State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
January 18, 2024 – 8:00am – 9:00am

Virtual Meeting Summary

Attendance
Andrea Galgay (RIPCPC), Caitlin Kennedy (Coastal Medical), Christopher Dooley (CharterCARE), Cory King (OHIC), Dr. Ana Stankovic (United Healthcare), Dr. Barry Fabius (UnitedHealthcare), Dr. Beth Lange (Pediatric Medicine), Dr. Farah Shafi (BCBSRI), Dr. Peter Hollmann (Brown Medicine), Dr. Victor Pinkes (BCBSRI), Elena Nicolella (RIHCA), Heather Beauvais (NHPRI), Hemant Hora (Point32Health), Howard Dulude (HARI), Jeffrey Bechen (CharterCare), John Tassoni (SUMHLC), Kara Lefebvre (CharterCARE), Karen Bouchard (United Health Group), Karen Labbe (BCBSRI), Katlin Carver (BCBSRI), Krysten Blanchette (Care New England), Laurie Marie Pisciotta (MHARI), Maria Zammitti (CharterCare), Michelle Crimmins (Prime Therapeutics), Richard Glucksman (BCBSRI), Scott Sebastian (United Healthcare), Shamus Durac (RIPIN), Stacey Paterno (RIMS), Tara Pizzi (Care New England), Teresa Paiva Weed (HARI),

Not in Attendance
Al Charbonneau (RI Business Group on Health), Dr. Christopher Ottiano (NHPRI), Dr. Scott Spradlin (Aetna), Mark Lorson (NHPRI), Melissa Campbell (RIHCA), Sam Hallemeier (PCMA)

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. **Data Review**
   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 that today's objective was to review the data OHIC has received in response to their data request.

   Taylor Travers (OHIC) began by reviewing the first content slide (slide #3), the tree map depiction provided a simple and broad overview of service categories with the corresponding number of prior authorization requests reported by 3 carriers commercial lines. As seen in the graph, radiology services account for a large piece of the total volume of prior authorization requests. There is a large gap between radiology with 61,082 requests and the next largest service category of cardiology advanced imaging and diagnostic (stress testing, echo(s) and heart cath(s)) with 12,088 requests. Some of the smaller volume categories included eye procedures (459 requests), bariatric surgery (462 requests), and durable medical equipment (815 requests). She stated that the depiction is reflective of the volume alone, without approval percentages. The data is also limited to what was reported and does not represent other categories that also may or may not require prior authorization.

   Cory King (OHIC) asked task force members if this data is consistent with what they would expect the data to show.

Richard Glucksman (BCBSRI) asked how much of the community that the data represented.

Cory King (OHIC) stated that data was received by Aetna, BCBSRI and NHPRI. Point32Health and United Healthcare is not reflected in the slide presentation, as data was not available.

Richard Glucksman (BCBSRI) outlined that he would like the meetings to continue beyond February 1st. He would like additional meetings to tackle issues or address items such as the spreadsheet that outlined the Statutes and providers/payers' responses.

Cory King (OHIC) stated that OHIC is also open to continue the meetings.

Howard Dulude (HARI) asked if the data was limited to physician services and asked about prior authorizations relating to skilled nursing facilities, nursing homes, rehab centers, and hospital admissions.

Taylor Travers (OHIC) outlined that this data is reflective of what was provided to OHIC in response to the data requests.

Hemant Hora (Point32Health) apologized for not being able to provide data in time. He does agree that radiology services account for one of the bigger buckets of prior authorization required services. He also outlined, in response to Howard's question that hospital admissions would be classified as concurrent reviews and would not be included in their prior authorization data. He emphasized that acute skilled nursing facility, and acute rehab data is significant, and he hopes to be able to provide and review that information in the future.

John Tassoni (SUMHLC) addressed that a major concern is the MCO's not providing the necessary data in order to make relevant decisions.

Cory King (OHIC) outlined that he anticipates a response from Point32Health soon. He added that this is an open public process, and in the legislative report he can address who participated and offered requested data in order to make data driven assessments.

Taylor Travers (OHIC) continued with slide #4 which displayed a bar graph inclusive of both volume, and approval percentages. The top seven categories of prior authorization volume were shown, these included echo, stress testing, home nursing, genetic testing, spinal procedures, CT, and MRI. Prior authorization requests for echo's accounted for 9,232 requests with 97% approval. Stress testing accounted for 2,401 requests with a 60% approval rate. Home nursing services accounted for 2,831 requests at a 99.9% approval rate. Genetic testing made up 2,619 requests with an approval rate of 73.7%. There were 3,682 spinal procedure requests with an approval rate of 92.8%. CT services accounted for 20,544 requests with an approval rate of 89%. MRI services accounted for 34,772 requests with an approval rate of 87%. According to data provided, bariatric surgery had the highest approval rate at 100%. Stress testing had the lowest approval rate at 60%. Radiology and Cardiology, according to data received had the highest volume of requests.

Dr. Victor Pinkes (BCBSRI) Asked if there was a breakdown available that showed who was requesting the services. He added that it might be a key factor in decreasing administrative

burden for primary care physicians. He expects that for radiology services, it would be a mix of providers that are requesting those specific services. It would be helpful data, but also may be difficult to obtain.

Stacey Paterno (RIMS) added that with this data and the approvals being so high, the insurer's say that it helps to reduce costs, she asked what those savings might look like.

Hemant Hora (Point32Health) responded that home nursing, skilled nursing in the homes, and echos are services that are in zones that they are currently reviewing. The services that have more than a 95% approval rate are being reviewed to see what the actual savings would be. That then would be indicative of the administrative savings, and the burden decrease. If they were to eliminate prior authorization on services less than 95%, depending on the type of service and unit cost; they would have to assess it more carefully, because the denials could be significant. He added that it would be important to see who ordered which services. A brain MRI being ordered by a PCP versus a neurologist could have very different approval and denial rates. An MRI ordered by a neurologist could have a 98% approval rate and a PCP ordered MRI could have perhaps an 85% approval rate.

Dr. Victor Pinkes (BCBSRI) clarified that the straw model proposal was for services above 95%. He then responded to Stacey that BCBSRI has probably only a few items over 95%, adding that volume is a key metric to consider. He added that BCBSRI has a detailed process, including a scoring process that takes into account approval rates and volume. He further added that Karen Labbe (BCBSRI) might be able to provide additional information.

Karen Labbe (BCBSRI) affirmed that the tool they utilize does take into consideration volume of services, approval rates, and mandates. It also takes into consideration, the type of product such as commercial.

Hemant Hora (Point32Health) Added to Karen's explanation that the product does make a significant difference. He stated that home nursing services for commercial products the justification for removal might be able to be made.

Dr. Barry Fabius (United Healthcare) added that there are additional dynamics that need to be reviewed in addition to the volume, approval rates and costs. He further added that the medical economics team has a fairly complex calculation for these types of decisions.

Taylor Travers (OHIC) continued with the review of slide #5 which showed a breakdown of service codes, with the corresponding number of requests. This depicted the top 15 of 25 codes reported by two insurer's, the other 10 (of 25) did vary by insurer. Code 73721 had 5,166 requests, 74177 has 4,467 requests and code 70553 had 3,815 requests. Code 72148 had 3,697 requests, code 71250 had 2,990 requests and code 73221 had 2,892 requests. Code 71260 had 2,680 requests, code 72141 had 2,199 requests and code 70551 had 2,059 requests. Code 74183 had 1,919 requests, code 72197 had 1,527 requests and code 78452 had 1,253 requests. Code 62323 had 818 requests, code 64483 had 805 requests and code 27447 had 698 requests.

Andrea Galgay (RIPCPC) asked the payers, that if a service that was originally ordered with contrast, and the radiologist determined it should be without contrast, would that be considered an approval, or would it be considered a modification.

Karen Labbe (BCBSRI) responded that she thinks it would be considered an approval, she can look at her data and circle back with the group on that type of scenario.

Taylor Travers (OHIC) continued with slide #6 which provided another representation of the top 15 (of 25 total) codes reported by two insurers with the number of requests and approval rates. The lowest approval rate shown being 67.07% for code 72141 with 2,199 requests. The highest approval rate shown was 95.98% for code 70553 which had 3,815 requests. Code 73721 had an approval rate of 91.17% with 5,166 requests. Code 74177 had an approval rate of 93.82% with 4,467 requests. Code 72148 had an approval rate of 68.54% with 3,697 requests. Code 71250 had an approval rate of 93.04% with 2,990 requests. Code 73221 had 2,892 requests with an approval rate of 79.66%. Code 71260 had 2,680 requests with an approval rate of 91.19%. Code 70551 had 2,059 requests with an approval rate of 96.35%. Code 74183 had 1,919 requests with an approval rate of 92.65%. Code 78452 had 1,253 requests with an approval rate of 93.29%. Code 70450 has an approval rate of 95.43% with 942 requests. Code 62323 had an approval rate of 93.27% with 818 requests. Code 64483 had 805 requests with an approval rate of 92.17%. Lastly, code 27447 had an approval rate of 95.55% with 698 requests.

Taylor Travers (OHIC) continued reviewing slide #7 which showed the top 5 highest requested codes with the highest approval rates. Code S9131 for physical therapy, in the home, per diem had 490 requests at a 100% approval rate. Code S9123 for nursing care, in the home, by registered nurse, per hour accounted for 1,886 requests with an approval rate of 99.90%. Code 27447 for arthroplasty, knee, condyle and plateau; medial and lateral compartments, with or without patella resurfacing had 583 requests with an approval rate of 99.40%. Code 27130 arthroplasty, acetubular/proximal femoral prosthetic replacement with or without autograft/allograft had 428 requests with an approval rate of 99.30%. Code 64493 for injection(s) of diagnostic or therapeutic agents, paravertebral facet joint or nerves, with imaging guidance, lumbar or sacral, single level had 584 requests with an approval rate of 95.40%.

Taylor Travers (OHIC) reviewed slide #8 which connected the data reviewed thus far with the straw model proposal that was originally brought forth in the 2022 task force sessions. The parameters of part A of the straw model proposal suggested to eliminate prior authorization from services with an average approval rate of 95% or higher and cost an average of $25,000 or less. Based on the available data and cost estimates provided by the insurer's, the following codes fit the straw model criteria: 70553 (3,815 requests and 95.98% approval), 70551 (2,059 requests and 96.35% approval), and 27447 (698 requests and 95.55% approval). The following codes 70486 (1,386 requests and 96.03% approval), 64493 (798 requests and 96.86% approval), 93306 (9,055 requests and 96.99% approval), 71271 (2,780 requests and 95.53% approval) fit the straw model criteria based on additional independent research for cost estimates. As an example, the elimination of these 7 codes would eliminate roughly 20,591 prior authorization requests.

Dr. Barry Fabius (United Healthcare) asked if the codes on slide #8 were the same codes listed on slide #7.

Taylor Travers (OHIC) added that code 27447 was on both of the slides.

Dr. Barry Fabius (United Healthcare) added that the codes on slide #7 were not indicative of primary care, which is a primary focus of the reduction in administrative burden.

Hemant Hora (Point32Health) asked if this data was reflective of behavioral health codes as well.

Taylor Travers (OHIC) added that only medical services were reviewed in these slides. The data was limited to the provided data, which did not reflect behavioral health services.

Stacey Paterno (RIMS) added that a specialist is probably requesting a lot of the same codes over and over, whereas a primary care provider has a broader scope. She further added that perhaps 95% is too high of a criterion for primary care.

Cory King (OHIC) addressed that for insurers there may be a lot of back-end data management and reporting responsibility but if they were able to parse out the data by provider specialty to provide a focus on primary care versus the remainder of providers it would be an interesting analysis. He added that this data may not be true representation of the full experience in the market, but it is indicative of the data provided to OHIC. From this data it does look like there is ability to make some reductions in prior authorization volume by adopting the straw model proposal. He also reminded the task force members that the individual parameters are flexible.

Howard Dulude (HARI) asked if there was raw data that was available to be reviewed. He added that this data could be a subset of the full picture.

Cory King (OHIC) added that they would review the submissions and perhaps combine it so as to not share any individual payer's data.

Richard Glucksman (BCBSRI) added that another important piece is the provider perspective on their individual pain points. He also added that there is more to consider, much to Karen Labbe and Dr. Victor Pinkes previous comments.

Elena Nicolella (RIHCA) stated that she is curious as to the methodology that the insurers go through to make the determinations.

Karen Labbe (BCBSRI) responded that BCBSRI reviews all of the codes in the service categories that are currently on the prior authorization list. They then use the tool, mentioned previously, to look at the different elements to determine whether or not they would make the recommendation to remove a service from the PA list. The recommendation would then be reviewed by medical directors, as well as utilization management and greivance and appeals professionals.

Elena Nicolella (RIHCA) asked if they were able to review and separate data by provider.

Karen Labbe (BCBSRI) added that BCBSRI does look at that aspect, but it can sometimes be difficult. She added that overall, it is considered. She provided, as an example a majority of home care requests come from home care agencies.

Richard Glucksman (BCBSRI) expressed that this conversation and the recent Primary Care Report released by OHIC has been beneficial and has drawn additional focus on the work to reduce provider burden and the processes surrounding prior authorization.

Hemant Hora (Point32Health) outlined that the Point32Health process is similar to the process that Karen Labbe of BCBSRI provided. He further added that they review codes with the highest approval rates, and that then goes through an assessment which will then go to the Medical Policy Approval Committee. This committee then decides on the removal of certain codes from the prior authorization list. The removal of 400 plus codes in the last two years can be attributed to this process.

Cory King (OHIC) stated that it would be beneficial in the final report, if OHIC could provide some narrative on the insurer process to refine their prior authorization lists over time.

Dr. Victor Pinkes (BCBSRI) noted that prior authorization is not the only thing that they are looking at. BCBSRI is also looking into referrals, and the need for a referral for certain specialties. As these are also a tremendous burden for primary care or could be in his opinion. It also decreases the overall member experience. He questions the effectiveness and adds that BCBSRI is reviewing everything from the provider burden aspect.

Howard Dulude (HARI) responded that for providers, pain points such as the changing of rules, and the notice given or not given is also important to consider. He also questioned if there may be limits in terms of how frequently rules can be changed.

Dr. Victor Pinkes (BCBSRI) responded that BCBSRI has a process they are bound by, that he thinks is regulatory. There is a 60-day notice of any change that must be communited to providers. With regards to hospital criteria, it is usually based on changes from InterQual, which is an Optum product that both hospitals and payers use to determine level of care. They constantly review for any changes, and they then notify providers of any changes which is based off of existing provider contracts.

Hemant Hora (Point32Health) added that any changes made to a certain medical guideline or policy is posted as provider notifications within a 60-day notice.

Richard Glucksman (BCBSRI) responded to Howard that if there is a sense in the community of an opportunity to make this process better, this is a great avenue to hear the concerns and thoughts.

Taylor Travers (OHIC) noted this conversation served as a segway into slide #9 which provided some background on the provider perspective, as data thus far was largely from the payer side. These items, related to prior authorizations and administrative burden, include timeframes for reporting changes (for deadlines, reporting, submissions of PA's, etc.), the ability to appeal for medical necessity on administrative denials, transparent and clear communication for both payers and providers, increased consistency across timeframes for SNF approvals and denials (can contribute to increased length of stay in the hospital), and increased consistency across payers and their individual products.

2. **Discussion**

Hemant Hora (Point32Health) added that timeframes for reporting, and appeals are consistent and clear at present. There are regular timeframes through NCQA (National Committee for Quality Assurance) and CMS that they are required to adhere to. He also noted that there are standard appeals and expedited appeals that vary in timeframe. Standard appeals have a 30-day turnaround time and expedited appeals are done a daily basis. The ability to appeal for medical necessity and administrative denials would be more so classified as benefit denials. Point32Health does have a benefit appeals committee, and they are reviewed as such, and that a Physician does sit on these appeal committees.

Karen Labbe (BCBSRI) agreed with Hemant's points, adding that the administrative denials would be a benefit denial and not a medical necessity denial. Looking at skilled nursing facility approvals and denial timeframes there are regulatory timeframes that they follow. She added that for expedited requests, they would have to provide that decision within 72 hours. She further cited that BCBSRI has committed to a 3-hour turnaround timeframe for any member being discharged from a hospital.

Howard Dulude (HARI) explained that he does have examples on the hospital side where administrative denials have been denials of actual services that were medically necessary, and the provider may not have provided the accurate code in the beginning of the process. He further added that once it gets to be an administrative denial, even though it is a medically necessary service, there are from his perspective no clear-cut time frames and responsibilities to move the process(es) along.

Stacey Paterno (RIMS) added to Howard's point that a patient nor a physician sees the difference between an administrative denial and a medical necessity denial. To them, a denial is a denial.

Hemant Hora (Point32Health) asked for specific examples in order to provide additional clarity. He explained that a major piece of what they call administrative denials is because something that was requested was not a part of the members benefit through their individual plan. As for hospital denials, he would like clarification as to whether there are outpatient or inpatient denials as they are two different channels.

Howard Dulude (HARI) responded that he does think it is both, but he will provide examples of such.

Hemant Hora (Point32Health) added that, EMR is something he has been reiterating for a while. If the hospital systems could provide EMR access, it does have the potential to solve a lot of the administrative burden on both ends. If something is missing in the initial request, and the insurer has EMR access the nurse could review the notes and potentially remedy the issue within an hour or two rather than playing phone tag or relying on fax communications.

Richard Glucksman (BCBSRI) expressed that BCBSRI is also interested in reviewing specific examples of these issues raised. He is similarly interested in exploring the access to EMR as a way to make the process more seamless.

Teresa Paiva Weed (HARI) stated that they can certainly provide examples and requested that insurers provide additional information regarding their timeframes for administrative denials

and benefit denials as well. If they were able to suggest to them what their standards are, whether it be 60 days, 6 months or 3 years.

Dr. Victor Pinkes (BCSBRI) added that to be able to intelligently respond, they really do need specific examples from the hospitals.

Teresa Paiva Weed (HARI) clarified that the issue is not with BCBSRI specifically.

Dr. Barry Fabius (United Healthcare) agreed that EMR access would be extremely helpful, as well as looking at specific examples of concerns raised. Without examples it would be hard to say if this is a systemic problem or an isolated issue.

Cory King (OHIC) responded that specific examples will be compiled, and everyone can work through them together to figure out the root of the problem. He further added that OHIC will continue to accept data from the insurers, to potentially provide more high-level summary information as well as to give the legislature a report that shows as a group, the task force collaborated, collected and reviewed data.

Dr. Peter Hollmann (Brown Medicine) outlined that there is state law regarding takebacks, that Richard and others may have additional knowledge regarding who it applies to and what categories it addresses. He also added that the issue with accessing medical records has to do with cyber security rather than privacy. Events such as cyber-attacks are growing exponentially.

Hemant Hora (Point32Health) responded that Point32Health has had attacks, and it's both ways, they (Point32Health) have also seen hospital systems experience cyber-attacks. Point32Health has invested and made significant improvements to security measures. With the appropriate safety and security standards on both sides, it needs to be talked about amongst the IT teams within both organizations.

Cory King (OHIC) added that investments in cyber security programs at Rhode Island College was mentioned at the State of the State address the other night, so it will perhaps become a more important part of the workforce.

3. **Meeting Schedule**

Cory King (OHIC) asked for any public comments, and any additional comments from task force members.

Taylor Travers (OHIC) explained that there would be a modification to the calendar invites made to reflect future meetings beyond February 1, 2024.

Cory King (OHIC) thanked all attendees for their time and added that it has been one of the more interesting convenings of the workgroup in some time.

4. **Public Comment**

There were no public comments made.