State of Rhode Island Office of the Health Insurance Commissioner
Administrative Simplification Task Force
February 22, 2024 – 8:00am – 9:00am

Virtual Meeting Summary

Attendance
Cory King (OHIC), Dr. Ana Stankovic (United Healthcare), Dr. Barry Fabius (United Healthcare), Dr. Beth Lange (Pediatric Medicine), Dr. Christopher Ottiano (NHPRI), Dr. Gus Manocchia (BCBSRI), Dr. Peter Hollmann (Brown Medicine), Elena Nicolella (RIHCA), Heather Beauvais (NHPRI), Hemant Hora (Point32Health), Howard Dulude (HARI), Karen Labbe (BCBSRI), Katlin Carver (BCBSRI), Maria Zammitti (CharterCARE), Mark Gallagher (United Health Group), Richard Glucksman (BCBSRI), Sam Hallemeier (PCMA), Scott Sebastian (United Healthcare), Shamus Durac (RIPIN), Stacey Paterno (RIMS), Tara Pizzi (Care New England),

Not in Attendance
Al Charbonneau (RI Business Group on Health), Andrea Galgay (RIPCPC), Caitlin Kennedy (Coastal Medical), Christopher Dooley (CharterCARE), Dr. Farah Shafi (BCBSRI), Dr. Scott Spradlin (Aetna), Dr. Victor Pinkes (BCBSRI), Jeffrey Bechen (CharterCARE), John Tassoni (SUMHLC), Kara Lefebvre (CharterCARE), Karen Bouchard (United Health Group), Krysten Blanchette (Care New England), Laurie Marie Pisciotta (MHARI), Mark Lorson (NHPRI), Melissa Campbell (RIHCA), Michelle Crimmins (Prime Therapeutics), Sam Hallemeier (PCMA), Scott Sebastian (United Healthcare), 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. **Provider Responses to Statute Provisions**
   Cory King (OHIC) informed members of the task force that similar to the previous meeting, the statute provisions and responses will be reviewed one by one in order to create dialogue on each of the provisions. There were two submissions by health insurance carriers.

   Taylor Travers (OHIC) outlined each statute beginning with (v) 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 easily accessible to contracted providers. Such selective prior authorization programs shall be available when health care providers participate directly with the insurer in risk-based payment contracts and may be available to providers who do not participate in risk-based contracts.

   Response #1: Pharmacy has gold-carded providers for Pulmonary Arterial Hypertension that bypass prior authorization (PA) requirements on pharmacy benefit. These claims are audited retrospectively to ensure proper prescribing.

Response #2: Insurer does not currently "gold card." Insurer delegates high end radiology to a vendor: eviCore. Recognizing radiology is an area with significant prior authorization volume, eviCore currently has the capability and technology to replace clinical surveys to enable a faster, more efficient prior authorization process. eviCore's Intellipath technology has shown a 25% reduction in provider submission time and a 50% reduction in outreach for additional clinical documentation.

Dr. Peter Hollmann (Brown Medicine) thought that the responses were not necessarily directly responsive to the statutory phrase. Additionally, in reviewing the slides that were sent out in advance they read almost like advertisements for the insurer. As an example, they stated that they used Intellipath but didn't explain what that was, which would be an important piece. He cited that the response was not about gold carding and intellipath probably is a very good system, and it's probably an automated way of doing things but it did provide any additional information about what it actually does. He explained that there were a couple of responses, where they used a specific system or tool, but didn't explain the tool, and for those who do not use the tool, they are not familiar.

Richard Glucksman (BCBSRI) responded to Dr. Hollmann and mentioned that some of the responses were from BCBSRI. Regarding gold carding, he explained that it is something that they are looking at, but not right now and so they wanted to at least provide some information. The overall summary that they had for this response was the commitment to reducing the burden associated with utilization management. He added that the nature of the request, or how they saw responding, was describing the initiatives that they have now, or hope to have in the near term to make the prior authorization or utilization management process easier.

Taylor Travers (OHIC) reviewed the next statute (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 organization. Any changes to the list of medical services, including behavioral health services, and prescription drugs requiring prior authorization, shall be shared via provider accessible website.

Response #1: Providers are notified a minimum of 60 days in advance of the change to any prior authorization guidance. The notice is also posted to the provider new and updates page on their website. For medical services, the insurer completed a review of the list of medical prior authorization required benefits and services based on utilization, cost, and regulatory requirements in 2022. The insurer removed prior authorization requirements for 10 medical service categories as of 1/1/2023. The insurer has not implemented a standard process for the review of medical prior authorizations. Insurer investigates provider recommendations to change to prior authorization for clinical appropriateness. In regard to pharmacy services, the medical and pharmacy benefit and formulary management decisions are reviewed by the pharmacy and therapeutics (P&T Committee) on a quarterly basis. The P&T Committee includes physicians and pharmacists with specialties in allergy and immunology; family medicine; geriatrics, obstetrics, and gynecology; and behavioral health.

The P&T Committee is responsible for steering the insurer's formulary and assuring that formulary utilization management activities are clinically appropriate to meet the medical needs of their members. Pharmacy reviews at minimum quarterly all PA requests received and decisioned as well as appeal overturns and reconsiderations. Goals to monitor key performance indicators to quantitatively measure the application of utilization management (UM) criteria, volume of prior authorization requests, approval and denial rates, productivity, timeliness, and market trends.

Response #2: Insurer's medical policies are subject to review and periodic update. Providers can comment, and information is available publicly. Services currently requiring prior authorizations are reviewed on a quarterly basis. Services are evaluated for potential removal from the prior authorization list based on factor such as product (Commercial plan vs Medicare Advantage), approval rates, appeals on overturn rates, regulatory mandates, market trends, provider burden and impact to members. Annually, all medical policies are reviewed by the Medical Policy Review Committee as well as the Utilization Management Committee. Providers have the ability to comment on new and existing policies or submit requests or comments for policy updates and edits. New and annual reviews of medical policies are posted to the website for provider feedback. Insurer.com/providers/medical policies under the "Draft Policies" section. Draft and final policies are available on Insurer's website. Annually, drugs requiring prior authorizations are reviewed via the PBM P&T Committee as well as the plan's P&T Committees, which include participation of external physicians including those in the health plan's participating network. All formularies and prior authorization criteria are currently posted on the plan's website. They can be found on the on the Policies and Coverage page located within the provider portion of the Insurer.com website, which is available pre-authentication.

Dr. Peter Hollmann (Brown Medicine) explained that he was chair of the Blue Cross P&T Committee in the past and he has also participated in the P&T Committees of some national PBM's. Based on that experience, he thought this information was accurate and honest. But one of the things that people have to keep in mind is that posting something to a website and saying they will be reviewing a policy has some legitimacy to it; and he thinks it meets some requirements. Although it's not necessarily people getting actively involved in a lot of the things, whereas the P&T Committee is, a system where people are very actively involved. He added that the key thing that's missing there is that what's usually brought to committees is criteria. Are the criteria clinically appropriate, not the decision as to whether something should be a prior authorized or not. And that's a lot of what we're talking about is, is the prior authorization a valuable process. There's some of that discussion. But in general, the committee is just asked to look at is if the clinical criteria are appropriate.

Hemant Hora (Point32Health) commented that historically that is what was happening. They distribute criteria to the P&T Committees. For the past two years, they have been doing review with the lens of, can this service come off and literally have a column where they check off the box. He had a meeting just last week where they went through all their medical policies and checked off on those and highlighted them. As to red, blue, or red, yellow, and green. As to green, being the ones that they could potentially review to remove from the list.

Cory King (OHIC) added that as the task force members review the slides to keep in mind the structure of the statute and where each of the provisions fit in. He added that it ultimately begins with the establishing and convening of a workgroup which is essentially the administrative simplification work group. He further added that he is to submit a final report to the General Assembly by June 30, 2024, which includes the recommendations discussed during the course of these meetings. The Commissioner may implement with supporting rationale, and the work group shall consider and make recommendations for each of these provisions. He would like to surface whether there are things that OHIC should be doing through regulation to create some consistency across processes or create more of a focused analysis. For example, regarding the annual review of services, health plans review services subject to prior authorization, at least annually and the factors that should be considered include what services should remain on the prior authorization list. How that would be assessed in regard to compliance, which is to be determined.

Dr. Gus Manocchia (BCBSRI) asked in regard to Dr. Hollmann's comment, if he was referring specifically to pharmacy criteria or medical policy criteria.

Dr. Peter Hollmann (Brown Medicine) added that he was commenting more about pharmacy. As to medical, for a lot of plans they have to follow a national policy, so they have consistency. A lot of the decisions as to what is going to be covered is going to be made on a national basis. He does not think that there was evaluation as to whether the service actually had to undergo prior authorization. It was more work with the criteria.

(vii) Improve communication channels between health plans, health care providers and patients by: (A) Requiring transparency and accessibility of PA requirements, criteria, rationale, and program changes to providers, patients, and enrollees to provider/patient accessible websites

Response #1: For medical services, all PA criteria for medical benefits and services is available on the Insurer website. For pharmacy services the page on the website has posted all PA criteria, clinical medical policies, and formularies. Providers can reach out to Insurer to give thoughts/recommendations on changes they would like to see on policies and Insurer reviews for clinical appropriateness. Providers are noticed a minimum of 60 days in advance of change to any PA guidance. The notice is also posted to our provider News and Updates page.
The provider page on our website contains the quarterly provider newsletter and provider news section both which contains many specific updates on pharmacy policies, changes to benefits etc. The newsletter is also delivered via email to those providers registered.

Response #2: For medical services the Insurer's medical policies are subject to review and periodic update. Providers can comment, and information is available publicly. Services currently requiring prior authorizations are reviewed on a quarterly basis. Services are evaluated for potential removal from the PA list based on factors such as product (Commercial plan vs Medicare Advantage), approval rates, appeals overturn rates, regulatory mandates, market trends, provider burden and impact to members.

Annually, all medical policies are reviewed by Medical Policy Review Committee as well as Utilization Management Committee.

Howard Dulude (HARI) mentioned if there could be some suggestion about standards for communication to providers that would make it easier to understand what the changes are. He does not know what those standards should be, but could the group perhaps talk to providers and see what the best way to communicate is. He wonders if there are other ways to make sure the information gets out there in an easier format.

Dr. Peter Hollmann (Brown Medicine) added that the insurer responses are important statements and are necessary, but he thought the reality of it is the real time use of these policies. He himself looks at the provider updates monthly, and some of the items apply to him and some don't. He thought that the representatives at the insurance companies have a difficult time looking things up and ensure they are following the criteria. A lot of it has to do with how the information is being made accessible to people as they are processing the work that they are doing. He does not think that newsletters are all that helpful, and some websites are almost impossible to navigate, some being better than others. He wants to ensure that the processes are practical while the providers and office staff are doing the real time work. As far as providers attending the calls, he thinks this would be more office staff and office management that are participating in the calls.

Hemant Hora (Point32Health) building off of what Dr. Hollmann stated, he thinks this is the current state and what has been happening over the last few years. If looking at the first part of the statute, improve communication channels, improvement means something better than what is happening right now. He thinks the answer to this is some of what is seen in the CMS Interoperability and prior authorization rule that is coming. That will be solved mostly by the automation and the interoperability requirements that are coming down. This would allow the providers to have answers in real time, and the rationale in the event of denials. He does agree with Dr. Hollmann in the sense that providers do not have time to go up and down a website when requesting an MRI. Potentially, what they could do is click into the EMR, and with automation it could pair to the criteria in real-time for the specific patient and service. It could potentially pull from the EMR and approve it, if all the criteria were met within minutes. It would be a huge undertaking but it's something they are looking into working on.

Stacey Paterno (RIMS) commented that hearing these points reiterate that this current process is not practical. The idea of moving to improve the current state is critically important because it really is a lot of information that providers are expected to process through which takes a lot of time.

Dr. Gus Manocchia (BCBSRI) added that relative to the provider update calls, it is a vast majority of office staff and billing representatives that are attending. In many ways, it's because a lot of the discussion revolves around billing issues, coding, etc. Policies are also discussed, sometimes particularly critical policies that are being changed, or new policies. They assume that the information is then passed on to the providers in the practice., which would need to be addressed at the practice level. In his current role, he spends a fair amount of his day talking to providers on the phone in peer-to-peer conversations about requests that they've made. During the discussions, he explains why the case was denied and explains their policy on the request. In many cases, the provider is clearly not aware of the policy. Oftentimes they disagree with the policies and want to be involved in changing it, which they do allow. Providers are able to provide information, and potential policy changes are reviewed. He underlined again that providers are usually not aware of.

Statute (vii) Improve communication channels between health plans, health care providers and patients by: (B) (I) Supporting timely submission by providers of the complete information necessary to make PA determination as early in the process as possible.

Response #1: For medical services, Insurer's e-forms allow a provider to submit complete and necessary information in order to complete an authorization request. Reviewers reach out at soon as possible when additional documentation is needed. When denials are issued the insurer provides a detailed explanation of the required supporting documentation that is needed to complete the request. For pharmacy, Insurer posts the majority of authorization criteria electronically to support the physician in submitting a complete request upon electronic submission. Insurer actively encourages providers to submit requests electronically whenever possible. For medically administered drugs, there are e-forms available which allow providers to attach clinical documentation necessary for a review. When Insurer receives an incomplete request, the policies and procedures are to request the missing information in a timely fashion via outbound phones calls or faxes to providers' offices.

Response #2: For medical services, Insurer uses a medical management platform/provider portal, MHK, that includes the internal capabilities to review and make decision on prior authorization requests, as well as an external-facing provider portal to submit and monitor requests. This integrated application portal allows providers to submit authorization request to see a real-time view of their case and approval status. Providers can upload attachments and notes. If clinical information is missing from a provider's request, our UM team will make three phone/fax outreach attempts to gather the information needed. Regarding pharmacy services, the insurer has a PA Notify program in place which notifies prescribers 30 day prior to an existing authorizations expiration to allow the provider to renew the authorization mitigating interruption to therapy. Insurer also has a smart renew program which auto approves certain drugs based on the patient's active utilization of the Rx.

Additionally, all drug criteria forms are posted on the Policies and Coverage Page of Insurer.com. The forms capture all the clinical information which need to be provided so that a clinically appropriate decision is able to be made. If clinical information is missing from a provider's request, our PBM, which is delegated clinical review, will fax the provider requesting the specific information needed and make two phone outreach attempts to gather the information needed. It is very common that providers do not respond or do not respond within the regulatory timeframes.

Hemant Hora (Point32Health) advocated for EMR access, a recommendation that he has made previously which could solve many of the issues. There is a lot of back and forth, between phone calls and faxes which delays the process. With EMR, the nurse at the insurance plan could review the clinical notes and find missing information that enables them to make the decision. EMR access could provide solve a lot of the issues very effectively. He also added that the use of their portal should be used as much as possible rather than relying on fax. Lastly, he mentioned in Rhode Island there is a large Medicaid population and per the Medicaid rules and regulations, if a request does not have a decision within the turnaround time frame, it must be automatically denied. If all the information is available, but it hadn't reached them yet, it has to be denied causing angst for all parties. To shorten the timeframe, EMR access is key.

Howard Dulude (HARI) asked what percentage of primary care practices currently have EMR sophisticated enough to allow insurers that access, adding that hospitals probably do.

Hemant Hora (Point32Health) agreed that the hospitals probably do. He added that his team has done an assessment on the practices that they do have access to, and Howard is right that it is mostly hospitals systems as of right now. Given the fact that, in the future, they will have to automate to some extent. The first thing is, of course, reducing the number of codes. If they were to automate things, they would need those capabilities, requiring providers and payers to integrate their systems. He added that it can't be one sided, and the next step to their assessment is reviewing who has EMRs with those capabilities, and what could be done to upgrade them if needed.

Dr. Peter Hollmann (Brown Medicine) mentioned that there are not all that many different medical record systems in use in the state right now, and most of them are national platforms. He added that there are a lot of technical aspects of it, but the idea of security is a major issue. Every hospital in the country has had a problem where they've had to go to medical records on paper because of security issues. The idea of not being able to access emergently needed information because they've been hacked, or their systems have been shut down is an issue to consider with EMR access.

Hemant Hora (Point32Health) agrees with Dr. Hollmann, and security is one of the top 3 reasons they have heard as to why EMR access is not easily available. He thinks it does come down to having the IT teams at both the insurer and the practices working together to see what capabilities are available.

They have tremendously upgraded their capabilities, trying to keep the pace with all that is happening out there. He mentioned a cyber-attack recently on Change Healthcare which a lot of hospitals use, adding that national organizations are being targeted. There is a need for due diligence to make sure security protocols are up to date.

Richard Glucksman (BCSBRI) commented that while the group is walking through all of the items, it might be helpful to get a sense of prioritization. Potentially there are items that can be resolved in the near term versus the long term. He is not exactly sure what that looks like but while there is a group of collaborators on the call, they could tackle that as well.

Statute (vii) Improve communication channels between health plans, health care providers and patients by: (B) (II) Supporting timely notification of prior authorization determination by health plans to impacted providers/pharmacists/enrollees/patients by posting to prover/patient accessible websites.

Response #1: For pharmacy services, if a provider submits a request electronically, they will receive a decision notice electronically via the submission portal (i.e., CoverMyMeds) and via fax. Otherwise, we immediately fax decision notices to providers upon case completion. If a fax fails multiple times, we will mail out a decision letter.

Response #2: Insurer's provider portal, MHK allows providers to see a real-time view of their case and approval status. While our primary goal is to always 'auto approve' cases, some cases do not have sufficient information and need additional review. Some providers have invested in technology that automatically monitors the MHK provider portal for status updates and feeds the update into their specific EMR. As of September 1, 2023, provider correspondence is available in the "View Authorizations" section of Insurer MHK Provider Portal. The requesting provider of the authorization can now view correspondence which have been sent via fax or mail. For pharmacy services, the outcome of review is immediately faxed to the provider once a decision has been made. For hospitals, the outcome of a review is provided verbally to the UR/CM team at in-state facilities. Notably, in recognition of hospitals' concerns, Insurer has committed to providing authorization to our hospital partners for discharge to a skilled nursing facility or acute inpatient rehabilitation facility within three-hour turnaround time 24/365 days a year. Members receive a denial with rationale and appeal rights, this is also provided to the medical practitioner and can be viewed in the "View Authorizations" section of Insurer MHK Provider Portal.

Dr. Peter Hollmann (Brown Medicine) commented in terms of recommendations, he thinks a lot of the responses show a lot of dedication to improving the process by the health plans. They have been actually doing this over a long period of time, one of the things to think about is if some of the plans are offering that they have been doing it, it is a good idea to consider it being a requirement or a standard that must be met by health plans. He commended the plans that did respond and are on the call participating in the dialogue, adding that they have been supportive for a long period of time. Although, not everyone is necessarily following that, so that might be considered as item number one when making the final recommendations.

Howard Dulude (HARI) building off of Dr. Hollmann he added that there can be something in the recommendations really recommending the plans to continue to move in the direction or set some high-level goals to meet.

Statute (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/change of plan that may disrupt their treatment and when the provider determines that a transition may place the patient at risk.

Response #1: For medical services: Insurer allows for a 90-day continuity of care period for new commercial members. Insurer care managers are available to assist members with accessing the care they need in the case of a change in benefits. For pharmacy, they have continuity of coverage and transitions of care policies and procedures in place for Commercial members new to our plan within the first 90 days of their enrollment. We will allow members to continue on an already started treatment without needing to meet our criteria within those first 90 days, as long as the drug is not a benefit exclusion.

Response #2: Insurer helps members with continuing needs find alternative sources of care when members' benefits change or end, or when providers terminate from the Plan. Processes are in place to ensure continued member access to necessary medical care and services to prevent disruption or delays in treatment during periods of transition or changes in member benefits. For pharmacy services, continuity of care is taken into consideration in criteria for most drugs. The Plan allows a 30-day supply for certain drugs if a member is currently on therapy and the review is pending appeal. A letter is sent to the member advising they have that 30-day supply while their appeal is under review. Pharmacy prior authorization programs include as a component "risk of change" for some conditions and products, including behavioral health drugs, Biologic Immunomodulators and Inhaled Corticosteroid.

Dr. Christopher Ottiano (NHPRI) wanted to emphasize how important that point is to NHPRI. They have previously alluded to how many Medicaid members are in the state, and for the size of the state it is a pretty substantial population. This point is taken very seriously with members routinely going from Medicaid to the health benefit exchange and then back to Medicaid. They strive to ensure their members care does not get adjusted as much as their employment.

Dr. Peter Hollmann (Brown Medicine) thinks they are all good programs, and it's one of the areas where if you have a group that reviews certain items on an ongoing basis it would be an opportunity to reach a mutual understanding where some of the subtleties could be addressed. This is a good opportunity where people can sort of reach a middle ground and understand each other, which a lot of that has already happened. He thinks there is a lot of good consideration on both sides, but wanted to comment that this is an area of extreme subtlety.

Statute (viii) Increase and strengthen continuity of patient care by: (B) Requiring continuity of care for medical services, behavioral health services, and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive PA requirements.

Response #1: For medical services, the insurer is interested in hearing and understanding the providers experiences. Regarding pharmacy, the insurer has a follow-me-logic tool in place for when members switch plans within the insurer organization. This allows for authorizations to follow a member automatically preventing access to care issues and decreasing provider burden to resubmit PA request. We also implement lookback step therapy logic for preferred drug changes when a member is already stable on the affected medication.

Response #2: For medical services, the insurer is interested in hearing and understanding the providers experiences. Regarding pharmacy, the Pharmacy Smart Renew Program minimizes repetitive PA requirements. SmartRenew proactively identifies members who are currently utilizing drugs that have expiring approvals. Without an intervention, these members would likely experience disruption when trying to pick up their medication at the pharmacy due to the UM requirement and would need to work with their provider to seek renewal of the authorization. When the SmartRenew criteria are met, previous drug authorizations are extended, and the member is notified. Authorizations must meet several criteria to be included for extension. For example, the authorization must be longer than 6 months in duration and member must be adherent as evident by a recent paid claim. This automation eliminates drugs that are used for acute purposes. Not all medications are included in the program for different reasons and the list of included drugs is reviewed annually.

Statute (viii) Increase and strengthen continuity of patient care by: (C) Requiring communication between health care providers, health plans, and patients to facilitate continuity of care and minimize disruptions in needed treatment by posting to provider/patient accessible websites.

Response #1: For medical services, the insurer is interested in hearing and understanding the providers experiences.

Response #2: For medical services, the insurer is interested in hearing and understanding the providers experiences. For pharmacy services, the Pharmacy Smart Renew Program minimizes repetitive PA requirements. SmartRenew proactively identifies members who are currently utilizing drugs that have expiring approvals. Without an intervention, these members would likely experience disruption when trying to pick up their medication at the pharmacy due to the UM requirement and would need to work with their provider to seek renewal of the authorization. When the SmartRenew criteria are met, previous drug authorizations are extended, and the member is notified. Authorizations must meet several criteria to be included for extension. For example, the authorization must be longer than 6 months in duration and member must be adherent as evident by a recent paid claim. This automation eliminates drugs that are used for acute purposes. Not all medications are included in the program for different reasons and the list of included drugs is reviewed annually.

Howard Dulude (HARI) commented that the task force has primarily been talking about the amount of work that providers need to deal with in regard to prior authorizations and the navigating of the system. Adding that this is probably the area where individuals probably have the most frustration with the health plans and the whole health care system. There may be processes in place to try to minimize that, but looking at it from a patient perspective this one creates a lot of anxiety, frustration, and misunderstanding. If you talk to anyone that has health insurance they made a change, or the plan drops their drug, or they have to go through the prior approval process, they worry about their care and they worry about the process.

Statute (viii) Increase and strengthen continuity of patient care by: (D) Continuity of care for formulary or drug coverage shall distinguish between FDA designated interchangeable products and proprietary or marketed versions of a medication.

Response #1: For pharmacy services, they allow members within the COC period to continue on brand name medications. After their COC period has ended, we will allow continuation of the brand name product if a valid provider supporting statement is received with the request. Insurer also takes into consideration the need for members on narrow therapeutic index drugs (e.g., phenytoin, warfarin, levothyroxine etc.) to continue on the same brand/formulation.

Response #2: They believe the rational for this item is to preserve the plan's ability to administer changes when branded drug options become available. Insurer's strategy in those cases is to promote generics and/or lower cost therapeutically comparable drugs.

Richard Glucksman (BCBSRI) commented that the wording of that element, in the statute, prompted their response as a place holder, depending on the guidance that came out of conversations they wanted to have a placeholder there to say that there might be a difference for drugs as they move from brand to generic.

Statute (ix) Encourage health care providers and/or provider organizations and health plans to: accelerate use of electronic PA technology, including adoption of national standards where applicable.

Response #1: For medical services, the insurer encourages the use of E-forms. For pharmacy utilizes electronic PA submission for both medical and pharmacy benefit requests. Electronic versions are strongly encouraging on all provider facing communications and materials (website, provider news, phone messaging). Our oncology vendor (Evolent) uses online portal system additionally and has provided frequent provider training sessions and outreach for utilization. Additional outreach has been made by pharmacy team and Evolent to providers with high volume of alternate PA submission (phone, fax) types. Insurer has observed an increase in E-form submission from 2022 to 2023.

Response #2: For medical services, the insurer continually works to streamline the prior authorization process so we can enhance our member and provider experience. The insurer has a high adoption rate of use of the provider portal. That said, for any practitioner not using the portal, their adoption will improve the PA process for them and their patients.
Because of this, Insurer has dedicated resources to provide additional educational training sessions and we encourage all network providers to take advantage of this opportunity. These sessions are typically 30-60 minutes long and will consist of a demo of the authorization process and trained staff to answer questions. This is an opportunity to speak directly to our UM manager, administrators of our medical management platform (MHK), and a provider-relations representative. Regarding pharmacy services, CoverMyMeds is an online platform to submit PA requests, we have done reminders of the functionality in Provider Update.

Dr. Peter Hollmann (Brown Medicine) added that anytime a training can be archived so somebody can access it at a later time rather than attending a real-time session would be beneficial. Adding that anytime things can be made more intuitive so there is no need for training is helpful. With 5 or 6 different plans each having their own product. Each maybe using a different system, having a half hour training along with the other trainings required during the year it is impossible. Although, he thinks it is great that they are available.

Richard Glucksman (BCBSRI) mentioned the wording in the spreadsheet request titled, recommendations for improvement. He echoes, Point32Health as they are exploring options and what might be coming to better integrate with the EMR. It seems like an area for huge opportunity to make the burden and the administrative work reduced.

Howard Dulude (HARI) thinks it does make sense to integrate with the EMR but asks who would pay for that integration. That aspect does need to be considered because it's not an inexpensive process. Some systems would probably be easier than others, but there still is a cost to the practice.

Stacey Paterno (RIMS) added that, with the talks of cyber-attacks and the security of systems she wondered the feasibility from a risk management perspective.

Richard Glucksman (BCBSRI) commented that it is something that they are all trying to figure out how to work through and manage to protect themselves the best they can but at the same time not letting that stop the integration that would make the processes work better.

2. **Primary Care Provider Burdens**
Cory King (OHIC) introduced the next slide focusing on primary care provider burdens. The three categories include prescription drugs, advanced imaging, and referrals. Although referrals are not part of the prior authorization process, the process can be burdensome to providers. He also outlined the Primary Care Report released by OHIC in December. Highlighting how the agency can help to alleviate some of the burdens. They will be taking a look at each of the items and conduct analysis specific to primary care and develop a strategy for specifically alleviating administrative burden on primary care. Some of the discussions have taken place during this

workgroup and could be a preview for what could been seen as policy recommendations from OHIC in the near term.

3. **Discussion**

Dr. Gus Manocchia (BCBSRI) asked if there are primary care practices that actually see the value in prior authorization. Considering the fact that most of the primary care providers in the state right now are involved in some sort of risk sharing contract with the payers where they are incentivized to manage costs appropriately.

Cory King (OHIC) replied that he has not heard a primary care provider articulate that they see value in prior authorization, but he has not asked them directly.

Dr. Beth Lange (Pediatric Medicine) agrees with what has been said but wants to caution that the cost savings is not just to the insurance plans and the system. There is a cost burden to the primary care physician and the office. When looking at cost savings and what is being achieved with it, the costs on the staff side needs to be evaluated. In a time where staff retainment is difficult, the costs are not necessarily just on the insurer side.

Howard Dulude (HARI) asked Dr. Lange if there was a sense of the cost associated with the prior approval process?

Dr. Beth Lange (Pediatric Medicine) mentioned that she does not have a cost figure. But pointed out that during this meeting she received a note regarding a referral that was approved with the wrong CPT code listed and could it be resolved before the patient's appointment in the next two hours. She would love for an economist to be able to monetize the process. She added that it isn't possible to measure the emotional burden of having to do things more than once, it is a challenge. She appreciates this work and everyone's intent to try and make things better.

4. **Meeting Schedule**

Cory King (OHIC) outlined the meeting schedule which consists of one remaining meeting, to take place on Thursday, March 14. This will allow time for OHIC to review meeting summaries, comments, and task force recommendations in order to compile information for the final report due to the General Assembly in June. All presentations and summaries up to present time are available on the OHIC website.

Richard Glucksman (BCBSRI) asked if the office will continue to accept provider and payer input, data, or responses.

Cory King (OHIC) outlined that OHIC will continue to accept input through to the next meeting on March 14, 2024. He mentioned that perhaps in May, once a draft is prepared there could be a reconvening of the group to share the structure and what's being discussed in the report.

5. **Public Comment**

There were no public comments made.