State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
November 30, 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), Victor Pinkes (BCBSRI), Elena Nicolella (RIHCA), Hemant Hora (Point32Health), Howard Dulude (HARI), John Tassoni (SUMHLC), Kara Lefebvre (CharterCARE), Karen Labbe (BCBSRI) Laurie-Marie Pisciotta (MHARI), Maria Zammitti (CharterCARE) , Mark Lorson (NHPRI), Melissa Campbell (RIHCA), Michelle Crimmins (Prime Therapeutics), Richard Glucksman (BCBSRI), Scott Sebastian (UnitedHealthcare), Shamus Durac (RIPIN), Stacey Paterno (RIMS), Teresa Paiva Weed (HARI)

Not in Attendance
Al Charbonneau (RI Business Group on Health), Dr. Scott Spradlin (Aetna), Karen Labbe (BCBSRI), Sam Hallemeier (PCMA)

State of Rhode Island Office of the Health Insurance Commissioner Staff
Acting Commissioner Cory King, Molly McCloskey, 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 task force members. He reviewed the planned agenda for the meeting which includes the data request and straw model proposal.

2. **Data Review Request**
   Cory King (OHIC) outlined the goals of the data request, which includes having a data driven discussion about alignment of reduction in prior authorization. Taylor Travers (OHIC) reviewed the objectives for the data requests that have now been sent out to all insurers. This request comes from the CTC-RI recommendation for improving the existing data collection in order to measure meaningful reduction. These objectives include but are not limited to, the identification of trends and notable comparisons across all plans, the identification of services and codes with the highest number of prior authorization requests and the isolation of services with higher costs.

3. **Selective Prior Authorization: Gold Carding**
   Taylor Travers (OHIC) introduced the next topic of selective prior authorization through gold carding. She presented the consensus statement presented by the American Medical Association, which involves (1) the encouragement of using programs that selectively implement prior authorization requirements based on the stratification of health care providers' performance and adherence to evidence-based medicine. (2) Encouraging the development of criteria to select and maintain health care providers in these selective prior authorization

programs with the input of contracted health care providers and/or provider organizations; and making these criteria transparent and easily accessible to contracted providers. (3) Encouraging appropriate adjustments to prior authorization requirements when health care providers participate in risk-based payment contracts.

Dr. Peter Hollmann (Brown) clarified that the consensus statement brought forth by the American Medical Association was a joint consensus statement from the AMA in addition to the American Hospital Association, America's Health Insurance Plans (AHIP), the Blue Cross Blue Shield Association of America, Medical Group Management Association (MGMA) and American Pharmacists (APhA).

Cory King (OHIC) advised that the amendments to the statute reference selective prior authorization requirements. He noted that between the data request, the straw model proposal and the notion of gold carding there are two different approaches that are not necessarily mutually exclusive. The first approach being the creation of a uniform set of rules for the market that dictate what services are on the list and what services are off the list based on some predefined criteria. The second approach being the notion of gold carding where the payer would have the most discretion to determine what entities within the network would be granted this discretion. He noted that Rhode Island does have risk-based contracts in place among several entities, so that could potentially be a marker. He further added that collective action around public policies can sometimes be difficult. He invited members of the task force to share their thoughts on both approaches.

Stacey Paterno (RIMS) provided a bit of background in terms of the consensus statement. She shared that she would encourage all to try to approach this in the most uninform and standardized way possible for providers. If it goes back to payer provider contracts, the ability to have increased standardization will be lost.

Dr. Peter Hollmann (Brown) noted that gold carding may be a reasonable way to achieve part of the goal but for several reasons would not be considered his highest priority. His reasoning being the uniformity and complexity. He presented questions surrounding the time frame of providers being exempted the gold-carding status (i.e. yearly or lifetime). He added that, potentially, you could find that neurosurgery would be gold carded for Spine MRI's because they always get approved, but primary care would not be. This could cause issues in the referral process as the neurosurgery practice may require an MRI, which puts primary care in a challenging spot. These factors represent definite flaws in the idea of gold carding, but if you are in a risk group it seems a reasonable way to go.

Teresa Paiva Weed (HARI) echoed Stacey regarding the importance of uniformity. It may have the ability to work in some instances, but she has not seen documentation of its effectiveness. She raised the question if, gold carding could lead to increased retrospective denials which she has heard from some hospitals and providers.

Hemant Hora (Point32Health) asked Teresa to elaborate on the relationship between gold carding and the potential increase on denials.

Teresa Paiva Weed (HARI) clarified that the term denials should be used broadly in the sense that gold carding may increase the downgrading of codes submitted. From the providers

perspective, as the emphasis shifts to prior authorization at a national and state level, they are seeing a significant increase on the other end.

Hemant Hora (Point32Health) mentioned that the ability to have increased EMR (Electronic Medical Record) access would be greatly beneficial. If it's the same information that is being transmitted through fax, it would be more efficient for both parties to gather necessary clinical documentation for services. Utilizing the fax does contribute to a delay in processing in some instances.

Teresa Paiva Weed (HARI) mentioned the ability to continue that conversation with the OHIC team, and Howard Dulude.

Cory King (OHIC) expressed interest in assembling a body that meets periodically to convene for discussions between hospitals, physician group representatives and payers. Which is one of the recommendations put forth in the CTC-RI report.

Rich Glucksman (BCBSRI) supports the notion of convening periodically. Regarding data collection, he would be interested in hearing from the provider perspective, what certain pain points might be.

Andrea Galgay (RIPCPC) asked how providers would be evaluated year over year with gold carding, she thinks that there would still be clinical documentation that would need to be submitted. Secondly, she asked if gold carding should happen at the practice level versus the provider level. she noted that challenges may arise if a practice had one provider gold carded for certain items, and other providers within that same practice were not. Would that be worse than having no gold carding and go through the prior authorization process.

Hemant Hora (Point32Health) responded to Andrea that it would be probable that the entire practice of a particular specialty would be gold carded. He provided an example, that if there were a group practice, of cardiologists, probably the entire practice of that specialty would be gold carded rather than provider based. Secondly, he clarified the differences between gold carding and green lighting. In gold carding there is no need to submit any prior authorization at all, it would be accompanied by an audit at the end of each year. There would be some sort of threshold of approval, say 95% to then be gold carded for the following year. With green lighting a provider would not submit anything, however, on a back-end channel the information would be in the system and may be authorized retrospectively perhaps 4 months later. With gold carding, it could not be rescinded midway through the year, whereas with green lighting it could be rescinded when needed.

Cory King (OHIC) asked if there were any additional thoughts on gold carding. It will be kept on the table as something for providers and payers to consider but that it may not be the only solution.

4. **Straw Model Proposal**

Cory King (OHIC) presented the straw model proposal that was first brought forth in the 2022 task force meetings. Part A of the proposal is to remove prior authorization requirements from all medical services meeting the criteria of an average threshold approval of 95% or higher and costs an average of $25,000 or less. Part B of the proposal would remove prior authorization

requirements for all in-network behavioral health services. Cory emphasized that this model does not include prescription drugs. Adding that parameters could be modified and that he would appreciate thoughts from all task force members. He noted that BCBSRI has removed prior authorization services from both in-network and out-of-network behavioral health services. He added that regulations need to be something that can be understood, implemented and monitored it cannot just be a set of goals. The straw model signals that there are some types of rules of action that could be considered for implementation.

Stacey Paterno (RIMS) asked what the rationale behind BCBSRI's decision to remove prior authorizations from behavioral health services was, what impact it has had, and its effectiveness.

Dr. Victor Pinkes (BCBSRI) answered that he himself was not at BCBSRI when the decision was made to remove the initial prior authorization, but he was when the decision was made to discontinue concurrent review and use notification of admission and discharge instead. He noted that the reason behind this was to eliminate barriers to behavioral health services. Regarding utilization, there may be a slight increase but not what others may expect. He added that behavioral health is still a significant cost driver, so it is something that are watching carefully.

Rich Glucksman (BCBSRI) added that part of it came out of conversations with the Office of the Health Insurance Commissioner and looking at the difficulties in behavioral health of applying PA. The impact may be hard to measure due to the pandemic, which has changed the demand for those services. It has also changed the length of stay of those services. Something to look at further would be, with taking off those rules, what happened with readmissions. He is not yet sure where that data will land.

Dr. Victor Pinkes (BCBSRI) added that one of the objectives was to decrease emergency room visits as the first point for access to behavioral health services and increase outpatient access. In his opinion, it is not the correct place for an initial behavioral health evaluation although there are significant emergencies and urgencies that must be taken care of. So that was one of the purposes, to drive down emergency visits for behavioral health by creating access.

Rich Glucksman (BCBSRI) noted another part that they are hopeful about is facilitating transitions of care, and not needing to worry about getting prior authorizations.

Teresa Paiva Weed (HARI) commented that there was overwhelming response at the Children's Behavioral Health forum sponsored by HARI, that this had improved access for children.

Cory King (OHIC) added that, if services were taken off the med surg side, there needs to be a parity analysis, of whether there is a similar or equivalent service on the behavioral health side to meet parity law. One way to eliminate that would be to just eliminate the non-quantitative treatment limitation on the behavioral health side.

Hemant Hora (Point32Health) asked as a follow up to Dr. Victor Pinkes (BCBSRI) if Blue Cross of Mass had also eliminated prior authorization for behavioral health services.

Dr. Victor Pinkes (BCBSRI) responded that he is not familiar with their practices, he added that it may be selective. He added that Blue Cross of Mass has a significant number of digital offerings that BCBSRI does not have.

Rich Glucksman (BCBSRI) clarified that BCBSRI and Blue Cross of Mass are separate entities.

Hemant Hora (Point32Health) added that Point32Health does very few behavioral health prior authorizations. He further mentioned that there is no guidance around the parity law and the review of services, which can make it a bit of a cumbersome process.

Dr. Peter Hollmann (Brown) commented that having a body that convenes periodically would be in line with one of the CTC-RI recommendations. He then added that the first thing to do for part A of the straw model would be to prioritize the evaluation of services over a certain number, with an approval over an average percentage. He does see this as a reasonable starting point, underlining the importance of data collection and on ongoing group. Regarding Part B of the proposal, he added there may need to be consideration for medical necessity, contract exclusions, utilization review practices, and if a service is investigational. Another aspect would be if prior authorization is removed, would it therefore not be subject to retrospective denial as Teresa (HARI) had mentioned. He further added that if there is no process that is put in place that's required to be done on a continuous review all year long, that would be a major shortcoming.

Cory King (OHIC) added that this work is important to the provider community, the payers are investing in it, and he is hopeful for ongoing data driven discussions.

Dr. Victor Pinkes (BCBSRI) commented that for proposal part A, the volume of services should be included. He also mentioned that the referral aspect does need to be taken into consideration as that does lead to administrative burden as well, in addition to the member and provider experience.

Hemant Hora (Point32Health) echoed Dr. Pinkes statement regarding the importance of volume of services in part A of the straw model proposal.

5. **Discussion**

Rich Glucksman (BCBSRI) added that in relation the legislative that was amended, the ongoing convening body for discussions would satisfy item #6 referring to an annual review of services. This could be used to build off the data request and could there be some indicator for safety or newness.

Cory King (OHIC) expressed that he does think the task force has made more progress than last year and puts OHIC in a better position to write a good report to the legislature.

Teresa Paiva Weed (HARI) explained that the most challenging area for the hospitals right now is discharges, and transitions of care. Which can impact the cost and increase the patient's length of stay.

Hemant Hora (Point32Health) again expressed that EMR access could be greatly beneficial for all parties. Utilizing the EMR access over fax transmissions could increase efficiency which could

potentially decrease the barriers to discharges and transition of care that the hospitals are experiencing. He added that in his opinion, he does not see the barriers to discharge being attributed to prior authorization.

Rich Glucksman (BCBSRI) added that it is important to recognize OHIC's statutory framework to regulate health insurers. Adding that inviting the providers to communicate pain points and contribute to data collection is equally important.

Elena Nicolella (RIHCA) conveyed the connection between the provider capacity and prior authorization. In the context of behavioral health services for Medicaid eligible individuals, it is less about prior authorization and more about there being nobody to refer to. With the discussions of data, could there be some way to capture data in relation to capacity. Would prior authorization resurge because there is then an increase in utilization.

Hemant Hora (Point32Health) mentioned the development of an innovative model to do some sort of monitoring on the back end to measure results and shortcomings of any initiatives made. He added that there should be some sort of contingency plan as well.

Dr. Peter Hollmann (Brown) added that there should be guidance in relation to a review process. If there is a greater than X percentage increase over a certain period then you need to re review. There would need to be ongoing data collection, and an ongoing body to be able to continue to reevaluate. He asked Cory if it would be helpful to get a consensus on continuing data driven discussions around the parameters for the straw model proposal parts to draft a more effective report to the legislature.

Cory King (OHIC) communicated that there would need to be a consensus reflected in the task force around a framework. The numerical thresholds could then be determined later but to start with a concrete consensus around a screening mechanism for addressing prior authorization over time. He added that there could be rules, not in terms of regulations but rules in terms of how the data is reviewed and evaluated.

Stacey Paterno (RIMS) added that, again with BCBSRI's prior authorization elimination of behavioral health services, have there been any lessons learned, how is it evaluated on an ongoing basis and if there have been any increases in labor costs.

Dr. Victor Pinkes (BCBSRI) replied that there has been ongoing evaluation. There has not been any reduction in labor. Instead, there may be a repurposing and increase on focus on other parts of behavioral health that are important to their members, such as quality, access and evidence-based practices.

Cory King (OHIC) expressed that the task force has made great progress this year. At the next meeting, OHIC could come back to the group with additional language surrounding a potential screening process for services requiring prior authorization for reduction, and a public body convened by OHIC to continue these discussions. In addition to reviewing some of the amendments outlined in the legislature that has not yet been covered, and remaining recommendations from the CTC-RI report. Following the collection of additional data, the task force can also identify the specific pain points in certain service categories for providers.

Rich Glucksman (BCBSRI) added that in terms of the data collection, he has been thinking about what data may be useful for this work, and how the pain points for providers could be included or represented in the data.

Cory King (OHIC) outlined that Taylor has received some data thus far, and further suggested a working group comprised of interested members of the task force to address the data specifically. Mandatory participation would be required from the payers as they are the data submitters.

Howard Dulude (HARI) asked if there should also be a request sent out to providers.

Cory King (OHIC) advised that at this time they are focusing on the identification of high volume prior authorization requests, and then utilize that data to gain additional insight from providers.

Rich Glucksman (BCBSRI) agrees with Howard on the importance of provider input regarding data, as there may be other pieces to it that the data will not show.

Dr. Peter Hollmann (Brown) commented that on the provider side you can get a perception or qualitative survey, which is valuable information. Although, it would be hard to get quantitative data from providers.

Teresa Paiva Weed (HARI) agrees that provider input on data would be helpful as raw data would simply read, 'x number of prior authorizations were approved.' Whereas conversations conducted before the CTC focused on the length of time that it takes to get that prior authorization approved. She outlined that the administrative burden experienced by hospitals and providers may not be reflected in the data submitted by the insurers.

Hemant Hora (Point32Health) added that there are multiple levels to requesting a prior authorization. The first is the actual submission of documentation, which includes faxing in many instances. Second, is the actual turnaround time for the approval or denial. Then there is potentially a peer to peer if the service was denied, and perhaps an appeal as well if not approved on peer to peer. He outlined that based on his experience, 50% of reviews are approved on peer to peer. This could be due to a small clinical detail was missing on the original submission. He further added that EMR access could have significant impact on this.

Cory King (OHIC) thanked all members for their ongoing participation.

6. **Meeting Schedule**
   Cory King (OHIC) advised task force member of the next scheduled meeting being December 14th. Unlike the 2022 task force sessions, this year the task force will continue to meet into the new year (2024) with the following meeting tentative for January 18th.

7. **Public Comment**
   There were no public comments made.