State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
February 1, 2024 – 8:00am – 9:00am

Virtual Meeting Summary

Attendance
Caitlin Kennedy (Coastal Medical), Christopher Dooley (CharterCARE), Cory King (OHIC), Dr. Barry Fabius (UnitedHealthcare), Dr. Beth Lange (Pediatric Medicine), Dr. Christopher Ottiano, Dr. Farah Shafi (BCBSRI), Dr. Peter Hollmann (Brown Medicine), Dr. Victor Pinkes (BCBSRI), Donna Paine (BCBSRI), Elena Nicolella (RIHCA), Kara Lefebvre (CharterCARE), Karen Bouchard (United Health Group), Karen Labbe (BCBSRI), Katlin Carver (BCBSRI), Laurie Marie Pisciotta (MHARI), 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), Andrea Galgay (RIPCPC), Dr. Ana Stankovic (United Healthcare), Dr. Farah Shafi (BCBSRI), Dr. Scott Spradlin (Aetna), Heather Beauvais (NHPRI), Hemant Hora (Point32Health), Howard Dulude (HARI), Jeffrey Bechen (CharterCare), John Tassoni (SUMHLC), Krysten Blanchette (Care New England), Maria Zammitti (CharterCare), 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

Straw Model Proposal Parameters
Cory King (OHIC) outlined the first agenda item, the straw model proposal parameters. He emphasized achieving a targeted reduction of 20% in prior authorization volume. The straw model proposal and its parameters could be used to create guardrails for the application of prior authorization in the future. He also mentioned the convening of a public body that can review data and over time curate the process. He noted that there might not be a consensus around the straw model proposal parameters. He reviewed part A of the proposal which proposed the elimination of prior authorization for services that meet the criteria of an average threshold approval of 95% or higher and cost an average of $25,000 or less. He emphasized that the proposal parameters, approval and cost are flexible, and members of the task force can suggest alternatives. He added that there needs to be an identification of the true volume of prior authorization services in order to determine what the 20% reduction would look like for each payer.

The next slide provided an overview of part B of the straw model proposal, this would remove prior authorization from all in-network behavioral health services. He added that this part of the proposal would create some consistency in the market between Blue Cross Blue Shield RI and the other plans. He provided an overview of the potential process of reducing the services requiring prior authorization. This involved the identification of the base volume of services and the determination of 20% for each payer. The application of the straw model proposal by implementing part A and part B, and the reduction of services as well as an ongoing review process. He emphasized that there is always going to be a need for continued application of utilization management policies, but that there does need to be a guardrail

around it. He asked for any preliminary feedback on the slides thus far pertaining to the straw model proposal and the potential application of the proposal.

Richard Glucksman (BCBSRI) commented that he has been thinking about trying to reduce the burden overall, which may or not be separate from the straw model proposal. He added that during these meetings, there has and is a commitment to reducing prior authorization volume. However, there are questions related to applying the straw model on a strict percent of approval and dollar value. He noted that there are other considerations that go into it.

Cory King (OHIC) acknowledged that there are other factors that do play into it. He outlined that many plans have already removed services from the prior authorization list. He then asked if there is some consistency across the plans regarding the services being removed from the list. He asked then how those determinations had been developed. Further adding that if there are prior authorizations that continue to be applied where the approval rate is high, why is that.

Richard Glucksman (BCBSRI) responded that there are probably a couple different pieces to that. One is consistency across payers, which is a valuable piece. He added that he thinks there has been success on the harmonization of quality measures, and there could be additional work on that. He also added that something considered by payers is the continued prior authorization requirement if approval rates are high. Looking at the approval rates over time, a strong factor continues to be cost. He further added that there is a range of factors for plans and providers that are taken into consideration. He does not think its limited to the two factors represented within the straw model proposal. He emphasized the commitment of the task force to the reduction.

Dr. Hollmann (Brown Medicine) commented that there may be different ways to get to a reduction and different ways to improve the processes. He added that it is important to have an option on the table that can be used to achieve it unless an alternative is presented, clearly measuring their rates of review, the numbers they are reviewing and then getting to the 20% reduction. He adds that it is a fairly reasonable proposal, with a very high approval rate it appears reasonable. He would add one thing, which is the ongoing meeting or process to review consistently, there does need to be a process put in place as the CTC-RI report mentioned.

Cory King (OHIC) responded that he does envision a standing body that meets quarterly, and that he does want to adhere to the CTC-RI recommendations as close as possible.

Dr. Victor Pinkes (BCBSRI) advocated for the inclusion of volume of a service or prior authorization within the straw model proposal parameters. He does think it is a missing variable that matters, considering if there are 5,000 procedures at $20,000, the 5% would be significant.

Cory King (OHIC) asked how this would be represented within the proposal.

Richard Glucksman (BCBSRI) asked to clarify that when talking about a 20% reduction, is it the number of services that require prior authorization or is it the number of prior authorization requests.

Cory King (OHIC) thought that it would be prior authorization requests, as those are what drive the burden on providers.

Stacey Paterno (RIMS) voiced her support to Dr. Hollmann's comments. She does wonder on the reporting side if or how you evaluate the progress. She mentioned the BCBSRI initiative on behavioral health, and how do they know that it is effective.

Cory King (OHIC) added those were all good points. During the course of the meetings, he would like to be able to identify the specific burden and concerns of primary care. He asked if the prior authorization data could be filtered by the providers that are requesting the services. This could then be used to narrow down the top 5 requests that primary care providers encounter that should be looked at in order to reduce burden specifically for those primary care providers. He is cognizant of the fact that the legislation was advocated for by the Rhode Island Medical Society as a whole, which is broader than just primary care. He added that there are specific intentions at OHIC to leverage changes for primary care. He also added that OHIC will follow up with a request to the health plans and providers to get a greater sense of what the primary care specific services look like. If there are other items outside of prior authorization that seem to be driving primary care provider burnout, they should be identified as to plan for the future.

Teresa Paiva Weed (HARI) supported the concept of an ongoing group with quarterly meetings. She would like to potentially focus on the hospital perspectives going forward.

Cory King (OHIC) would like to dedicate time in the future to the hospital perspective. He is also hearing from legislators that there should be a focus on prescription drugs and step therapy.

Dr. Christopher Ottiano (NHPRI) wanted to build on Teresa's points of having dedicated time to narrow in and focus on the three perspectives. These being the hospitals, primary care providers and outpatient services which would be the specialists. He suggested having future separate meetings to focus in on one area at a time to narrow the discussions.

Cory King (OHIC) agreed that a narrower focus may be beneficial.

Responses to Statute Provisions

Taylor Travers (OHIC) introduced the next topic, which delved into the responses to the statute provisions. The request for responses was sent out on December 19, 2023, to all task force members. The first item, article v, states 'to develop and implement the use of programs that implement selective prior authorization requirements, based on stratification of health care providers' performance and adherence to evidence-based medicine with the input of contracted health care providers and/or provider organizations. Such criteria shall be transparent and accessible to contracted providers. Such selective prior authorization requirements shall be available when health care providers participate directly with the insurer in risk-based contracts and may be available to providers who do not participate in risk-based contracts.' Article vi, 'Require the review of medical services, including behavioral health services, and prescription drugs subject to prior authorization on at least an annual basis, with the input of contracted health care providers and/or provider organizations. Any changes to the list of medical services, including behavioral health services, and prescription drugs requiring prior authorization, shall be shared via provider accessible websites.'

Taylor Travers (OHIC)outlined the response heard asking if the payers were able to streamline authorization requirements and processes across all products under one payer. In addition to the payer's ability to consider 'like' procedures. CPT codes are submitted and approved, and at the time of

service the procedure may change, and the claim is denied. Those claims then are rarely overturned for medical necessity.

Michelle Crimmins (Prime Therapeutics) advised that drug claims are processed differently from medical benefits. Oftentimes those claims are handled by different providers. She suggested having separate conversations because any recommendations made might not fit the specific process whether it be for medical or pharmacy.

Cory King (OHIC) asked for additional clarification on the process for prescription drug claims.

Michelle Crimmins (Prime Therapeutics) clarified that when she refers to drug claim platforms those are physical systems. There are different billing codes, different reasoning codes, and different computer systems that process a health claim versus what processes a pharmacy benefit claim. Furthermore, a provider clinical is not going to be billing a pharmacy benefit manager for drug services; a pharmacy is going to be doing that. The systems do not talk together the same way as health benefit claims talk to each other.

Dr. Hollmann (Brown Medicine) outlined that there are differences, but he does not think that necessarily means that the principles have to be inherently different. He outlined one of the differences within the prescription process being step therapy. In regard to implementation, there would have to be considerations made for those differences. He added that a lot of things are not directly billed by the provider of the service. It is the ordering clinician that gets the prior authorization rather than the billing clinician, which is the same thing as the ordering clinician that gets the prior authorization for the medication. The base issue at the pharmacies is patients being turned away at the point of sale because a prior authorization is required. It is not counted in the process of the prior authorization, but it is by far the most common aggravation that primary care providers and specialists face. A lot of specialty drugs are well known to require a prior authorization and that is similar to high-end imaging or other things that are well known to also require a prior authorization.

Richard Glucksman (BCBSRI) commented that it felt great to delve into this part of the work that reflects the legislative work and look into the processes to hopefully reduce some of the administrative burden; while also recognizing that prior authorization has a role and how to make it work best. He further added that the template for statute responses was helpful but did ask to separate each statute provision on its own slide. He also added that the provision that included gold carding and implementing it in conjunction with risk-based contracts felt really important and is a really important consideration for BCBSRI. They do not currently practice gold carding, but it is something they are considering, and looking at to see what would be involved with that and how it would work with the priority of other things they are trying to do. In regard to the review and communication provision (vi) BCBSRI does have a lot of processes that they utilize to disseminate a lot of information at different stages. They are interested in quarterly conversations to better understand where the current processes are working, where it is not working, and what could they do differently. Lastly, he added that feedback from providers on provisions v and vi would be helpful in better understanding where the pain points are.

Dr. Victor Pinkes (BCBSRI) asked if the streamlining of authorization requirements required collaboration with all payers to create a one-payer system.

Cory King (OHIC) advised that what he thinks it was referring to was if there are multiple lines of business, to streamline commercial, Medicare Advantage, Medicaid.

Dr. Victor Pinkes (BCBSRI) commented that there does need to be a payer perspective on that, as there would need to be provider partnerships and willing partners to collaborate and streamline the processes. There would also need to be partnerships on both sides, where the provider allows you into the medical record and from his perspective that is not always easily achieved.

Stacy Paterno (RIMS) thought that, although it was not her submission, that the responder meant streamlining and standardization across products under one plan. Adding that, from her experience, a more standardized approach could be beneficial for providers.

Cory King (OHIC) advised that the only way to feasibly achieve more standardization across payers is through regulation. He does not see there being willingness from all payers in the market today to collaborate on their processes without the glue that regulation would bring to the table.

Karen Labbe (BCBSRI) advised that BCBSRI always tries to ensure that if they are putting medical necessity criteria on a particular service for commercial and Medicare to try to keep the medical necessity criteria the same. Though, at times, Medicare rules may be different than what the commercial medical policies might be.

Taylor Travers (OHIC) continued with the next slide. Article vii, 'Improve communication channels between health plans, health care providers and patients by (A) requiring transparency and accessibility of prior authorization requirements, criteria, rationale, and program changes to contracted health care providers, patients and enrollees to provider accessible websites. (B) (I) Supporting timely submission by health care providers of the complete information necessary to make prior authorization determinations as early in the process as possible. (B) (II) Supporting timely notification of prior authorization determination by health plans to health plan enrollees, impacted providers and/or rendering providers, and dispensing pharmacists by posting to provider accessible websites or similar electronic portals.'

Taylor Travers (OHIC) outlined what was heard, which was the proposed development of a clear avenue for communications from the payers on changes and requirements. Some communications are not received, may be late or vague. Second, the ability to have retrospective reviews and medical necessity overrides for administrative failures.

Teresa Paiva Weed (HARI) added that the issue of medical necessity overrides of administrative failures had been raised a lot by members.

Richard Glucksman (BCBSRI) thought that this felt like a critical part of the process and asked what next steps were with the request to payers and providers for this information and how it might be compiled.

Cory King (OHIC) added, transparently, that there was only one response received from the provider perspective. He is happy to continue to collect the data and come back to the group with a discussion around the additional responses, if provided. If that surfaces specific actions, that can be taken on collectively. He added that there is no one present to speak for the information received.

Richard Glucksman (BCBSRI) added that it feels helpful in that it gets to the administratively burdensome parts of the prior authorization process. He further added that the 20% reduction sounds like a worthwhile goal to help take off some of the administrative burden. Additionally, he mentioned

what the subsequent year works out on that, asking if it continued to be 20% off of the 20%. Finally, he added that in the response from BCBSRI (not covered in this meeting) they outlined what they were currently doing and what they hoped to do next. He outlined BCBSRI's commitment to engage in ongoing conversations to reduce the administrative burdens.

Cory King (OHIC) advised that in future meetings OHIC could combine the provider and payer feedback received. That would provide the framework to have a dialogue regarding the responses. He added that he needs to see more dialogue between the provider and the payers to see if this is something that can be handled independently in their own negotiations or if the taskforce needs to be pushed to come to some sort of consensus around the regulatory requirements. Ultimately, the task force is to inform OHIC on any policy or regulatory requirements that should be considered to be adopted.

Richard Glucksman (BCBSRI) added that there is value in having OHIC convene the meetings.

Taylor Travers (OHIC) continued with the next slide, containing article viii 'increase and strengthen continuity of patient care by: (A) Defining protections for continuity of care during a transition period for patients undergoing an active course of treatment, when there is a formulary or treatment coverage change or change of health plan that may disrupt their current course of treatment and when the provider determines that a transition may place the patient at risk; and for prescription medication by allowing a grace period of coverage to allow consideration of referred health plan options or establishment of medical necessity of the current course of treatment. (B) Requiring continuity of care for medical services, including behavioral health services, and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive prior authorization requirements; and which for prescription medication shall be allowed only on an annual review, with exception for labeled limitation, to establish continued benefit of treatment.'

Taylor Travers (OHIC) outlined the response that was heard was that authorization requirements sometimes change midstream during active treatment course cycles causing denials and the potential for disruptions in treatment.

Dr. Hollmann (Brown Medicine) stated that some of those statements would reduce the prior authorizations, and some of them would impact the outcome of the prior authorization. He does think there could be a reduction in the volume of prior authorizations however a substantial amount of that might still require prior authorization, but it would then regulate what the outcome of that prior authorization may be.

Cory King (OHIC) added that the bullet point of feedback from the provider seemed to be really critical, that if a patient is within an active course of treatment and there is a change in the rules; it sounds like the provider is saying that the patient is experiencing disruptions or potential harm from that. He asked for additional perspective on that point, as the patient is supposed to be at the center of this, and what could be done to mitigate that.

Stacey Paterno (RIMS) thought that this could be explored further, potentially with additional feedback from providers on this point. She mentioned that there was a hearing, on one of the PBM bills where a family physician testified, and it related to annual formulary changes and the amount of burden it places on the providers.

Richard Glucksman (BCBSRI) added that this was really helpful to understand.

Taylor Travers (OHIC) outlined article viii (C) 'Requiring communication between health care providers, health plans, and patients to facilitate continuity of care and minimize disruptions in need treatment by posting to provider accessible websites. (D) Continuity of care for formulary or drug coverage shall distinguish between FDA designated interchangeable products and proprietary of marketed versions of a medication.'

Taylor Travers (OHIC) what was heard from the provider was that there are repetitive requirements in cases where treatment plans or formulary needs change.

Michelle Crimmins (Prime Therapeutics) asked if someone could expand on that thought and where the particular pain point was. Her understanding is that if the prior authorization is not on a product and if the formulary changes, they would then have to complete a prior authorization which would be a new requirement not a repetitive one. She added that these two points are a really good point of why drugs are a little bit different than medical benefits.

Cory King (OHIC) advised that unfortunately there was no one on the call to be able to speak to this exact feedback received. He asked if anyone had thoughts to share on this matter.

Caitlin Kennedy (Coastal Medical) added that although she cannot speak to this response specifically, she thinks that it may not necessarily be a new prior authorization. If the drug goes from being covered to not being covered, rather than doing a prior authorization it is getting switched to a new medication. Then say the next quarter the same thing happens, the formulary changes and now the medication that was changed is no longer preferred, and the cycle continues to repeat itself.

Teresa Paiva Weed (HARI) added that on the hospital side a repeated concern they hear is that there are constant changes in the middle of treatment. Communication could really just be a notice, letting people know prior to the changes, rather than having people go to a website and find where it may or may not be.

Dr. Ottiano (NHPRI) added that, in regard to continuity of care, there is so much to unpack, and that may be one of the biggest areas healthcare leaders really need to think about. A lot of variables change in Rhode Island health care on a yearly basis, formularies can change, and there is a high degree of churn of members who go from Medicaid to the Health Benefit Exchange and then go back based on job status. He added that there is then a reasonable amount of movement between the MCO's and the commercial plans, and every time a member or a patient makes an adjustment, either formularies change, they change plans, or they change lines of business.

Michelle Crimmins (Prime Therapeutics) asked a follow up question for Teresa regarding communication practices, if there was a formulary change that happened through the course of the year there would typically be either a letter or fax to the provider, is that not making it to the providers?

Teresa Paiva Weed (HARI) added that fax volume is one of the frustration points for providers. Additionally, she thought that providers are receiving the notice when the change is occurring rather than prior to the change occurring.

Taylor Travers (OHIC) outlined article ix 'Encourage health care providers and/or provider organization and health plans to: Accelerate the use of electronic prior authorization technology, including adoption of national standards where applicable.'

Taylor Travers (OHIC) outlined that what was heard was that all payers do not support electronic submission of prior authorizations and second, processes vary from product to product under one payer.

Stacey Paterno (RIMS) added that this is where the idea of standardization would make it easier for providers.

Discussion

Dr. Hollmann (Brown Medicine) added that he does think there will be a lot of technological innovation, and some plans have already adopted it over the years. He added that it is not just processes varying from product to product under one payer, it's also from service to service under one payer in the same product. He commented that pharmacy is different than advanced imaging, they are all slightly different.

Cory King (OHIC) asked if this format was helpful for the group.

Dr Hollmann (Brown Medicine) stated it was useful to have one specific point to work through. He does think it will be more helpful with additional responses. He also thought that is useful to keep in mind that a case represents 1% of the issue, there are a lot of things that can be done that will take care of a vast majority of the concerns.

Cory King (OHIC) responded that OHIC would send out the template again in a request for additional responses. If feedback is provided, if the organizations could also attend the forthcoming meetings in order to have a dialogue around the points.

Meeting Schedule

Cory King (OHIC) advised the taskforce members of the upcoming meeting schedule, to include meetings on February 22 and March 14, 2024.

Public Comment

There were no public comments made.