# Administrative Simplification Task Force

March 14, 2024

RHODE ISLAND

# Agenda:

1. Task Force Review
    a) Problem Statement
    b) CTC-RI Recommendations
    c) Straw Model Proposal
    d) Insurer Data Review
    e) OHIC's Powers and Duties Statute
    f) Provider Response to Statute Provisions
2. Next Steps
3. Public Comment

# Task Force Problem Statement:

"Prior authorization is a form of utilization management that has an important role to play in the provision of medically necessary care under health benefit plans. However, health care providers and those speaking from the patient perspective, have articulated reasonable concerns with the application of prior authorization and the resulting burdens placed on those involved in the provision of patient care."

**Provider View:**

- Increased administrative burden
- Increased operating costs
- Potential jeopardizing of patient safety
- Contributor to clinician burnout

**Patients' View:**

Experience of care can be materially and adversely impacted when the application of prior authorization creates real, or perceived, barriers and delays in accessing care.

**Payor View:**

- Utilization management tool promoting evidence-based care
- Reduced wasteful spending
- Promoting patient safety and affordability for health care purchasers

# CTC-RI Recommendations:

### Reduce the prior authorization volume

Two considerations:

1) Reducing overall number of prior authorizations

2) Reducing the prior authorizations burden for providers by way of improved processes.

Reducing the number of prior authorizations based on history of use in fully-insured commercial plans; target of 20%.

### Improve the prior authorization data collection

To measure reduction, baseline data must be made available. Ad hoc group to gather data of:

-Rate of prior authorizations per insured member

-Prior authorizations approved and those approved with modification

-Method of reporting the specific service codes that require prior authorization by a plan.

### Create on-going statewide advisory committees

The creation of a statewide steering committee to improve simplification, facilitate communication and collaboration, and develop methods. This committee would oversee two additional committees, the Medical Services Committee and Pharmaceutical Services Committee who will review PA's for burden reduction and simplification and report recommendations & methodologies to the advisory steering committee.

### Evaluate therapeutic substitutions at the pharmacy

Convene a workgroup led by CTC-RI and URI College of Pharmacy to evaluate possible change in legislation allowing therapeutic interchange. Made up of pharmacists in retail outlets, pharmacies, plans and hospital pharmacists experienced with therapeutic substitution processes. *This recommendation is not anticipated to be per se part of the Administrative Simplification processes of the OHIC.*

### Implement technologies that improve the process

Existing agencies such as the HIT Steering Committee should be leveraged to monitor and report on technology changes and compliance with state and federal requirements associated with prior authorization. identification of a workgroup potentially within the HIT steering committee to meet twice annually to review changes and facilitate implementation of enhancements is ideal.

### Identify & reduce processes that are 'PA-like'

There are many communications, requirements, etc. that should be appropriately considered for burden reduction, reasonably classified in the rubric as PA or 'PA-like' and should be considered for burden reduction by any entity overseeing the PA process, even if not subject to regulation. These processes are felt to be among the most burdensome.

# Straw Model Proposal:

**Part A**

**Remove prior authorization requirements from all medical services meeting the following criteria:**

Average threshold approval of 95% +
&
Average cost of $25,000 or less

**Part B**

**Remove prior authorization requirements for all in-network behavioral health services.**

Conversations surrounding the straw model proposal indicate the necessary inclusion of volume, and safety/health concerns as necessary components within the parameters of the proposal.

# Data Review: Insurer 1

| Code | Description | Cost | # of Requests | # of Requests Approved | Difference |
|---|---|---|---|---|---|
| 93306 | Echocardiography, transthoracic, real-time with image | Not reported | 9,055 | 8,783 | 272 |
| 73721 | MRI, Any Joint, Lower Extremity; W/O Contrast Matl | Not reported | 5,166 | 4,710 | 456 |
| 74177 | Computed Tomography, Abdomen And Pelvis; With Contrast Material(S) | Not reported | 4,467 | 4,191 | 276 |
| 70553 | MRI, Brain; W/O Contrast, Then W/Contrast & Further Sequences | Not reported | 3,815 | 3,662 | 153 |
| 72148 | MRI, Lumbar Spine; W/O Contrast | Not reported | 3,697 | 2,534 | 1,163 |
| 71250 | Computed tomography, thorax, diagnostic; without contrastmaterial | Not reported | 2,990 | 2,782 | 208 |
| 73221 | MRI, Any Joint, Upper Extremity; W/O Contrast Matl(S) | Not reported | 2,892 | 2,304 | 588 |
| 71271 | Computed tomography, thorax, low dose for lung cancer screening, without contras | Not reported | 2,780 | 2,656 | 124 |
| 71260 | Computed tomography, thorax, diagnostic; with contrast material(s) | Not reported | 2,680 | 2,444 | 236 |
| 72141 | MRI, Cervical Spine; W/O Contrast | Not reported | 2,199 | 1,475 | 724 |
| 70551 | MRI, Brain; W/O Contrast | Not reported | 2,059 | 1,984 | 75 |
| 74183 | MRI, Abdomen; W/O Contrast Matl(S) Followed By Contrast Matl(S) & Further Sequen | Not reported | 1,919 | 1,778 | 141 |
| 77049 | MRI BREAST C-+ W/CAD BI | Not reported | 1,728 | 1,348 | 380 |
| 72197 | MRI, Pelvis; W/O Contrast Matl(S), Followed By Contrast Matl(S) & Further Sequen | Not reported | 1,527 | 1,407 | 120 |
| 70486 | Ct Scan, Maxillofacial Area; W/O Contrast Matl | Not reported | 1,386 | 1,331 | 55 |
| 78452 | Myocardial Perfusion Imaging, Tomographic (Spect); Mult Studies, At Rest &/ Stre | Not reported | 1,253 | 1,169 | 84 |
| 74176 | Computed Tomography, Abdomen And Pelvis; Without Contrast Material | Not reported | 1,221 | 1,143 | 78 |
| 95810 | Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist | Not reported | 1,230 | 942 | 288 |
| 70450 | Ct Scan, Head/Brain; W/O Contrast Matl | Not reported | 942 | 899 | 43 |
| 29881 | Artrs knee surg w/meniscectomy med/lat w/shvg | Not reported | 911 | 903 | 8 |
| 62323 | NJX DX/THER SBST INTRLMNR LMBR/SAC W/IMG GDN | Not reported | 818 | 763 | 55 |
| 64483 | Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level | Not reported | 805 | 742 | 63 |
| 64493 | Injection(s), Diag/Therapeutic Agent, Paravertebral Facet Joint or Nerves, W Image Guidance, Lumbar/Sacral; Sgl Level | Not reported | 798 | 773 | 25 |
| 95811 | Polysom 6/>yrs sleep w/cpap 4/> addl param attnd | Not reported | 784 | 632 | 152 |
| 27447 | Arthroplasty, Knee, Condyle & Plateau; Medial & Lateral Compartments, W/Wo Patella Resurfacing | Not reported | 698 | 667 | 31 |

# Data Review: Insurer 2

| Code | Description | Cost | # of Requests | # of Requests Approved |
|---|---|---|---|---|
| 0345U | Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of CYP2D6 - Last Update 01/01/2024 | 1,303.85 | Not provided | Not provided |
| 36475 | Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated | 2,654.57 | Not provided | Not provided |
| 62323 | Injection(s), of diagnostic or therapeutic substance(s) (eg, anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, interlaminar epidural or subarachnoid, lumbar or sacral (caudal); with imaging guidance (ie, fluoroscopy or CT | 678.79 | Not provided | Not provided |
| 64483 | Injection(s), anesthetic agent(s) and/or steroid; transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level | 675.71 | Not provided | Not provided |
| 81162 | BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (eg, hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (ie, detection of large gene rearrangements) | 1,083.14 | Not provided | Not provided |
| 81256 | HFE HEMOCHROMATOSIS GENE ANAL COMMON VARIANTS | 98.27 | Not provided | Not provided |
| 81420 | Fetal chromosomal aneuploidy (eg, trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21 | 568.43 | Not provided | Not provided |
| 81443 | Genetic testing for severe inherited conditions (eg, cystic fibrosis, Ashkenazi Jewish-associated disorders [eg, Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (eg, ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH) | 860.8 | Not provided | Not provided |
| 81479 | UNLISTED MOLECULAR PATHOLOGY PROCEDURE | 1,670.69 | Not provided | Not provided |
| 87505 | NFCT AGENT DNA/RNA GASTROINTESTINAL PATHOGEN | 305.5 | Not provided | Not provided |
| 87798 | IADNA NOS AMPLIFIED PROBE TQ EACH ORGANISM | 103.97 | Not provided | Not provided |
| 87799 | IADNA NOS QUANTIFICATION EACH ORGANISM | 159.16 | Not provided | Not provided |
| 95810 | Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist | 1,321.29 | Not provided | Not provided |
| 95811 | Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist | 675.36 | Not provided | Not provided |
| E0748 | Osteogenesis stimulator, electrical, noninvasive, spinal applications | 2522 | Not provided | Not provided |
| J0585 | Injection, onabotulinumtoxinA, 1 unit | 942.37 | Not provided | Not provided |
| J0897 | Injection, denosumab, 1 mg | 1,362.65 | Not provided | Not provided |
| J1745 | Injection, infliximab, excludes biosimilar, 10 mg | 2,980.90 | Not provided | Not provided |
| J2350 | Injection, ocrelizumab, 1 mg | 36,242.48 | Not provided | Not provided |
| J2506 | Injection, pegfilgrastim, excludes biosimilar, 0.5 mg | 5,320.33 | Not provided | Not provided |
| J3380 | Injection, vedolizumab, 1 mg | 9,978.09 | Not provided | Not provided |
| J7323 | Hyaluronan or derivative, Euflexxa, for intra-articular injection, per dose | 111.81 | Not provided | Not provided |
| J9217 | Leuprolide acetate (for depot suspension), 7.5 mg | 813.74 | Not provided | Not provided |
| Q5103 | Injection, Infliximab-dyyb, biosimilar, (Inflectra), 10 mg | 4,128.39 | Not provided | Not provided |
| Q5121 | Injection, infliximab-axxq, biosimilar, (avsola), 10 mg | 1,890.30 | Not provided | Not provided |

# Data Review: Insurer 3

| Code | Description | Cost | # of Requests | # of Requests Approved | Difference |
|---|---|---|---|---|---|
| Code not provided | RADIOLOGY SERVICES | $288 | 4072 | 3,972 | 100 |
| Code not provided | INPATIENT ACUTE | $8,664 | 812 | 769 | 43 |
| Code not provided | CHIROPRACTIC | $82 | 664 | 664 | 0 |
| Code not provided | PHARMACY | $8,439 | 525 | 521 | 4 |
| Code not provided | PAIN MANAGEMENT | $388 | 340 | 339 | 1 |
| Code not provided | Behavioral Health Hospital Inpatient Services - Residential, partial hospitalization, stabilization unit | $2,315 | 288 | 287 | 1 |
| Code not provided | SLEEP STUDIES | $410 | 160 | 160 | 0 |
| Code not provided | Physical Therapy | $166 | 149 | 149 | 0 |
| Code not provided | DME (DMENSION) | $471 | 100 | 97 | 3 |
| Code not provided | Behaviorial Health Outpatient  Services | $1,091 | 96 | 94 | 2 |
| Code not provided | VARICOSE VEIN TREATMENT | $725 | 92 | 91 | 1 |
| Code not provided | OON OFFICE AND CLINIC VISITS | $98 | 87 | 56 | 31 |
| Code not provided | BREAST REDUCTION OUTPATIENT | $3,226 | 85 | 72 | 13 |
| Code not provided | GENETIC TESTING | $398 | 80 | 62 | 18 |
| Code not provided | HOME HEALTH CARE SKILLED NURSING | $226 | 78 | 78 | 0 |
| Code not provided | INPATIENT VAGINAL DELIVERY | $6,419 | 73 | 73 | 0 |
| Code not provided | OPHTHALMOLOGICAL SURGICAL SERVICES | $130 | 69 | 68 | 1 |
| Code not provided | OUTPATIENT SURGERY AND PROCEDURES (OTHER) | $954 | 68 | 59 | 9 |
| Code not provided | ACUPUNCTURE | $256 | 67 | 66 | 1 |
| Code not provided | OON OUTPATIENT SURGERY AND PROCEDURES | $704 | 58 | 34 | 24 |
| Code not provided | HOME HEALTH CARE SKILLED NURSING SERVICES | $242 | 57 | 57 | 0 |
| Code not provided | Occupational Therapy | $111 | 56 | 56 | 0 |
| Code not provided | INFERTILITY | $1,057 | 51 | 51 | 0 |
| Code not provided | BARIATRIC SURGERY INPATIENT | $5,441 | 46 | 42 | 4 |
| Code not provided | SKILLED NURSING FACILITY SKILLED CARE LEVEL I | $3,187 | 43 | 35 | 8 |

# Data Review: Insurer 4

| Code | Description | Cost | # of Requests | # of Requests Approved |
|---|---|---|---|---|
| 66984 | CATARACT ***CODE SINCE REMOVED*** | $2,017 | 168 | Not provided |
| 72148 | MAGNETIC RESONANCE IMAGING | $489 | 140 | Not provided |
| 36475 | ENDOVENOUS ABLATION THERAPY | $2,287 | 132 | Not provided |
| 71250 | CT THORAX W/O CONTRAST | $281 | 132 | Not provided |
| 70553 | MRI OF BRAIN W/O & W/ CONTRA | $828 | 120 | Not provided |
| 73721 | MRI; ANY LOWER EXTREMITY JNT | $639 | 114 | Not provided |
| 74177 | CT ABD&PELV W/CONTRAST | $678 | 106 | Not provided |
| 71260 | CT THORAX DX W CONTRAST | $435 | 102 | Not provided |
| 73221 | MRI; ANY UPPER EXTREMITY JNT | $620 | 95 | Not provided |
| 64483 | NERVE BLOCK EPI L/S 1 | $585 | 84 | Not provided |
| 72141 | MRI CERVCIAL SPINE | $541 | 80 | Not provided |
| 72197 | MRI, PELVIS | $975 | 80 | Not provided |
| 78452 | MYOCARDIAL SPECT | $1,106 | 71 | Not provided |
| 70551 | MRI BRAIN | $527 | 63 | Not provided |
| 78815 | PET | $1,760 | 60 | Not provided |
| 74177 | CT THORAX DX W CONTRAST | $681 | 60 | Not provided |
| 66982 | CATARACT ***CODE SINCE REMOVED*** | $404 | 56 | Not provided |
| 27447 | TOTAL KNEE ARTHROPLASTY | $19,472 | 49 | Not provided |
| 62323 | EPIDURAL LMBR/SAC | $608 | 44 | Not provided |
| 74183 | MRI ABDOMEN W/O & W DYE | $843 | 40 | Not provided |
| 27130 | TOTAL HIP ARTHROPLASTY | $23,094 | 38 | Not provided |
| 71275 | CT ANGIO/CHEST | $448 | 38 | Not provided |
| 64484 | NERVE BLOCK SOMATIC NERVE | $256 | 36 | Not provided |
| 70450 | CT HEAD | $206 | 34 | Not provided |
| 23472 | SHOULDER JOINT RECONSTRUCTION | $20,604 | 33 | Not provided |

# Data Review:

| 19 of the top 25 reported codes (2+ carriers) | |
|---|---|
| 73721 **5,280 requests** (2 carriers) | 78452 **1,324 requests** (2 carriers) |
| 74177 **4,633 requests** (2 carriers) | 72148 **1,303 requests** (2 carriers) |
| 70553 **3,935 requests** (2 carriers) | 95810 **1,230 requests** (2 carriers) |
| 71250 **3,122 requests** (2 carriers) | 70450 **942 requests** (2 carriers) |
| 73221 **2,987 requests** (2 carriers) | 64483 **889 requests** (3 carriers, 1 did not report volume) |
| 71260 **2,782 requests** (2 carriers) | 62323 **862 requests** (3 carriers, 1 did not report volume) |
| 72141 **2,279 requests** (2 carriers) | 95811 **784 requests** (2 carriers, 1 did not report volume) |
| 70551 **2,122 requests** (2 carriers) | 27447 **747 requests** (2 carriers, 1 did not report volume) |
| 74183 **1,959 requests** (2 carriers) | 36475 **132 requests** (2 carriers, 1 did not report volume) |
| 72197 **1,607 requests** (2 carriers) | **Total requests = 38,919** |

# OHIC's Powers and Duties Statute:

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.

(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 healthcare 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;

(vii) Improve communication channels between health plans, health care providers, and patients by:

A) Requiring transparency and easy accessibility of prior authorization requirements, criteria, rationale, and program changes to contracted health care providers and patients/health plan enrollees which may be satisfied by posting to provider accessible and member accessible websites; and

# OHIC's Powers and Duties Statute:

B) Supporting:

(I) Timely submission by health care providers of the complete information necessary to make a prior authorization determination, as early in the process as possible; and

(II) 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 or services; and

(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 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;

# OHIC's Powers and Duties Statute:

(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

(C) 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 or services;

(D) Continuity of care for formulary or drug coverage shall distinguish between FDA designated interchangeable products and proprietary or marketed versions of a medication.

(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.

# Provider Response 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

**What we heard:**

"Such criteria shall be transparent and easily accessible to contracted providers". I feel this needs to be determined on who determines if this is met as the companies currently don't give any information and just deny.

Why is prior auth needed in risk bearing contract? Isn't cost already part of the performance formula? Don't downward adjustments/performance payments negate the roll of prior auth? In lieu of case by case prior auth, can audits of compliance with clinical guidelines be used as a quality metric? It sounds like this is describing "gold carding." I would think this would be the option offered for non-risk bearing (FFS) providers. I agree with the need for transparency regarding the criteria for gold card status and I expect the bar will need to be quite high. Again, this determination may need to be based on audits of compliance with established clinical guidelines.

# Provider Response 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.

**What we heard:**

This sounds good. It might represent a bit of an administrative burden. Who are the contracted health care providers and provider organizations that will be part of these yearly reviews? Representatives from each relevant discipline should probably be considered stakeholders. People with an awareness of the positions of national or state specialty societies should be included. While I support this provision in general, it may prove difficult to consistently convene the right stakeholders.

# Provider Response to Statute Provisions:

(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

What we heard:

The more this can be centralized the better. Perhaps OHIC or EOHHS could serve as a repository for these policies. This would allow providers/patients one site to visit. Conversely, it isn't realistic to expect providers to navigate the web sites of multiple payors. More importantly, centralizing the PA requirements, criteria, rationale and program changes would serve to hold the payors accountable to applicable RI state legislation/policies. CMS is moving towards FHIR. All payors should be required to use compatible technology and CMS policies should be considered a bare minimum template for commercial variations.

# Provider Response to Statute Provisions:

(vii) Improve communication channels between health plans, health care providers and patients by:

(B) (I) Supporting timely submission by health care providers of the complete information necessary to make PA determination as early in the process as possible.

What we heard:

See above. Perhaps technology can facilitate this.

(B) (II) Supporting timely notification of prior authorization determination by health plans to health plan enrollees, impacted providers but not limited to, ordering providers and/or rendering providers, and dispensing pharmacists by posting to provider accessible websites or similar electronic portals.

What we heard:

The understanding is that the goal of FHIR is to make this real time within a CCHIT EHR. Posting to a variety of separate websites does not seem like a reasonable option.

# Provider Response to Statute Provisions:

(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.

What we heard:

Who is responsible for communicating with the patient when there is a formulary or treatment coverage change or change of health plan that may disrupt their current course of treatment? The contract regarding coverage is between the patient and their insurance company. From a provider's perspective, these are unpleasant, long conversations that we often don't agree with. Basically, we are being forced into a situation that is damaging to our provider/patient relationships and takes a lot of our time in order to do the bidding of the insurance company. I personally don't feel there is compensation that makes this something I want to do.

# Provider Response to Statute Provisions:

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

(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 PA 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.

What we heard:

Is there an option to continue established care indefinitely, or only until the next annual review? Will the payor instituting the policy change offer the affected beneficiary education as to why the new treatment is better than their established treatment?

# Provider Response to Statute Provisions:

(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 which may be satisfied by posting to provider accessible websites or similar electronic portals.

What we heard:

There needs to be a line that also focuses on patient communication by the insurance. Many of my patient's have gotten approvals. They get called once by the specialty pharmacy and if they don't answer are never contacted again and therefore are approved but the medication gets delayed until they see me next and my MA contacts the specialty pharmacy.

# Next Steps:

- Draft Report Discussion (Tentative Meeting)
- Ongoing Public Body
- Final Report of Recommendations to the General Assembly June 30, 2024

# Public Comment:

# Thank you

RHODE ISLAND