State of Rhode Island Office of the Health Insurance Commissioner

Administrative Simplification Task Force

March 14, 2024 – 8:00am – 9:00am

Virtual Meeting Summary

Attendance

Andrea Galgay (RIPCPC), Caitlin Kennedy (Coastal Medical), Dr. Ana Stankovic (United Healthcare), Dr. Barry Fabius (United Healthcare), Dr. Christopher Ottiano (NHPRI), Dr. Peter Hollmann (Brown Medicine), Dr. Victor Pinkes (United Healthcare), Elena Nicolella (RIHCA), Erin Boles Welsh (Point32Health), Howard Dulude (HARI), Kara Lefebvre (CharterCARE), Karen Labbe (BCBSRI), Krysten Blanchette (Care New England), Maria Zammitti (CharterCare), Michelle Crimmins (Prime Therapeutics), Richard Glucksman (BCBSRI), Scott Sebastian (United Healthcare), Sharon Picozzi (NHPRI), Stacey Paterno (RIMS), Tara Pizzi (Care New England)

Not in Attendance

Al Charbonneau (RI Business Group on Health), Christopher Dooley (CharterCARE), Dr. Farah Shafi (BCBSRI), Dr. Gus Manocchia (BCBSRI), Dr. Scott Spradlin (Aetna), Jeffrey Bechen (CharterCare), John Tassoni (SUMHLC), Karen Bouchard (United Health Group), Laurie Marie Pisciotta (MHARI), Mark Lorson (NHPRI), Melissa Campbell (RIHCA), Sam Hallemeier (PCMA)

State of Rhode Island Office of the Health Insurance Commissioner Staff

Acting Commissioner Cory King, Alyssa Metivier-Fortin, Courtney Miner, Molly McCloskey, Taylor Travers

1. **Task Force Review**

   Acting Commissioner Cory King (OHIC) outlined that much of the meeting would encompass a review of the work of the task force thus far. Ensuring that the working group touched on all necessary components.

2. **Problem Statement**

   Taylor Travers (OHIC) presented slide three, which included the problem statement that the task force came to a consensus on during the 2022-2023 task force session. “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.” She then outlined the provider review which consisted of increased administrative burden, increased operating costs, potential jeopardizing of patient safety, and contributor to clinician burnout. The patient view consisted of “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." The payer view consisted of utilization management tool promoting evidence-based care, reduced wasteful spending, promoting patient safety and affordability for health care purchasers.

3. **CTC-RI Report of Recommendations**

   Taylor Travers (OHIC) proceeded to slide 4, which reviewed the recommendations brought forth by the Care Transformation Collaborative, CTC-RI.

   Recommendation #1 is to reduce the prior authorization volume with two considerations being, reducing the overall number of prior authorization requests and reducing the prior authorizations burden for providers by way of improved processes.

   Recommendation #2 was to improve the prior authorization data collection. In order to measure reduction, the baseline data must be made available. The recommendation of an ad hoc group to gather data that includes the rate of prior authorizations per insured members. Prior authorizations approved and those approved with modification, and the method of reporting the specific service codes that require prior authorization.

   Recommendation #3 was the creation of an ongoing statewide advisory committee to improve simplification, facilitate communication and collaboration and develop methods. This would include the formation of a medical services committee and a pharmaceutical service committee. These two committees would review the respective services and report recommendations and methodologies to the statewide advisory committee.

   Recommendation #4 was to evaluate therapeutic substitutions at the pharmacy, although this is not per se apart of the administrative simplification task force. This effort would be led by the CTC-RI and URI College of Pharmacy to evaluate possible changes in legislation to allow for therapeutic substitutions.

   Recommendation #5 was the implementation of existing technologies to improve the prior authorization process. The leveraging of existing agencies such as the HIT steering committee in order to monitor and report on technology changes and compliance with state and federal requirements associated with prior authorization.

   Recommendation #6 was to identify and reduce processes that are 'pa-like.' There are many communications and requirements while not considered prior authorizations, should still be considered for burden reduction. As these processes are thought to be among the most burdensome.

4. **Straw Model Proposal**

   Taylor Travers (OHIC) presented the straw model proposal which has been presented to the task force numerous times. Part A is the proposed elimination of services that require prior authorization that meet criteria being an average approval rate of 95% or higher and cost an average of $25,000 or less. Part B is the proposed elimination of prior authorization for all in-network behavioral health services. The task force has expressed in prior meetings the inclusion or consideration of volume of overall services, and health and safety concerns within the straw model parameters.

Cory King (OHIC) explained that this is just a recap, and not representative of OHIC's final decision.

5. **Insurer Data Review**

Taylor Travers (OHIC) reviewed the data submitted by four insurance carriers. Carrier one provided the top 25 services codes, the code descriptions, the number of requests received and the number of approved requests (as seen on slide six). The cost for each service was not provided, and Taylor determined the difference of requests received and those requests approved. Carrier two provided the top 25 service codes, the code descriptions, and the average cost (as seen on slide seven). The number of prior authorization requests and the number of prior authorization requests approved for each service code was not provided. Carrier three did not provide specific codes, rather they provided the top 25 service groups (as seen as slide eight). They also reported the average cost for each service group, as well as the prior authorization requests received, and the number of requests approved. Taylor determined the difference of requests received and requests approved. Carrier four provided the top 25 specific service codes, the code descriptions, the average costs for each code and the requests received (as seen on slide nine). Carrier four did not report the number of prior authorization requests approved.

Cory King (OHIC) outlined that although it is a representation, it is not the best representation as the information provided is not consistent across all carriers.

Taylor Travers (OHIC) also reviewed slide ten which depicted the top 19 (of 25 codes) reported by two or more insurance carriers. The 19 specific service codes, and the number of requests were shown which amounted to 38,919 total requests.

Howard Dulude (HARI) asked referring to the straw model proposal parameters, is the 95% average approval rate based on each carrier or as a whole by the state.

Cory King (OHIC) explained that the 95% average approval rate criteria was to be by carrier, as it was meant to be a carrier facing policy. Although, that could be imposed and there would still be differential outcomes as well as a lack of consistency across carriers.

Stacey Paterno (RIMS) noted that this shows how difficult it can be to get information from insurers in a standardized way, representative of what provider practices face every day.

Dr. Peter Hollmann (Brown Medicine) outlined that this was one of the reasons that the first recommendation from the CTC-RI was the creation of a group to improve the prior authorization data. He thanked the carriers that reported and added that there are things that can be learned from this. He added that there is a need for consistent data and a reporting mechanism so better decisions can be made going forward.

6. **OHIC's Powers and Duties Statute**

Taylor Travers (OHIC) briefly reviewed the amendments to OHIC's powers and duties statute which have been covered in depth at previous meetings.

(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

(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;

(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.

7. **Provider Response to Statute Provisions**

Taylor Travers (OHIC) outlined the newly received provider responses to the statute provisions. For provision (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.

Provider response: for item "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."

For provision (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.

Provider response: "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."

Regarding provision (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.

Provider response: “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.”

Provision (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.

Provider response: “See above. Perhaps technology can facilitate this.”

Provision (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.

Provider response: “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.”

Provision (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.

Provider response “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.”

Provision (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.

Provider response: “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?”

Provision: (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.

Provider response: “There needs to be a line that also focuses on patient communication by the insurance. Many of my patients 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.”

Howard Dulude (HARI) added that with utilization review work, there can be a lot of positives with it, but he wonders if it costs more to do than the value that comes from it. He wonders if one of the recommendations might be to conduct a study of the overall cost of this. He thinks interesting results could be determined, which may or may not have a positive impact. Looking at the total cost of the health care system, how much the insurers expend on this versus the potential net to the system. Is it worth the value of doing it when all factors are taken into account.

Cory King (OHIC) noted that it could be a complicated analysis globally. If one, or a couple providers were identified as a case study, there could be some work done to try and understand the cost. He thinks it could be mentioned in the report that a general concern is that the cost benefit analysis isn't there.

Howard Dulude (HARI) agrees that the study would prove challenging.

Dr. Peter Hollmann (Brown Medicine) thinks that the benefits are overstated and agrees there is a lot of cost on the provider and on the plan side. He does not think this will ultimately affect what the group is striving to do, which is reduce the number of prior authorizations. He further added that there is a certain amount of improving the process that is going to be a significant amount of work. People are going to have to decide that it is worth the time, as people have decided during the course of these meetings. He does think it is important to recognize that there will be efforts made by people to make it better, which include significant investments of their effort, brain power and time. The group does need to be realistic that any change made is going to be imperfect, but to remain open and honest with the best outcomes that can possibly be achieved.

Cory King (OHIC) was thinking that the concern, that if a provider is engaged in risk-based contracting what is then the role of prior authorization and is there any role. He thinks that would depend on the degree of integration between the providers that are within the contract. If there is a primary care ACO that doesn’t have any specialists engaged with it, they are just acting on the outside even though their decisions and actions impact the claims experience that the primary care group is being held accountable for. In that instance, some of the primary care controllable costs and prior authorizations could be considered not necessary but all of those activities would be done by providers outside of that group. If you had a really integrated system where primary care specialists and hospitals were all under the same corporate ownership, and all accountable to achieving the same objectives. Then maybe specialists could be brought in,

and maybe some of the prior authorizations would not be necessary. He highlights that that is just a preliminary thought, he welcomes people's thoughts based on their knowledge of the different structures of risk-based contracts in the state.

Dr. Victor Pinkes (BCBSRI) thinks that Cory is right, and he was going to make a similar comment. He adds that there a lot of different types of risk-based contracts and he thinks that if you have a full risk contract that prior authorization is probably not going to be necessary, and it is really delegated to the provider at that point to do their own utilization management. He added that there are also other types of payment models, so it would really depend on the risk-based contract and also the organization of the provider structure and the collaboration.

8. **Next Steps**

Cory King (OHIC) outlined the next steps for the Administrative Simplification Task Force. He plans to schedule a meeting, perhaps in May to share a preview of the draft report of recommendations prior to the submission. He is also working out the logistics of an ongoing public body to review data and promote communication and collaboration. Once the details are worked out, the public body will be formed and begin meeting. He also informed the group that the final report of recommendations is due to the General Assembly by June 30, 2024. Looking at OHIC's regulation, there's an administrative simplification section and he is reviewing the changes that may want to be made there. He will be incorporating some of the discussions had during this process to create some guardrails around the use of prior authorization. Ultimately, whether they go to rule making is OHIC's decision, and the rule-making process follows a formal process where everyone gets to weigh in as part of public comment and that will be happening concurrently with the drafting of the report.

Taylor will reach out to the task force once a draft report is ready to be shared with the group and the meeting will be scheduled. All presentation materials, including agendas, slide decks, and meeting summaries are available to view on the OHIC website under administrative simplification task force.

Andrea Galgay (RIPCPC) asked, depending on what route is taken legislatively, OHIC has jurisdiction over the fully insured commercial market, is there the ability to have it be more broad reaching. There still would be the issue of the self-funded or out of state individuals, are there any mechanisms that would make it more comprehensive.

Cory King (OHIC) advised that the cross-state issues are challenging, he hopes that any changes on the fully insured side would also be made on the self-insured side although there is no guarantee. Medicare and Medicaid are outside of the picture, and that's a reality that has to be dealt with. He further explained that if there is a model, that the task force comes up, that works well for providers and payer then perhaps there would be agreement to extend that model more broadly.

Elena Nicolella (RIHCA) regarding Medicaid and Medicare, if the report is going to speak to reporting and transparency, she requests that it is done with an eye to the Medicare and Medicaid prior authorization metrics that will be required in 2026, which are pretty extensive. They do not discuss cost, but they do require the reporting of any service or item that requires

prior authorizations, the median time for approval and the percentage of services/items not approved. This in addition to the Medicaid procurement, included some reporting requirements around behavioral health services as well related to prior authorization. Coordination with those would be helpful.

Draft CMS 0057-F [cms.gov]

Cory King (OHIC) thanked Elena for that flagging. He asked if they thought the task force had done a better job this year, and he hoped the answer would be yes.

Richard Glucksman (BCBSRI) thinks Dr. Hollmann said it well that, we are trying to bring a refreshed thought to this process. He thinks it has been more helpful than the prior session, especially having the framework from the legislation, in addition to the data to help move the conversations. He thinks another piece is the other work that OHIC has done related to primary care. He thinks it feels appropriate to have a special focus on the burden for primary care providers. He also wants to be mindful and understanding about the safety component, and recognizing what the provider practitioner community is saying in terms of patient safety and patient experience. Lastly, there is appropriately a focus on the cost impact and recognizing that there are administrative costs of this, as medical care costs are pretty extensive.

Dr. Peter Hollmann (Brown Medicine) thinks that starting with the CTC-RI work and carrying on through this, he saw much more of a collaborative process. He saw people really trying to come together to make sure that all the goals related to the different perspectives were addressed as best as they could be. There were limitations to this particular structure, but he thinks it was very different in terms of the collaboration and the willingness on both sides. He appreciates all the work that was done, and the support that was given through the CTC process as well.

Cory King (OHIC) thanked the CTC for taking on this work and putting the task force in the position that they did in order to make progress.

Richard Glucksman (BCBSRI) referring to the last CTC recommendation, regarding 'pa-like' processes, is there any way to rise up the idea that referrals are the other processes that are considered to be a burden.

Cory King (OHIC) will make sure to emphasize that as theme within the final report so that everyone understands there are other factors that lead to administrative burden which were not fully discussed at the task force.

Richard Glucksman (BCBSRI) emphasized, regarding the straw model proposal, that there are more parameters that the plans consider than just percent and dollar. There are also costs that are broader than just the specific service getting prior authorization. The cost can be different than just the cost for that one individual code.

Cory King (OHIC) appreciates the comments and reiterated that there has not been a decision made as to whether that exact framework will be utilized in any way. Although, he thinks it helped to motivate some discussion.

Dr. Barry Fabius (United Healthcare) added that early data on United Healthcare's Project Promise has been promising. In the Medicaid population, they have reduced prior authorization by 20%, and in the D step population it has been reduced by 28% within the early months.

Cory King (OHIC) thanked Dr. Fabius for providing that update, and for sharing their prior authorization data with OHIC.

9. Public Comment

There were no public comments made.