CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

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ADVANCING INTEGRATED HEALTHCARE

Prior Authorization Steering Meeting

April 13th, 2023

Care Transformation Collaborative of RI

Agenda

Topic	Duration
Welcome and introductions	10 mins
Brief recap of OHIC Report	10 mins
Review of Charter	10 mins
Structure and Function of Committee	10 mins
Scope of Work	10 mins
Data Needs	15 mins
Next Meeting: May 11th 2023 / Next Steps	5 mins

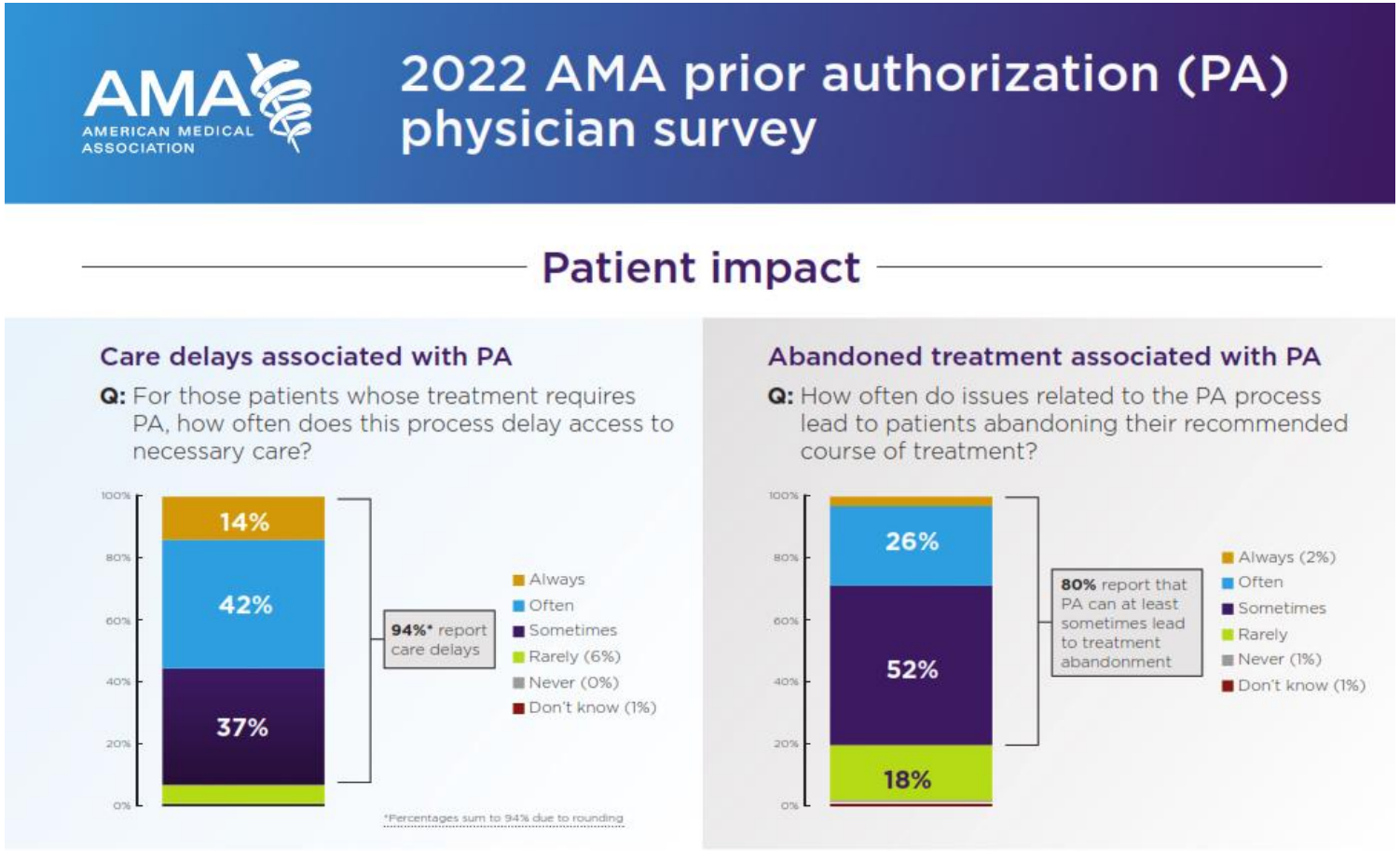
January 1, 2018

Consensus Statement on Improving the Prior Authorization Process

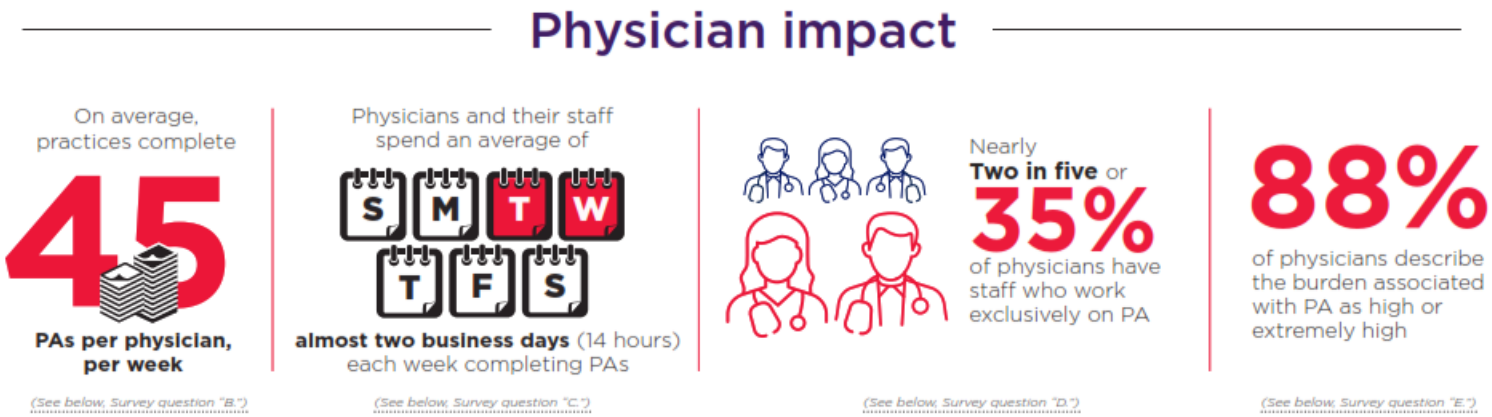
Our organizations represent health care providers (physicians, pharmacists, medical groups, and hospitals) and health plans. We have partnered to identify opportunities to improve the prior authorization process, with the goals of promoting safe, timely, and affordable access to evidence-based care for patients; enhancing efficiency; and reducing administrative burdens. The prior authorization process can be burdensome for all involved—health care providers, health plans, and patients. Yet, there is wide variation in medical practice and adherence to evidence-based treatment. Communication and collaboration can improve stakeholder understanding of the functions and challenges associated with prior authorization and lead to opportunities to improve the process, promote quality and affordable health care, and reduce unnecessary burdens.

The following five areas offer opportunities for improvement in prior authorization programs and processes that, once implemented, can achieve meaningful reform.

2022 Perceptions



Practice Impacts – AMA survey



Current Status

- Support staff shortages
- Primary Care physician positions extremely difficult to fill
  - Students/Residents do not choose primary care
- Most RI residents are in an ACO like (Value Based Purchasing) payment model with clinicians at risk for Total Cost of Care

Areas of cost

Prescription Drugs

Cost Containment spend is 18% of doctor visit spend

US vs other OECD nations

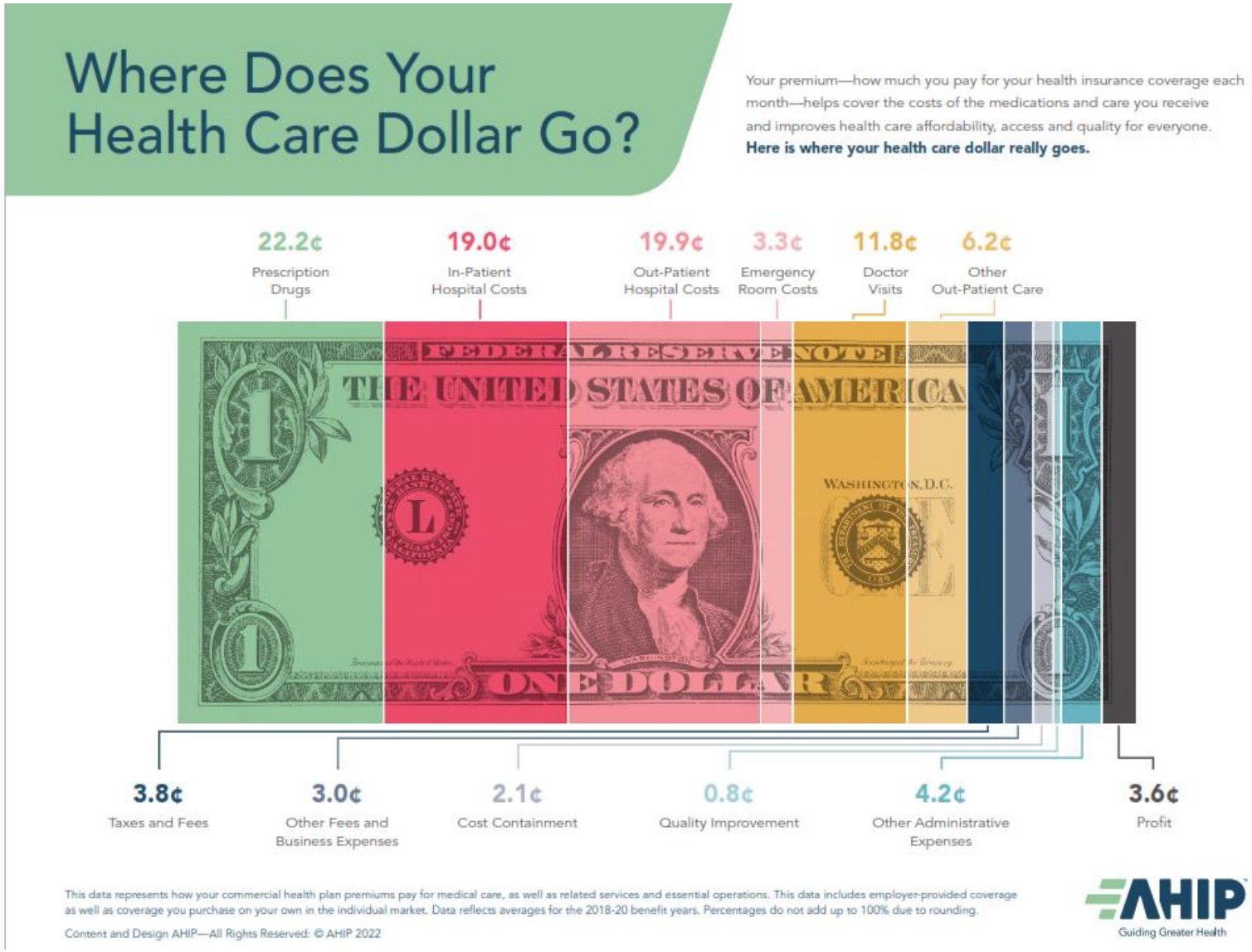
High Administrative Costs

High Prices

Average to lower utilization

https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022

JAMA. 2018;319(10):1024-1039. doi:10.1001/jama.2018.1150



OHIC Admin Simplification Task Force

Largest volume areas (excl dental)

Imaging, Lab

Pharmaceutical

"Approved" and "modified" are not the same thing, but the majority are approved in some manner

Data Overview – Medical/Surgical

Prospective: medical necessity denials

Dental	2182
Durable Medical Equipment	14
Emergency	11
Hospital Inpatient	76
Lab, Diagnostic testing, Imaging	1930
Other	8
Other Hospital Outpatient Services	80
Other Professional Services	29
Pharmaceutical	1870
Physician Services	71
Total	4177

Prospective: accepted, modified or otherwise approved

Dental	35883
Durable Medical Equipment	84
Emergency	1
Hospital Inpatient	346
Lab, Diagnostic testing, Imaging	14692
Other	86
Other Hospital Outpatient Services	825
Other Professional Services	916
Pharmaceutical	4621
Physician Services	812
Total	58265

Prospective: number of requests

Dental	38065
Durable Medical Equipment	98
Emergency	1
Hospital Inpatient	422
Lab, Diagnostic testing, Imaging	16646
Other	94
Other Hospital Outpatient Services	904
Other Professional Services	945
Pharmaceutical	6548
Physician Services	932
Total	64655

OHIC will bring analyses of these reports to future meetings, as necessary.

8

Utilization Review

- Total cost is Price x Utilization (with factor of mix)
- Utilization review looks at one of the two aspects only
- What is mix?
  - A high-cost service vs a low-cost service in the same category e.g., a single 30-day supply of a generic drug vs. the same supply of a brand drug.
  - Same unit
  - The price of each drug did not change

Health Facts (APCD) – Medical Services

Medications #9

Ave cost $383

MRI #25

Ave cost $288

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ADVANCING INTEGRATED HEALTHCARE

Total Paid Amount | | 2021 | (All)

Rank	Procedure Category	Type of Setting	Claim Count	Total Paid Amount	Paid Amount per Claim
1	Office/outpatient services - Office visits	Provider	2,911,497	$267,532,047	$91.89
2	Ancillary services	Provider	772,362	$244,789,802	$316.94
3	Emergency department services	Outpatient	211,891	$188,184,426	$888.12
4	Psychological and psychiatric evaluation, therapy	Provider	1,398,780	$144,329,749	$103.18
5	Medications (injections, infusions, other forms)	Outpatient	548,221	$129,651,595	$236.50
6	Non-hospital-based care (home health, hospice)	Provider	1,213,977	$129,469,146	$106.65
7	Alcohol and drug management, treatment, and rehab.	Provider	449,379	$74,128,096	$164.96
8	Office/outpatient services - Preventive visits	Provider	497,891	$60,665,432	$121.84
9	Medications (injections, infusions, other forms)	Provider	143,349	$54,895,499	$382.95
10	Physical/occupational/speech therapy - Exercises	Provider	1,504,002	$47,052,992	$31.29
11	Observation care services	Outpatient	17,101	$42,798,144	$2,502.67
12	Anesthesia	Provider	157,320	$42,325,177	$269.04
13	Hospital inpatient services	Provider	413,746	$41,426,898	$100.13
14	Laboratory - Chemistry and hematology	Outpatient	2,204,268	$38,906,167	$17.65
15	Emergency department services	Provider	230,252	$35,951,279	$156.14
16	Non-hospital-based care (home health, hospice)	Home Health	291,967	$32,825,306	$112.43
17	Office/outpatient services - Office visits	Outpatient	204,352	$30,173,913	$147.66
18	DME and supplies	Provider	390,153	$29,749,948	$76.25
19	Peritoneal dialysis	Outpatient	67,540	$28,830,687	$426.87
20	Transportation - Patient, provider, equipment	Ambulance	222,074	$28,723,779	$129.34
21	Colonoscopy and biopsy	Outpatient	36,804	$28,551,097	$775.76
22	Microscopic examination (e.g., lab, toxicology)	Outpatient	612,099	$26,794,769	$43.78
23	Ophthalmologic/otologic diagnosis and treatment	Provider	544,439	$23,304,317	$42.80
24	Ungrouped Procedures	Independent Labs	283,375	$21,631,761	$76.34
25	MRI (magnetic resonance imaging)	Provider	73,036	$21,014,763	$287.73

Health Facts - Pharmacy

Noteworthy for high cost “specialty” drugs

Total Paid Amount | (All) | 2021 | (All)

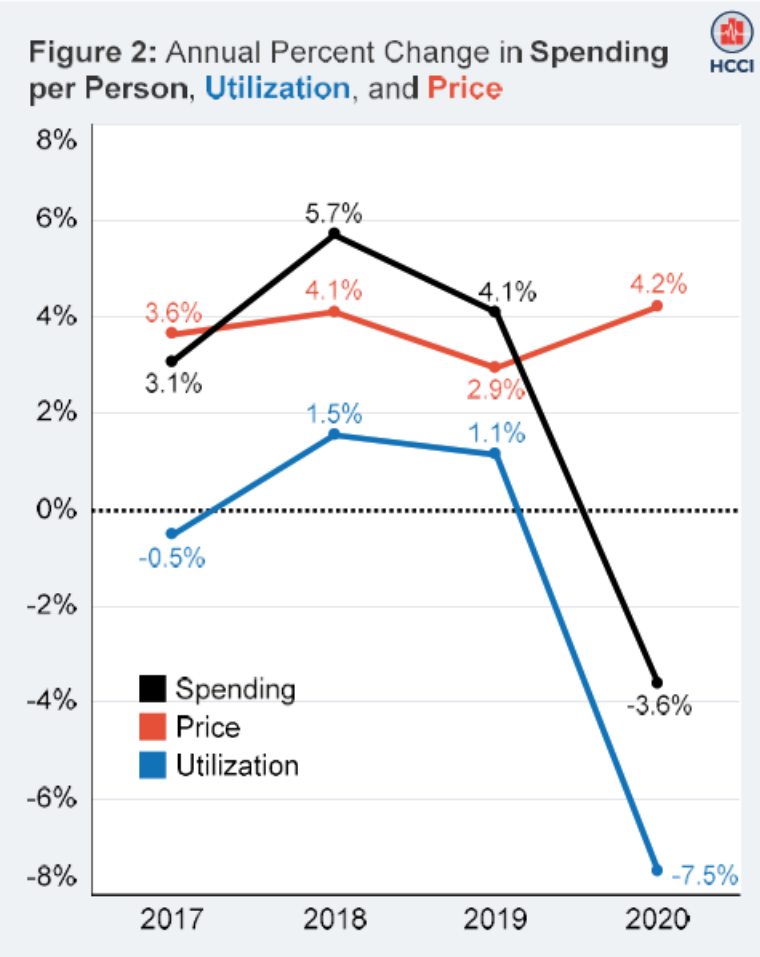
Rank	Drug Name	Drug Class	Claim Count	Total Paid Amount	Paid Amount per Claim
1	Humira	Immunosuppressants	13,245	$81,737,350	$6,171.19
2	Stelara	Immunosuppressants	2,235	$42,682,249	$19,097.20
3	Eliquis	Blood formation/coagulation agents	76,679	$41,307,176	$538.70
4	Biktarvy	Anti-infective agents	12,604	$33,753,941	$2,678.03
5	Trulicity	Hormones and synthetic substances	29,504	$25,102,420	$850.81
6	Enbrel	Immunosuppressants	4,249	$23,810,009	$5,603.67
7	Xarelto	Blood formation/coagulation agents	30,013	$19,367,010	$645.29
8	Jardiance	Hormones and synthetic substances	27,250	$18,479,286	$678.14
9	Revlimid	Pharmacotherapy agents - Miscellan..	936	$14,755,543	$15,764.47
10	Trikafta	Respiratory agents	890	$14,115,481	$15,860.09
11	Dupixent	Immunosuppressants	4,459	$13,081,473	$2,933.72
12	Tremfya	Immunosuppressants	1,073	$11,714,799	$10,917.80
13	Januvia	Hormones and synthetic substances	16,914	$11,463,937	$677.78
14	Invega Sustenna	Central nervous system agents	5,944	$11,445,124	$1,925.49
15	Lantus Solostar Pen	Hormones and synthetic substances	20,296	$11,273,525	$555.46
16	Basaglar	Hormones and synthetic substances	33,058	$11,202,749	$338.88
17	Latuda	Central nervous system agents	9,474	$10,747,738	$1,134.45
18	Cosentyx	Immunosuppressants	1,673	$9,959,623	$5,953.15
19	Genvoya	Anti-infective agents	3,780	$9,929,969	$2,626.98
20	Vyvanse	Central nervous system agents	29,964	$9,286,259	$309.91
21	Trelegy Ellipta	Hormones and synthetic substances	14,795	$8,691,071	$587.43
22	Breo Ellipta	Hormones and synthetic substances	21,971	$8,403,422	$382.48
23	Symbicort 160/4.5	Hormones and synthetic substances	17,391	$7,755,852	$445.97
24	Gilenya	Pharmacotherapy agents - Miscellan..	824	$7,135,180	$8,659.20
25	Skyrizi	Immunosuppressants	476	$6,974,695	$14,652.72

Data Overview | Data Availability | Medical Procedures | Drug Prescriptions | Terms & Measures

Health Care Cost Institute 2020 Report

2020 anomalous

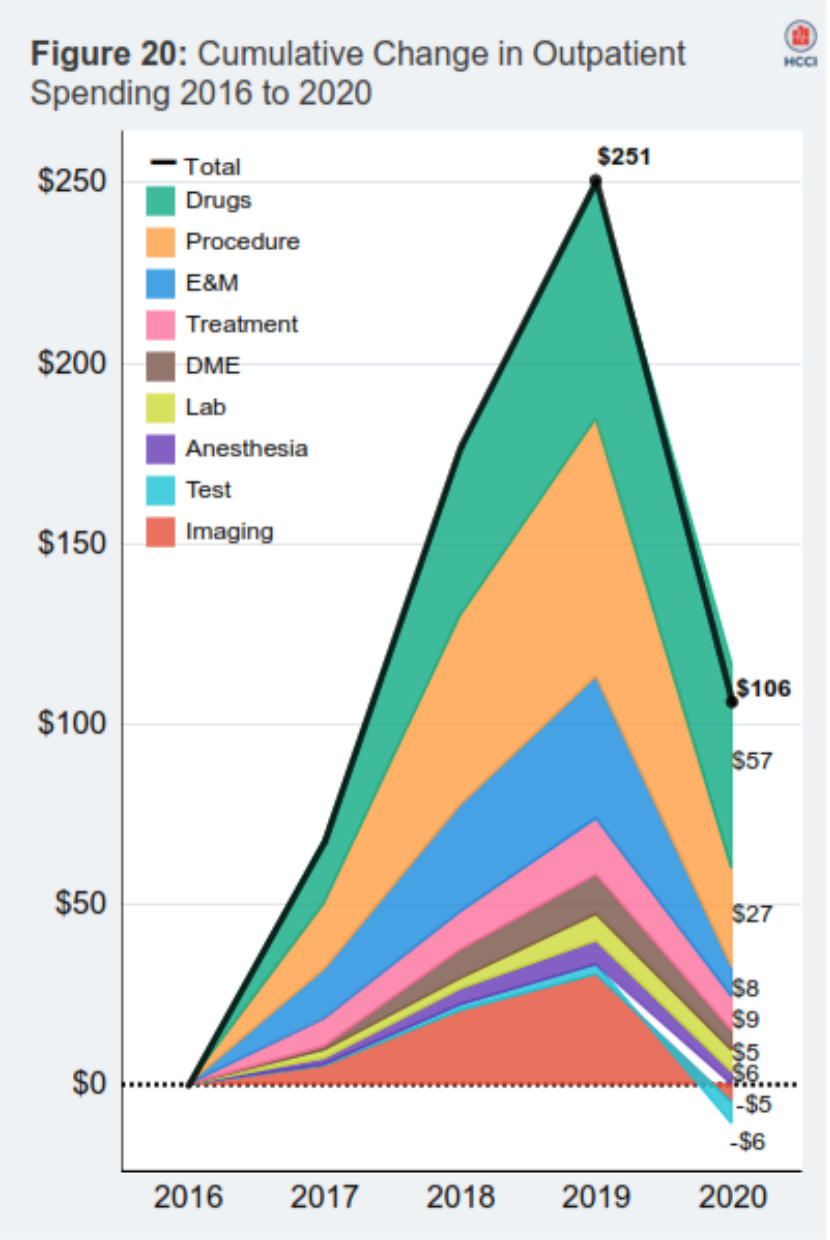
Price is the major driver nationally



HCCI - Outpatient

Drugs a major driver

Note percentage change over base in any category matters

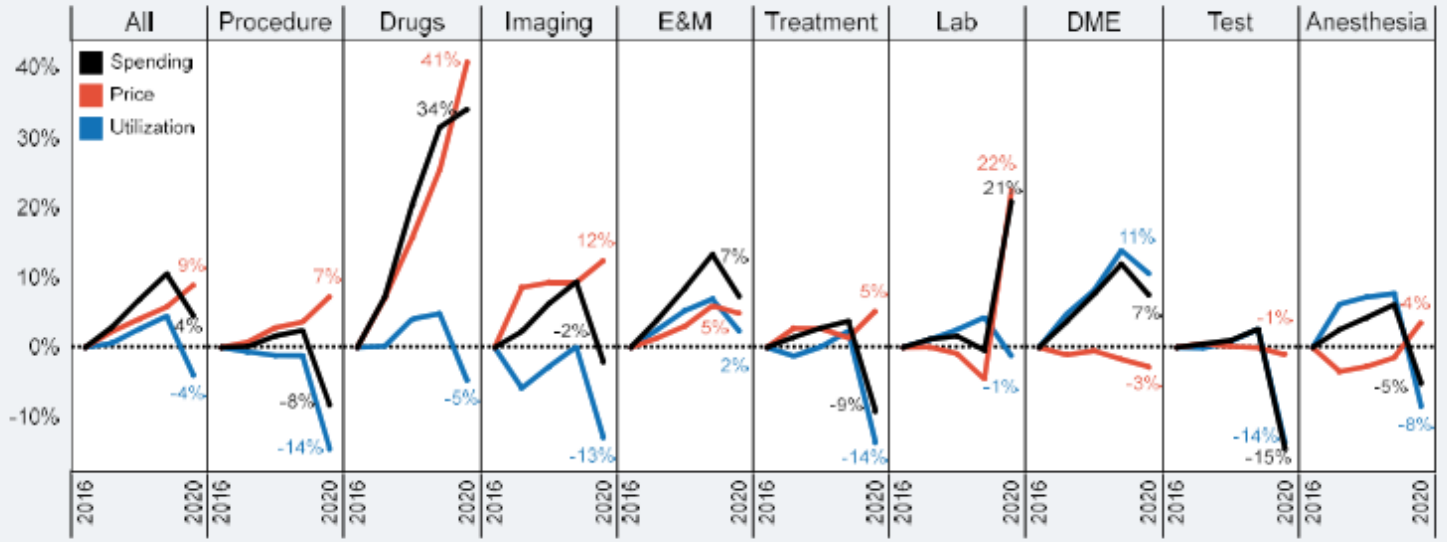


HCCI - Professional

Pre 2020 utilization growth modest relative to price growth

Trends in Professional Services Spending, Utilization, and Price

Figure 29: Cumulative Change in Professional Services **Spending per Person**, **Utilization**, and **Price** from 2016 to 2020 for Select Services



Overall, growth in the average price of professional services continued from 2016 through 2020, leading to cumulative **spending** growth of 4% over the five-year period [Figure 29]. Among sub-categories of professional services, spending rose most for physician-administered drugs (34%) and lab (21%). The increase in lab service spending was likely due at least in part to the inclusion of COVID-19 tests in this category.

Brief Recap of OHIC Report

- The **final problem statement** from the OHIC task forces reads as follows:
- 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.
  - Payers view prior authorization as a utilization management tool to promote evidence-based care, reduce wasteful spending, and promote patient safety and affordability for health care purchasers.
  - Providers view prior authorization as causing increased administrative burden, increased operating costs, and potentially jeopardizing patient safety. Providers have identified prior authorization as a contributor to clinician burnout.
  - Patients' 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.

Review of Charter

ADVANCING INTEGRATED HEALTHCARE

Prior Authorization
Committee Charter
Draft for Discussion

Background:
Rhode Island's Office of the Health Insurance Commissioner (OHIC) reconvened the Administrative Simplification Task Force on September 13, 2022, to seek input from organizational representatives who understand the operational and policy complexities of the prior authorization process.

> *Prior authorization (PA) is a cost-control process that requires health care professionals to obtain advance approval from health plans before a prescription medication or medical service qualifies for payment and can be delivered to the patient. (AMA)*

For referen https://rules.sos.ri.gov/regulations/part/230-20-30-14

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> - Patients' 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.

Task Force Recommendation
At the final Task Force meeting on December 13, there was discussion and a recommendation suggested by OHIC that the Task Force members appeared to agree. This was to have the Care Transformation Collaborative of Rhode Island Board of Directors review the report and consider whether there are opportunities in Rhode Island to collaborate and to work with OHIC and Medicaid as well as other organizations to continue these discussions.

Project Approved by CTC Board
This project was discussed at the January 24, 2023 CTC-RI Board of Directors meeting, where it was agreed that this project is consistent with our mission would be a good contribution to the primary care and specialist community. The project was approved pending funding.

Charge to Committee:
To convene key stakeholder 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 patients' 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.

Co-Chairs:
- Peter Hollman, MD AGSF Chief Medical Officer Brown Medicine
- Karen Labbe, RN Managing Director of Utilization Management and Clinical Integration BCBSRI

Steering Committee Members:
A committee will be established with health plan representatives and other key stakeholders to advise on ways to improve the process. We will explore multi-payer solutions. Provider and patient voice representatives will be actively recruited as key participants in the meetings. Open meetings will be held to gain broad input from adult and pediatric primary care providers and specialists; patient representatives; and other interested parties to further identify potential issues and solutions.

Meeting Frequency:
Occur on a monthly basis through May 2024

Agenda Development and Project Support:
- **Planning Group:** A small group will be brought together to develop meeting agendas.
- **Project Team** from CTC will included Debra Hurwitz, Executive Director, a project manager and Nijah Mangual, Project Coordinator.

Committee Deliverables:
Deliverable will be a report with recommendations submitted to OHIC Acting Commissioner and other interested parties (e.g. Governor's office, state legislature) by Nov 1st 2023.

Goals

- Reduce the number of prior authorizations
- Streamline the prior authorization process

First Steps

- Can we agree on reducing volume?
- How can we improve the PA process?
- Do we have a first area or areas to explore?
- Should we create some structure of sub- work groups and invite specific guests related to area?

- We will have recommendations or actions to give to OHIC by November 2023 for report to Legislature before January

Structure and Function of Committee

- **Group Discussion**
- Potential Areas or Sub-workgroups
  - General Principles
  - Pharmacy and Specialty Drug
  - Inpatient concurrent review
  - Imaging
  - Technology tools in UR process
  - Data Needs/Definitions
  - Defining standardized ROI

Structure and Function of Committee

- **Group Discussion**
- Who are the Primary Parties?
  - Patients/consumers/public/employers
  - Providers
  - Health Plans
- Indirect participants/SMEs
  - UR agents
- Role of OHIC is as guest

Scope of Work

- **Group Discussion**
- Define the areas
  - What is open for consideration and what is not
  - For example-would we suggest a locally created technological “solution”?
- Prioritize
  - What should be prioritization criteria?

Data Needs – What do we need, when and why?

- **Group Discussion**
  - What are main areas, what is trend, what is cause of trend?
  - Volume of review, approvals without modification, with modification, denials, overturns
  - Cost of review process to plan/employer and method of payment (PMPM, guarantees, per review)

- PMPM in certain categories
  - Inpatient: This is mostly concurrent review, though there is OBS vs IP. This will be a major $$ category. What savings are generated? It would help to have 3 categories as not all get PA/concurrent. They are Med/Surg; Maternity; Psych

- Imaging:
  - This is usually just CT/MRI/nuclear cardiology/PET. This may require reviewing specific CPT codes

- Pharmacy:
  - Mostly “specialty”, but it is most likely broken down by therapeutic use, not “specialty” (vs. other brand/generic).

Data Needs – What do we need and why?

- **Group Discussion**
  - Do we just need to know numbers so we can determine if there is reduction?
  - What is unrealisticly provable?

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