OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

Administrative Simplification Task Force
2023 – 2024 Meeting Series Summary

Introduction

The Rhode Island Office of the Health Insurance Commissioner (OHIC) reconvened the Administrative Simplification Task Force on October 26, 2023. to seek input from organizational representatives who understand the operational and policy complexities of the prior authorization process. Prior authorization is the prospective assessment of a health care service prior to that service being rendered. Task Force invitations were sent out on September 27, 2023, to representatives of insurers, review agencies, providers (including organizational and individuals representing physical health, mental health, and substance abuse) and consumer advocacy groups.

Background

OHIC's purpose in this Administrative Simplification Task Force was to gain a better understanding of the existing prior authorizations environment across all levels. The Task Force's charge was to gather input and recommendations on prior authorization requirements and processes. Senate Bill 0290 Substitute A passed on June 22, 2023, required a workgroup of health care providers and health insurers convened by the Office of the Health Insurance Commissioner (OHIC) to make recommendations regarding the application of prior authorization. This report summarizes and provides the framework for recommendations derived from discussions of the Administrative Simplification Task Force which met from October 2023 to March 2024. This report also summarizes the Office of the Health Insurance Commissioner's applicable statutory authority and relevant information pertaining to the prior authorization process.

Meeting Dates and Participation

The Administrative Simplification Task Force reconvened on October 26, 2023, and held eight total meetings, ending on March 14, 2024. Members of the working group discussed numerous facets of the prior authorization process and its policies. The below table lists the task force members and the attendance at each of the meetings.

TABLE 1: Task Force Membership and Organizational Affiliation

Name	Organization	10/26	11/16	11/30	12/14	1/18	2/1	2/22	3/14
Andrea Galgay	RI Primary Care	X	X	X	X	X			X
Caitlin Kennedy	Coastal Medical	X	X	X	X	X	X		X

Christopher Dooley	CharterCARE	X	X	X		X			
Dr. Ana Stankovic	Point32Health	X			X	X		X	X
Dr. Barry Fabius	United Healthcare	X	X	X	X	X	X	X	X
Dr. Beth Lange	Pediatric Medicine	X	X	X	X	X	X	X	
Dr. Christopher Ottiano	NHPRI	X	X	X			X	X	X
Dr. Jill O'Brien	Lifespan								
Dr. Peter Hollmann	Brown Medicine		X	X	X	X	X	X	X
Dr. Scott Spradlin	Aetna/CVS	X	X		X	X	X	X	X
Dr. Victor Pinkes	BCBSRI	X	X	X	X	X	X		X
Elena Nicolella	RIHCA	X	X	X	X	X	X	X	X
Heather Beauvais	NHPRI					X		X	
Hemant Hora	Point32Health	X	X	X	X	X		X	
Howard Dulude	HARI			X	X	X		X	X
John Tassoni	SUMHLC	X	X	X		X			
Karen Labbe	BCBSRI		X	X	X	X	X	X	X
Krysten Blanchette	CNE	X				X			X
Laurie-Marie Pisciotta	MHARI	X	X	X	X	X	X		
Maria Zammitti	CharterCARE	X	X	X		X		X	X
Melissa Campbell	RIHCA	X	X	X					
Michelle Crimmins	Prime Therapeutics	X	X	X	X	X	X		X
Richard Glucksman	BCBSRI	X	X	X	X	X	X	X	X
Sam Hallemeier	PCMA	X	X					X	
Scott Sebastian	United Healthcare	X	X	X	X	X	X	X	X
Shamus Durac	RIPIN	X	X	X		X	X	X	
Stacey Paterno	RIMS	X	X	X	X	X	X	X	X
Teresa Paiva Weed	HARI		X	X		X	X		

TABLE 2: Office of the Health Insurance Commissioner Staff Participation

Name	Organization	10/26	11/16	11/30	12/14	1/18	2/1	2/22	3/14
Cory King	OHIC	X	X	X	X	X	X	X	X
Molly McCloskey	OHIC			X	X	X	X	X	X
Alyssa Metivier-Fortin	OHIC	X	X		X	X	X	X	X
Courtney Miner	OHIC		X	X	X	X	X	X	X
Taylor Travers	OHIC	X	X	X	X	X	X	X	X

In addition to the appointed members of the Administrative Simplification Task Force, some insurers/Utilization Review agents elected to have additional representatives participate as members of the public. These regular public attendees included:

1. Debra Hurwitz, Care Transformation Collaborative of Rhode Island (CTC-RI)
2. Donne Paine, Blue Cross Blue Shield of Rhode Island (BCBSRI)
3. Erin Boles Welsh, Point 32 Health
4. Dr. Farah Shafi, Blue Cross Blue Shield of Rhode Island (BCBSRI)
5. Jeff Bechen, CharterCARE
6. Kaitlin Carver, Blue Cross Blue Shield of Rhode Island (BCBSRI)
7. Kara Lefebvre, CharterCARE
8. Karen Bouchard, United Healthcare (UHC)
9. Dr. Gus Manocchia, Blue Cross Blue Shield of Rhode Island (BCBSRI)
10. Kristen Mclean, Blue Cross Blue Shield of Rhode Island (BCBSRI)
11. Lisa Tomasso, Hospital Association of Rhode Island (HARI)
12. Mark Gallagher, United Healthcare (UHC)
13. Mark Lorson, Neighborhood Health Plan of Rhode Island (NHPRI)
14. Shannon Picozzi, Neighborhood Health Plan of Rhode Island (NHPRI)
15. Tara Pizzi, Care New England (CNE)

The meeting structure consisted of the following:

1. October 26, 2023 – Review of Task Force Principles, Amendments to OHIC's Power and Duties Statute and Review of CTC-RI Recommendations.

2. November 13, 2023 – Discussion of Methodologies to Reduce Prior Authorization Implications.

3. November 30, 2023 – Discussion of Straw Model Proposal and the Request of Insurer Data.

4. December 14, 2023 – Review of Remaining Amendments to OHIC's Powers and Duties Statute and CTC-RI Recommendations.

5. January 18, 2024 – Review of Insurer Data Submissions.

6. February 1, 2024 – Straw Model Proposal Parameters and Provider Responses to Statute Provisions.

7. February 22, 2024 – Insurer Responses to Statute Provisions and Overview of Primary Care Provider Burdens.

8. March 14, 2024 – Task Force Meeting Series Review and Next Steps.

Task Force Principles

The first meeting on October 26, 2023, consisted of a reintroduction to the Administrative Simplification Task Force. Cory King, Acting Health Insurance Commissioner, opened the meeting by welcoming all attendees and highlighted the importance of their upcoming participation. OHIC staff introduced themselves, preceding staff introductions, each Task Force participant was asked to introduce themselves, their titles, and their organizational affiliation.

OHIC staff reviewed the history, purpose, and statutory charge of the Administrative Simplification Task Force. Previous topics and examples of work from past task force sessions was also reviewed. Examples of previous topics include external appeal requirements, retroactive terminations, coding and billing, benefit determination, external appeals, and medical management. OHIC then continued to outline the current scope and topic of this year's task force. Improving the process of prior authorization and reducing the administrative burden felt by prior authorization is the 2023-2024 task force objective.

Amendments to OHIC's Powers and Duties Statute

Cory King, Acting Health Insurance Commissioner reviewed changes made to the legislation which broadened the Office of the Health Insurance Commissioners powers and duties. Additional legislation was brought forth in June of 2023 that gave OHIC additional responsibilities in governing prior authorization. Additionally, there had been ongoing discussion with provider groups on the topic and pain points surrounding prior authorization. The amendments to OHIC's powers and duties were reviewed in detail during both the October 26, 2023, and December 14, 2023, task force meetings.

The amendments include the requirement to conduct the workgroup, and subsequently submit a report of recommendations to the Health and Human Services Committees of the Rhode Island House and Senate by June 30, 2024, prior to implementation of such recommendations. It also includes (iv) the uniformity in the processing of claims by payors; (v) the development and implementation of programs that implement selective prior authorization requirements based on stratification of health care providers performance and adherence to evidence-based medicine. Additionally, (vi) the required review of medical services, including behavioral health services, and prescription drugs subject to prior authorization on at least an annual basis. (vii) improved communication channels between health plans, health care providers and patient by (A) requiring transparency and easy accessibility of prior authorization requirements, criteria, rationale, and program changes; (B) (I) 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. (B) (II) Timely notification of prior authorization determinations by health

plans to impacted health plan enrollees, and health care providers. (viii) (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. (viii) (B) requiring continuity of care for medical services, including behavioral health services, and prescription medications for patient on appropriate, chronic, stable therapy through minimizing repetitive prior authorization requirements. (viii) (C) Requiring communication between health care providers, health plans, and patients to facilitate continuity of care and minimize disruptions in needed treatment. (D) continuity of care for formulary or drug coverage shall distinguish between FDA designated interchangeable products and proprietary or marketed versions of a medication. Finally, (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.

Task Force Problem Statement

During the 2022 Administrative Simplification meeting series, the task force was able to reach consensus on the following 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.” This problem statement was reviewed at the 2023-2024 sessions first task force meeting on October 26, 2023.

Care Transformation Collaborative of Rhode Island (CTC-RI) Recommendations

Following the 2022 Administrative Simplification Task Force Meetings, consensus was reached for the referral to the Care Transformation Collaborative of Rhode Island to review the progress of the workgroup and identify opportunities for collaboration. CTC-RI convened stakeholders’ representative of payers, providers, health systems, state agencies, community organizations, behavioral health, and substance use providers. This steering committee was charged with (1) to convene key stakeholders to build on the work produced by the OHIC Task Force on prior authorization in order to develop concrete consensus recommendations that take into account health plans (payers), providers, and patient’s needs for a more effective, less burdensome and resource intensive prior approval process, ultimately supporting evidence-based, affordable, high-quality care and reducing unnecessary/unsafe service and medication utilization. (2) Reduce the volume of prior authorizations and, (3) Improve the processes of prior authorizations. CTC-RI committed to a final deliverable to OHIC by November 1, 2023. The CTC-RI final set of recommendations consisted of the following:

1. *Reduce the prior authorization volume*. There are two considerations concerning a meaningful reduction in prior authorization from the ordering provider perspective: 1) reducing the number of overall prior authorizations, and 2) reducing the prior authorization burden for providers by way of improved processes. Regardless of how streamlined the prior authorization process is, there is burden and the most effective way to reduce the burden is to reduce the absolute number of prior authorizations. CTC-RI recommends reducing the number of prior authorizations based on history of use in fully insured commercial plans (excluding out-of-state plans), ie., a percentage reduction. Plans should have the flexibility to decide what types of changes they wish to make and there should be no requirements for plans to use the same methodology, although consistency across plans would simplify the process for providers. While all plans should

seek a reduction, there should be a consideration regarding the rate of prior authorizations per member to maintain fairness across plans. The committee recognizes that OHICs regulatory authority is limited to fully insured commercial plans, however, the committee agrees that, if possible, these recommendations should be extended to Medicaid (including managed) and voluntarily to Medicare Advantage and self-insured commercial plans. This may allow the payers greater flexibility in achieving the result of reductions of provider and patient burden. Reductions need to be in actual Prior authorizations triggered and not just the number of services listed that require a Prior authorization, which may be very low volume services and therefore rarely trigger a Prior authorization. Provider input should be a part of the reduction process, once mechanisms are established for this, though this should delay plans for reducing prior authorization. The committee agreed on an overall target recommendation of 20% for reduction in volume of prior authorizations to provide meaningful relief. The actual reduction per provider will depend on a variety of factors including payer mix and services provided by the provider. Reduction methodologies should include strategies such as selective preauthorization for providers in risk arrangements and continuity provisions for patients on stable chronic disease therapy as these are in the new statute. They should include behavioral health and substance use services if these services are presently subjected to PA and align with the continuity of care provisions of the 2024 Medicare final rule. It is estimated that a target reduction of 20% overall is unlikely to have a negative impact on cost and quality of care. In the summer of 2023 three national plans (CIGNA, UHC and Aetna) announced an intent to reduce PAs by approximately 20%. BCBSRI has already substantially removed prior authorizations for behavioral health. This should be evaluated and considered in any implementation of these recommendations. In some cases, process improvement and provider education will also reduce burden. For example, use of tools for providers to identify formulary medications can lead to avoidance of a prior authorization. Another example of process improvement is rapid and efficient review of hospital discharge post-acute care approvals. While these are all important, a reduction in the absolute number of prior authorizations is recommended.

2. *Improve the data collection on prior authorization*. To measure any reduction in the volume of prior authorization requests, baseline data must be gathered from commercial health insurance plans (and, if possible, Medicaid and Medicare managed care plans and the state Medicaid program). The goal is to know the rate per member as compared to an absolute number. Currently there is no single data repository that collects this information or in a manner that can determine a plan rate per member. The committee recommends convening an ad hoc data committee that will define the desired data elements and reporting method. The goal is to create a rate of prior authorizations per insured member, quantify and differentiate prior authorizations that have been approved, and those that have been approved with modifications, and a method of reporting the specific services by code that require authorization by a plan (i.e., procedure codes, pharmaceutical codes, and durable medical equipment items). This would include appeals and appeals results. This work could be completed in a limited number of meetings. Pharmacy rejections at the point of dispensing are not prior authorization, but often result in similar effort and administrative burden on providers to resolve and should be quantified so processes can be streamlined or eliminated. This data is not currently required to be reported as it is not a PA. We recommend that an ad hoc workgroup specific to this data element be convened to determine if there is a possible tracking method that does not create an administrative burden. It would be acceptable to

approximate this volume. For example, it may be able to track total rejections for all causes and use a factor that is based on a sample methodology that a certain percentage of rejections relate to a drug requiring a PA or an alternative/revised order. The determination of feasibility and processes should be able to be determined in a limited number of meetings.

3. *Create on-going statewide advisory committees*. A statewide advisory steering committee is recommended to continuously improve simplification, facilitate communication and collaboration, and develop methods and expertise locally. Members should include representatives of all insurance plans and contracted providers as required in the OHIC regulation. The committee will be advisory in nature and will generate publicly reported recommendations with expected plan responses. This committee should also approve the methods by which the annual review is undertaken. For example, screens could be created for focusing assessment of the value of PAs that result in high rates of approval. This steering committee would oversee the work of two other committees: a medical services committee and a pharmaceutical services committee. However, it would not be required to approve/reject/modify those committees' recommendations regarding specifics of PAs. Because evaluating the efficacy and burden of PAs is a substantial and on-going task, two standing committees are recommended. These would meet approximately quarterly and make recommendations regarding burden and volume reduction. Prescription drug processes are a large class of PAs and have unique issues related to formulary changes, pharmacy benefit managers, the NCPDP claims system etc., and therefore would be a unique committee with another "medical services" committee addressing all other PAs. The members of these committees should be those delivering care but plans and their agents should attend based upon the agenda or as they wish. Meetings should be able to be conducted virtually to allow maximum access and registration should be open. The Medical Services Review Committee should be comprised of physicians, non-physician professionals (e.g., PA, RNP, PT) and behavioral health and substance-use providers. The Pharmaceutical Review Committee should be comprised of prescribers, community retail pharmacists and practice embedded pharmacists. These groups would do the actual review of the PAs looking for burden reduction and simplifications. They would suggest methodologies to the steering committee. None of the suggested entities would revise the actual PA criteria used or require a plan to revise the list of services that require a PA. However, these statewide entities can likely produce recommendations that will simplify processes and promote inter-plan and intra-plan consistencies.

4. *Evaluate the feasibility and advisability of therapeutic substitution at the pharmacy*. This recommendation is not anticipated to be per se part of the Administrative Simplification processes of the OHIC. Rejections at the point of dispensing are a common burden. They are not PA denials, but a statement that a PA for a specific agent is required, if it is to be dispensed as prescribed. Therefore, they are not reported as PAs. These are commonly due to issues such as changes in insurance plan drug formularies or changes in patient insurance plan coverage. They constitute a significant administrative burden for providers. Prescribers most commonly can revise the prescription to meet with payer expectations, but the expectations are not always easily known and may require research. Prescribers commonly state a willingness to revise the prescription to align with the plan coverage and find substitutions clinically appropriate. Allowing the pharmacists to make a therapeutic substitution or interchange would eliminate the burden on providers and reduce the delay of patients getting needed therapeutics.

Under current RI law therapeutic substitution is not allowed outside of the hospital pharmacies.

5. *Implement technologies that improve the process*. Existing entities such as the state 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 is recommended to convene at least twice annually to update and educate interested parties as well as to facilitate implementation of technological enhancements. CTC-RI and RIQI (HIE) are also evaluating a simple use case regarding potential use of existing patient data to provide needed clinical information for a PA and will report any future findings to the OHIC. Massachusetts is embarking upon technical streamlining. Some participants noted concerns with the process in Massachusetts, but it warrants monitoring for potential dissemination regionally and to RI.

6. *Identify and reduce processes that are 'PA-like.'* As noted, point of dispensing rejections are not PA processes, yet are felt to be among the most burdensome. There are other communications, requirements etc. that may be appropriately considered for burden reduction that are reasonably classified in the rubric of PA or 'PA-like'. These should be able to be considered by any entity overseeing the PA processes, even if not subject to regulation.

Straw Model Proposal

The straw model proposal was originally presented to task force members during the 2022 Administrative Simplification Task Force meetings. The proposal was subsequently reintroduced at the second meeting on November 30, 2023. This straw model proposal consisted of two parts, Part A being the elimination of prior authorization from all medical services with an average approval rate of 95% or higher and that cost an average of $25,000 or less. Part B was the proposed elimination of prior authorization requirements from all in-network behavioral health services. The straw model proposal was briefly reviewed again on January 18, 2024, in response to the data submission and outlined which services may fall under the current proposal parameters in relation to insurer data. It was again reviewed on February 1, 2024, in order for task force members to come to a consensus on the specific parameters associated with the proposal and to provide feedback on any missing criteria, if any. The task force came to a consensus that one of the parameters of the straw model proposal should be volume. The topic of selective prior authorization measures including gold carding was also reviewed for feasibility.

Data Request and Submission

Task force members representative of payers were asked to provide data in order to have data driven conversations regarding possible reduction measures. This data would then be reviewed and analyzed for alignment. Available data from insurance carriers was first requested on November 21, 2023, which included the top 25 requested services requiring prior authorization and any subsequent data available that could be provided. The submitted data was reviewed during the January 18, 2024, meeting which focused on the most requested service categories, specific codes and the aligning request volume, and approval rates of the prior authorization required services. All carriers asked to provide data, did submit; however, there were limitations in the ability to analyze the data provided by the insurance carriers. The limitations included: all carriers did not provide the average cost of the service and all carriers did not provide specific

codes, rather some carriers provided service categories. Additionally, all carriers did not report the number of prior authorizations requests received, approved and those approved with modification.

Statute Request and Responses

A request to both providers and insurers was sent out in response to the amended statute provisions in the legislation. This request served as a guide to better understand how providers and insurers currently operate in relation to the provisions, and any recommendations they may have to improve the processes associated with the statutory provisions. OHIC received two responses from insurers to the request originally sent on December 19, 2023, and subsequent request sent to all task force members on February 1, 2024. OHIC received two responses from providers to the request originally sent on December 19, 2023, and subsequent request sent to all task force members on February 1, 2024.

Conclusion

The 2023 – 2024 Task Force meetings assisted in laying the framework for the report of recommendations due in June. The Acting Health Insurance Commissioner informed meeting participants that there would likely be a subsequent meeting in order to review the draft report of recommendations prior to the final report submission due by June 30, 2024.