Administrative Simplification Task Force

February 22, 2024

RHODE ISLAND

Agenda

1. Responses to Statute Provisions
2. Primary Care Provider Burdens
3. Discussion
4. Meeting Schedule
5. Public Comment

Responses to Statute Provisions:

(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	Response 2
Pharmacy 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.	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.

Responses to Statute Provisions:

(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.

Response 1	Response 2
Providers are notified a minimum of 60 days in advance of the change to any PA guidance. The notice is also posted to our provider News and Updates page. **Medical** Insurer completed a review of list of medical PA required benefits and services based on utilization, cost and regulatory requirements in 2022. Insurer removed PA requirements for 10 medical service categories as of 1/1/23. Insurer has not implemented a standard process for review of medical PA's. Insurer investigates provider recommendations to changes to PA for clinical appropriateness. **Pharmacy** 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 Insurer's formulary and assuring that formulary utilization management activities are clinically appropriate to meet the medical needs of our 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.	**Medical** 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. Providers have the ability to comment on new and existing policies or submit requests or comments for policy updates/edits. New and annual reviews of medical policies are posted to the web for provider feedback on Insurer's website at Insurer.com/providers/medical policies under the "Draft Policies" section. Draft and final policies are available on Insurer's website. **Pharmacy** Annually, drugs requiring prior authorization 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.

Responses to Statute Provisions:

(vii) (A) Improve communication channels between health plans, health care providers and patients by:
Requiring transparency and easy accessibility of prior authorization requirements, criteria, rationale, and program changes to contracted health care providers, patients, and health plan enrollees to provider accessible websites.

Response 1	Response 2
Medical All PA criteria for medical benefits and services is available on the Insurer website. **Pharmacy** Pharmacy page on our 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 pharmacy specific updates on policies, changes to benefits etc. The newsletter is also delivered via email to those providers registered.	**Medical** All Medical and Payment policies can be found on the Policies and Coverage page located on the provider page of Insurer.com website, pre-authentication. Insurer's Provider Relations team shares monthly a "Provider Update" which is a monthly newsletter that delivers updates on policies, changes to benefits, and other news providers need to know. "Provider Update" can be found on the Provider Update page located on the provider page of Insurer.com website. In addition, our Provider Relations team conducts monthly calls with providers - typically 80-100 providers participate in these calls. We encourage providers to submit questions or topics. Provider Relations also will send email blasts for targeted communications and any ad hoc emergency communications as well. **Pharmacy** All formularies and prior authorization criteria are currently posted on the plan's website. They can be found on the Policies and Coverage page located on the provider page of Insurer.com website, pre-authentication. Regarding changes, Provider Update in April and October informs providers that the changes are posted to our web page. The plan publishes all upcoming formulary changes to our online Provider Update 30 days prior to the effective date of change. Impacted members receive notice at least 30 days prior to the effective date of change. Multiple areas internally also receive the update so they are able to assist members if they contact the plan.

Responses to Statute Provisions:

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

Response 1	Response 2
Medical Insurers e-forms allow a provider to submit complete and necessary information in order to complete an auth request. Reviewers reach out as 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. **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.	**Medical** 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. **Pharmacy** 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 an 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.

Responses to Statute Provisions:

(vii) (B) (II) Improve communication channels between health plans, health care providers and patients by:
Supporting timely notification of prior authorization determinations by health plans to impacted health plan enrollees, and health care providers, including, but not limited to, ordering providers, and/or rendering providers, and dispensing pharmacists which may be satisfied by posting to provider accessible websites or similar electronic portals.

Response 1	Response 2
Pharmacy If a provider submits a request electronically, they will receive a decision notice electronically via the submission portal (i.e., Cover-my-meds) 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.	**Medical** 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. **Pharmacy** The outcome of review is immediately faxed to the provider once a decision has been made. **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.

Responses to Statute Provisions:

(viii) (A) Increase and strengthen continuity of patient care by:
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 treating physician 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.

Response 1	Response 2
Medical 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. **Pharmacy** We 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.	**Medical** 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. **Pharmacy** 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.

Responses to Statute Provisions:

(viii) (B) Increase and strengthen continuity of patient care by:
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.

Response 1	Response 2
Medical Insurer is interested in understanding providers experiences. **Pharmacy** We have follow-me-logic in place for when a member switches 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.	**Medical** Insurer is interested to hear providers experiences to help us understand and respond. **Pharmacy** Our 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.

Responses to Statute Provisions:

(viii) (C) Increase and strengthen continuity of patient care by:
Requiring communication between health care providers, health plans, and patients to facilitate continuity of care and minimize disruptions in needed treatment which may be satisfied by posting to provider accessible websites or similar electronic portals.

Response 1	Response 2
Medical Insurer is interested in understanding providers experiences.	**Medical** Insurer is interested to hear providers experiences to help us understand and respond. **Pharmacy** Our 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.

Responses to Statute Provisions:

(viii) (D) Increase and strengthen continuity of patient care by:
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	Response 2
Pharmacy We 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.	We 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.

Responses to Statute Provisions:

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

Response 1	Response 2
Medical Insurer encourages the use of E-forms. **Pharmacy** Pharmacy utilizes electronic PA submission for both medical and pharmacy benefit requests. Electronic versions are strongly encourages 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.	**Medical** Insurer continually works to streamline the prior authorization process so we can enhance our member and provider experience. 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. **Pharmacy** CoverMyMeds is an online platform to submit PA requests, we have done reminders of the functionality in Provider Update.

PRIMARY CARE PROVIDER BURDENS

Drugs

Advanced Imaging

Referrals

Although not part of the prior authorization process, the referral process can be burdensome to primary care providers.

Discussion

Next Meetings:

Last Meeting: March 14, 2024

Public Comment

Thank you

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