral that must be updated annually and has a 99% acceptance rate seems to be a burden. It would be beneficial if this were to be included in the language.

Hemant Hora (Point32Health) asked for clarification regarding what Andrea meant by referrals.

Andrea Galgay (RIPCPC) clarified that it is seen more with the Medicare Advantage product lines, but also with a few commercial product lines. She outlined that the patient may need to see a cardiologist with whom they have seen for the past 10 years, but a form needs to be submitted annually by the PCP on behalf of the patient.

Hemant Hora (Point32Health) asked if this was something that needed to be submitted as a prior authorization request or as a notification.

Andrea Galgay (RIPCPC) added that it is not a prior authorization, and more of a notification but a time-consuming process, nonetheless.

Hemant Hora (Point32Health) mentioned that on behalf of Point32Health, they could certainly investigate that. He added that simplifying the processes is what everyone wants. He added that the ideal state would be where you're in the EMR and you are able to click on a particular service or medication and within seconds you receive an answer. The rules regarding what product line the member has, or certain formulary would be built into the system. He added that this is not something that can happen overnight and realistically would probably be delivered in mid-2025.

Howard Dulude (HARI) added that with multiple plan designs each with different rules tied to them, it would be an underestimation that it could be done quickly. Regarding regulation, if the plan is going to require prior authorization, they should have some sort of lookup tool or process by way of the subscriber number that outlines the rules related to what might be required for each service.

Cory King (OHIC) mentioned that this is the type of feedback that is beneficial to this process. Following the meeting, OHIC could create and send out a table with each of the components

covered today and have participants submit feedback. For a provider, what requests would be made for improving the process. For a payer, what are the current practices, and any process changes that may be forthcoming. To provide some substantial content to be put into the final report. He then asked if anyone would like to open discussion on the continuity of care provisions outlined in the statute.

Dr. Peter Hollmann (Brown Medicine) addressed that he believes plans are already currently doing this, it is just a matter of timeframe. There is this issue of ongoing approvals for the same therapy time after time. He thinks a lot of it has to do with individuals changing health insurance plans or the plans changing their formulas. There should be a set timeframe for a grace period, consistent across all plans. If they were to follow the Medicare processes, that would be ideal. Furthermore, he thinks plans should make an effort to minimize repeat prior authorization requests. As an example, he was reviewing utilization review practices for an organization, and they require re authorization every 6 months for certain controlled substances. It is a stated as a safety issue, but for patients on chronic therapies where their condition has not changed it can be seen as a burden.

Stacey Paterno (RIMS) agrees with Dr. Hollmann's points and believes that the timeframe for grace periods should be consistent across all plans.

Cory King (OHIC) asked how an insurer would know the patient's history prior to getting that clinical documentation from the provider.

Stacey Paterno (RIMS) believes that if the patient has on record prescriptions, it should be honored, as it can become a big issue for consumers. This can become increasingly difficult if the new plan has rules about which prescriptions they can take, even if the patient has an established prescription that they have been successful with.

Hemant Hora (Point32Health) outlined that Point32Health has a 90-day grace period policy for almost everything within their organization as they have many different plans under their Medicaid, Medicare, and Commercial lines. He thinks one of the key components of the CMS Interoperability rule of 2026 is that plans would be required to talk to one another and collect almost a member file, to honor authorizations such as these. Accordingly, Point32Health is planning to do this for their commercial lines.

Dr. Peter Hollmann (Brown Medicine) thinks that plans currently share a fair amount of information, as part of the rating process. He mentioned that there might still be a need to mitigate prior authorizations after the initial 90 days. There wouldn't be an elimination of the process but an ideal way to do it, would be to have a set number of days across all plans, to increase consistency.

Michelle Crimmins (Prime Therapeutics) offered from a PBM perspective that they currently do have these types of processes in place to ensure there is continuity of care when members are changing from plan to plan. Within the first 90 days, any step therapy or PA requirements are typically waived which allows the member to build up enough claim history that would then show them that they have a repeated history of use of a medication.

Dr. Victor Pinkes (BCBSRI) acknowledged that BCBSRI also uses a 90-day grace period for continuity of care.

Howard Dulude (HARI) asked if it seemed to be primarily an issue with pharmacy.

Michelle Crimmins (Prime Therapeutics) clarified that her response in particular was regarding their pharmacy continuity of care practices. They ensure patients have a claim history for any drugs they may be taking, which would waive the PA and step therapy requirements to ensure the patient does not experience a gap. She thinks that is standard practice across the PBM industry.

Hemant Hora (Point32Health) asked if this was a pharmacy benefit drug issue or a medical benefit drug issue.

Dr. Peter Hollmann (Brown Medicine) thinks that the most common is prescription medications because formularies change, people change plans and there's many different formularies in general. He noted that many individuals may have been getting their care in Massachusetts and then come to a more restrictive, HMO type model in Rhode Island.

Laurie Marie Pisciotta (MHARI) addressed that from a patient perspective, after struggling in finding the right antidepressant to manage chronic clinical depression, 90 days does not seem fair enough or safe enough. It can take a patient years to find the right medication, to have to then be weaned off of it over a 2–3-month period, and then hope that the next medication will work as well; that is a struggle that a patient should not have to endure. If the patient is doing well with a medication and the provider thinks it is working well, with as few side effects as possible that should be good enough for any insurance company.

Hemant Hora (Point32Health) addressed that in those 90 days, a patient would absolutely be covered. Those 90 days can then be used for the provider to submit a request regarding the patients documented stable medication history and could ultimately be given consideration. He added that there are many different steps that can be taken to make sure that whenever possible the same medication could be continued. He also added that many of the behavioral health medications are much more complex and involved.

Dr. Barry Fabius (UnitedHealthcare) added that this [Point32Health] process is like the practices at UnitedHealthcare, and that continuity of care can be a huge issue. Furthermore, a physician can say that a patient has tried numerous drugs, and has been stable on a particular one, which does become the drug of choice. He also added that the 6-month renewal could be an important point, because Rhode Island is a generic first state and there are multiple generics in the pipeline that are coming up. Particularly for biologics and very expensive drugs that transition could be important, especially on the Medicaid side.

Howard Dulude (HARI) thanked Laurie Marie for her openness, and it did invoke thoughts pertaining to if a 90-day continuity of care policy is enough. He asked when does a member know when they change that there could be a potential issue with their prescription coverage, is it when the member goes for the refill. He added that maybe a letter comes out outlining the changes, but what is the timeframe of receiving that letter and is the 90 days long enough to not add additional stress to the patient.

Rich Glucksman (BCBSRI) added that there are special considerations to take when it comes to behavioral health drugs and that risk of change. The other focus is cost, many of the brand drugs can be as high as $15,000 dollars a month or more. He added that plans may have different formularies, so when patients do switch it can be important to ask these questions. Additionally, requirements around notification, or annual approvals those are items that BCBSRI is looking at, and potentially there are areas of opportunity.

3. **CTC-RI Report**

Cory King (OHIC) briefly outlined the 6 recommendations of the CTC-RI report. These being, 1) reduce prior authorization volume, 2) improve data collection on prior authorization, 3) create on-going statewide advisory committees, 4) evaluate therapeutic substitutions at the pharmacy, 5) implement technologies that improve the process, and 6) identify and reduce processes that are 'PA-like'. He outlined recommendation #4 specifically and asked the task force members their thoughts regarding, as it was in the CTC report, but it may not be something that they focus on imminently.

Dr. Peter Hollmann (Brown Medicine) provided background for the recommendation. In the hospital, if you write for drug A and drug B and C are virtually the same but drug B is where the hospital has a contract, the pharmacists can switch it over automatically. There are plenty of times when a physician writes a prescription, but it then requires a prior authorization. The physician would be more than happy to switch it to the comparable drug. This could potentially happen at the pharmacy which would be great for all parties. This, however, would require a change in the statute regarding the pharmacies. He also added that pharmacies feel stress as well in response to staffing shortages, reduced hours, and retaining staff. This would create simplification for the prescribers if it were feasible.

4. **Standing Public Body**

Cory King (OHIC) addressed that one of the CTC-RI recommendations was the creation of an advisory committee to review data on services that require prior authorization, a separate committee that focuses on medical services, and a third that focuses on pharmaceuticals. He added that the statute specifically cites requiring the review of medical services, including behavioral health and prescription drugs that are subject to prior authorization at least annually. He further added that in the Primary Care Report released earlier in the week, there is a need to have an ongoing body that may not be the administrative simplification task force but may be a part of it. This would be the standing opportunity to engage in dialogue and bring forth systemic issues.

Karen Labbe (BCBSRI) would like to be a part of this ongoing committee; she could potentially share some of the processes they use to review.

Cory King (OHIC) Thanked Karen and added that it would be a group that includes both insurers and providers as well as anyone else who may be interested.

5. **Methods of Requesting Prior Authorizations**

Taylor Travers (OHIC) outlined the slides pertaining to methods of requesting prior authorizations. She addressed that there are numerous different methods including standard electronic transmissions, payer portals, multi-payer portals, fax, telephone, and secure

emails. Each method does have its share of advantages and disadvantages which can add to inconsistencies, furthermore, a provider may use a mix of methods depending on the payer or the service. She asked participants to share the methods that they may be currently utilizing.

Karen Labbe (BCBSRI) offered that BCBSRI does use a payer portal in addition to utilizing EHR for hospitals and skilled nursing facilities (SNF).

Howard Dulude (HARI) added that, this could be an uninformed opinion but why would faxing still be relevant now. Adding that whatever could make it electronic and simpler would make the most sense.

Hemant Hora (Point32Health) added that they utilize a portal as much as possible. However, they have heard in some states, that they do not have great broadband so they cannot simply turn off their faxes. With providers who do have EMR, they do still fax. Point32Health does encourage the use of the portal as it is more efficient, and better for the environment.

Rich Glucksman (BCBSRI) sees a large proportion of faxes as well. He added there is a real interest in figuring out how as a system across Rhode Island we would transition.

Dr. Peter Hollmann (BCBSRI) added that there is probably a different use for each one of the methods, and some may not have the ability to do more than fax. He also added that some faxes may be electronic to electronic and not actually printing out on a machine. Some methods may be more appropriate depending on the service. Ideally, the vast majority would go through a single payer portal. Most may be going through exterior portals, potentially a PBM or a radiology vendor.

Andrea Galgay (RIPCPC) added that there have been conversations regarding automated systems, and because the various plans use slightly different ones, the pushback they have received from the IT team or from a resource standpoint is the upfront cost or manpower associated with them. She cannot minimize the amount of effort that it takes on the EHR build, and that is within a system where they have access to the ability to build.

Howard Dulude (HARI) asked if anyone at OHIC had investigated the cost of this from an administrative perspective. There is certainly a savings associated with it, in terms of reducing medical necessity, and making sure the right services are provided but when you get into this there does seem to be a huge administrative cost within the system.

Cory King (OHIC) acknowledged that there would certainly be an administrative cost, but additional data would need to be collected to measure the specific costs associated with it. He added that we know how much we pay as a state to have a system of private health insurance, with the net cost of private health insurance calculations that we publish annually as part of the cost trends work.

Howard Dulude (HARI) added that it is probably several percentage points of premium.

Dr. Peter Hollmann (Brown Medicine) asked the reasoning behind looking at the different methods of requesting the prior authorizations.

Cory King (OHIC) acknowledged that there are a lot of different methods for getting to the same endpoint, and from conversations within the task force last year, one of the mantras from the payer community was to use technology to streamline everything.

Taylor Travers (OHIC) added that there are many different methods for a variety of purposes that each organization may use. To streamline and decrease administrative burden it is worthwhile to review the different processes currently utilized.

Cory King (OHIC) added that everyone is probably set with their current methods, whether it be faxing or the use of payer portals, etc.

6. **Discussion**

Cory King (OHIC) noted that the conversation points surrounding continuity of care and timeliness could be used in the final report.

Dr. Barry Fabius (UnitedHealthcare) added regarding the pharmacist functioning of the calculator license. There is opportunity there to decrease the administrative burden, and the patient does not need to go back to the provider for a new prescription. On the pharmacy side it would be a simplification as well.

Cory King (OHIC) offered that in a future reiteration of the task force, potentially there could be additional pharmacy representatives.

Dr. Peter Hollmann (Brown Medicine) regarding methods of requesting prior authorization, one of the CTC-RI recommendations was a sort of technology subgroup that could advance statewide electronic medical systems. He added that it is rapidly developing, and there would need to be input of experts in addition to people who do the work. Furthermore, he added that here have been a lot of improvements on the prior authorization process over the last decade. Additionally, there are some instances where faxes are still being utilized because they are simply unaware of the other alternatives available.

Rich Glucksman (BCBSRI) added that the provider perspective is important, and information should focus on the category of providers most impacted, including primary care. Identified areas should be examined for consistencies in burden across all providers, and entities.

Cory King (OHIC) outlined that in January OHIC hopes to have additional data from insurers so the task force can utilize it in order to address the reduction of volume of prior authorizations and the distribution of prior authorizations across different service categories more in depth.

7. **Meeting Schedule**

Cory King (OHIC) outlined that the task force will not meet again in December, and that the next meeting will be on January 18, 2024.

8. **Public Comment**

There were no public comments.