2018 Administrative Simplification Workgroup

Report to the Rhode Island Health Insurance Commissioner

Introduction

Rhode Island's Office of the Health Insurance Commissioner (OHIC) reconvened the Administrative Simplification Workgroup (Admin Simp) on October 3, 2018 to explore and develop regulatory parameters regarding the statutory requirement 27-18.9(7)(iii) for review agents to "**Establish and employ a process to incorporate and consider local variations to national standards and criteria identified herein including without limitation, a process to incorporate input from local participating providers".**

On August 3, 2017 Rhode Island's new Benefit Determination and Utilization Review Act §27-18.9 ("the Act") was signed into law, effective January 1, 2018. Section 7 of the Act outlines requirements for utilization review agents' use of clinical criteria and medical judgement in making utilization review decisions. OHIC assumed the authority and operations to enforce the Act from the RI Department of Health (DOH).

While drafting the Act's corresponding regulations, OHIC decided the above requirement needed further development. OHIC reconvened the Administrative Simplification Workgroup to seek input from organizational representatives who understand the operational and policy complexities of utilization review, in particular, this noted process for incorporating input.

Invitations were sent on September 12, 2018 to representatives of insurers, review agencies, providers (including organizations and individuals representing physical health, mental health and substance abuse) and consumers.

Background

The requirement outlined in 27-18.9(7)(iii) did exist under the former Act § 23-17.12, but there was little information about the processes used by insurers and review agents to solicit, consider and incorporate input.

OHIC's purpose in this Administrative Simplification Workgroup was to gain a better understanding of the existing processes, and to provide the Commissioner with regulatory parameter recommendations to add more specificity to this requirement for the Act's corresponding regulations.

From an Administrative Simplification perspective OHIC wanted to assure that the noted process was streamlined, transparent and most effective in assuring consumer protection.

Meeting Dates and Participants

The Administrative Simplification Workgroup convened on October 3 and held three additional meetings on October 18, November 1, and November 30. It is important to note that the final meeting, held November 30th was originally scheduled for November 15th, but needed to be rescheduled, which impacted attendance. The following chart lists the Workgroup membership and the attendance at each meeting.

Name	Affiliation	10/3	10/18	11/1	11/30
Wendy Lambert	BCBSRI	x	x	x	x
Janice Rowlands	CNE	x	x	x	
Teresa Paiva Weed	HARI	X (Jean Rocha)	X (Jean Rocha)	X (Jean Rocha)	X (Jean Rocha)
Christine Brown	LifeSpan/ MHA-RI				
Dr. Donnah Matthews	Lifespan	x	x	x	
Ruth Feder	MHA-RI	x	x	x	x
Stephanie Hagopian	NHPRI	x	x	x	
Steve DeToy	RIMS	x	x	x	x
Shamus Durac	RIREACH	x	x	x	
Dr. Susan Storti	SUMHLC	(invitation sent after first meeting)	x	x	
Patrick Ross	Tufts Health Plan		x		
Dr. Donald Stangler	United Health Care			X (Kimberly Roberts-Schulteis, Optum/UHC)	X (Kimberly Roberts-Schulteis, Optum/UHC)
Amy White Melanie Marquis	RI Primary Care Physicians Corp.	X (M.M.)	X (both)	X (A.W)	X (M.M)
Dr. James Thatcher	Beacon Health Options	x	x	x	x
Michael Ayotte	CVS/Caremark		X (Kristina Arnoux)	X (Kristina Arnoux)	
Thomas Chase	Delta Dental RI	x	x	x	x
Patrick Quinlan	Lobbyist	x	x		

In addition to the appointed members of Administrative Simplification Workgroup, some insurers/ UR agents elected to have additional representatives participate as members of the public. These regular public attendees include:

1. Melissa Worcester, Beacon Health Options
2. Kimberly Holway and Andrea Camara, BCBSRI

The Admin Simp Meeting structure consisted of the following:

1. Orientation - October 3, 2018
2. Discovery Phase – October 18
3. Proposed Regulatory Parameters – November 1
4. Final Recommendations/Options – November 30

Orientation

The first meeting on October 3, 2018 was an orientation for the 2018 Administrative Simplification Workgroup. The Commissioner opened the meeting by welcoming and thanking Workgroup members for participating and emphasized the importance of their upcoming participation.

OHIC staff then initiated the remaining meeting agenda items:

1. Workgroup Introductions

   OHIC staff introduced themselves and then asked each Workgroup participant to introduce themselves, their title and the organization that they are representing.

2. Setting of Ground Rules

   Workgroup members were asked to set ground rules to shape the upcoming Workgroup meetings. The following ground rules were established:

   - Stay focused on topic
   - Participate in discussion, generate ideas, offer recommendations
   - No cross talking
   - Start & End on time
   - No cell phones and iPads (aside from on-call staff)

3. History of Administrative Simplification and Workgroup's role

   OHIC discussed the history, purpose and statutory language of Administrative Simplification and gave examples of previous topics that Administrative Simplification Workgroups were charged with. Examples of previous Administrative Simplification Workgroup topics include external appeals requirements, retroactive terminations, coding and billing, benefit determination,

external appeals, medical management, and consumer cost sharing to be included in plan design.

4. Admin Simp Membership Composition

   Participants were invited to suggest other stakeholders who would be helpful additions to this Workgroup. Steve DeToy (RIMS) and Ruth Feder (MHARI) suggested that behavioral health providers should be included in the Workgroup (i.e. Bradley, The Providence Center, substance abuse providers/consumers, psychologist-Peter Oppenhiemer Coalition of Mental Health Professionals). Steve DeToy and Ruth Feder also recommended certain disease related advocate groups (arthritis, cancer, MS, diabetes, brain injuries, etc.)

5. Admin Simp 2018 topic

   OHIC explained why this topic was selected for further development:
   - OHIC is in the process of drafting updated Benefit Determination and Utilization Review (BD/UR) regulations
   - OHIC wants to learn more about how BD/UR agents and insurers are executing the input solicitation process that was briefly described in the recent BD/UR certification documents submitted to OHIC for review.
   - OHIC provides a historical overview of the requirements for the review and input from providers into BD/UR agency medical necessity criteria under the previous regulations and the requirements of the current regulations

   OHIC highlighted the goals and objectives for this year's Workgroup:
   - Discover and understand current input solicitation processes within the RI market
   - Review effectiveness, transparency and simplicity of input solicitation processes
   - Discuss and agree on framework for how the process of receiving, incorporating, and, responding to provider and member feedback will work according to statute
   - Based on that framework, make recommendations to the Commissioner to assist in regulation development

6. Statutory Requirement of 27-18.9(7)

   OHIC staff explained that this input solicitation requirement mandates that entities **establish and employ a process to incorporate and consider local variations to national standards and criteria identified herein including without limitation, a process to incorporate input from local participating providers;**

and provide updated description of clinical decision criteria to be available to beneficiaries, providers, and the office upon request and readily available accessible on the health care entity or the review agent's website.

OHIC discussed the statutory requirement for anyone making benefit determination/ utilization review decisions to utilize a clinical criterion that, not only is acceptable to the Commissioner, but also allows for flexibility to include local provider and member feedback.

7. Homework Assignment

   To begin the discovery phase, OHIC staff presented the clinical criteria homework worksheet for review agents and health entities, as well as other requests for information for the next session. Health care entities and UR agent Workgroup members were asked to submit a 1-2-page description of the process used for each category, Med/Surg, BH, RX or Dental, if applicable. When describing the processes for incorporating local provider and member feedback, OHIC asked that UR agents address the who, what, where, when, how this process is implemented. This information will be organized in a matrix that will outline activities, commonalities and differences.

   Post deadline for the homework submissions, OHIC staff shared with Workgroup members a folder with all the submissions received, and a template for the proposed Matrix that would help members better analyze the information and identify commonalities and differences. The Matrix will be used as a reference tool for discussion and recommendations in the rest of the Administrative Simplification Workgroup meetings.

Discovery

The purpose of the second session held on October 18 was to explore the insurers and review agents' current processes used to solicit, consider and incorporate input from local participating providers and members.

At this meeting, OHIC asked the insurers and review agents about the homework assignment and the source documentation used to describe the process for soliciting, considering and incorporating input on the clinical criteria used. A majority of participants who submitted the descriptions concurred that the primary source used was their utilization management policies and procedures.

The Matrix template provided by OHIC staff was segmented into four phases of the overall process, (1) Solicitation of input (2) Consideration of input (3) Incorporation of input, and (4) Feedback closure. OHIC staff explained the elements of the Matrix and how they populated the fields with information participants provided. Most, but not all organizations, completed the Matrix.

While working with the Matrix, discussion topics arose such as delegate oversight, specifically how insurers who delegate certain services ensure that this statutory requirement is being met. BCBSRI responded that they maintain responsibility to oversee delegated Pharmacy Benefits Management (PBM). For example, BCBSRI Pharmacy & Therapeutics (P&T) committee reviews decisions after PBM's P&T. NHP also responded that they have an oversight policy and process of reporting, meetings, policy & procedure (P&P) review.

The most significant commonality across the Matrix was the use of committees for the review of clinical criteria within their organizations. The participants agreed that their committees were standing committees not ad-hoc and followed their organization's P&P for periodic review of clinical criteria.

Lifespan asked about the member composition of these review committees. How are they selected? What is the selection criteria? Are there term limits? BCBSRI representatives countered that committee composition derails us from the Workgroup's primary topic. OHIC advised group of the need to stay on topic but did state that committee composition would arise if the insurer or review agency claimed that their review committees included local participating providers to comply with statute.

Workgroup members agreed that the Matrix's largest gaps were in the incorporation and feedback closure fields. It appeared that solicitation and consideration of input was the end of the processes described. Some group members recommended that fellow members add more detail to these two fields in the Matrix. What happens to input? How is input used?

Other questions were posed for the review agents to consider when filling the gaps, e.g. How are changes tracked?; Do you keep the rationale for and origins of input?; How does anyone (members, providers, public) know that this criterion has gone through an evaluation process or revision?; How do we know that members are accurately represented (multiple languages) and is the criteria made available in a contextualized way for members of different cultural backgrounds?

The most significant discussion ensued about solicitation of member input vs. provider input. OHIC explained that member input was included in the topic because some insurers, in their descriptions, stated that they acquire member input through their complaint and appeals process. As a result of discussion, the Workgroup asked OHIC staff to add a member column to the summary Matrix to reflect this information.

OHIC encouraged the insurers and review agents to strongly consider providing more detail to the summary Matrix based on the Workgroup discussion. OHIC informed the Workgroup that the revised Matrix, including the member column and any other information gained from this session, will be sent to them so they can complete the Matrix in preparation for the Workgroup to begin forming the recommended regulatory parameters.

Regulatory Parameters

The purpose of the third Admin Simp meeting, held November 1st, was to begin drafting some regulatory parameters that will augment the noted requirement in the BD/UR statute. To assist the Workgroup, OHIC staff drafted some parameters based on the statute, information gained from review agents certification documents, and the insurers/review agents descriptions provided about their existing input processes.

OHIC emphasized that BD/UR regulations are being drafted, so these parameters will be used to make recommendations to the Commissioner. The recommended parameters will be considered by the Commissioner for incorporation into the BD/UR corresponding regulations and filing instructions.

OHIC will not be prescriptive about the methods and mechanisms used, only defining process. Upon review of OHIC's proposed parameters, Workgroup members asked for clarification on some information, and offered their comments and suggestions.

<u>Solicitation Parameters</u>

- **Agencies conducting Benefit Determination/ Utilization Review(BD/UR) shall establish a process to solicit comments from Rhode Island providers and stakeholders, including but not limited to local consumer advocacy groups, medical professional associations, chronic disease associations concerning clinical criteria. This process must include mechanisms to improve the input process to increase transparency of stakeholder engagement.**
- **If a [health care entity] HCE/UR agent is relying solely on unaltered national clinical criteria (e.g. MCG, Delta Dental National Association, InterQual), the HCE/UR agent may not alter the national criteria, and thus is not required to obtain local provider and stakeholder input.**
  - **a.** MHARI asked that "medical providers" to include behavioral health
    - i. The group agreed to remove the word medical all together and just refer to local providers
  - b. RIMS stated that using the term comment is too passive, as it does not hold entities accountable for actually considering the feedback or objections
    - i. The group preferred "input" vs. "comments"
  - c. Beacon asked about what the term "transparency" refers to
    - i. OHIC clarified that it is looking for transparency throughout the process, but especially in the Feedback closure category
  - d. MHARI asked if UR agency can delegate the local input process
    - i. OHIC clarified that if the HCE is delegating to BD/UR agency, the BD/UR agency cannot re-delegate
    - ii. OHIC suggested taking out HCE and just leave BD/UR
  - e. RIPIN asked for the definition of stakeholder

i. OHIC clarified that we are not defining and limiting who the stakeholders are, just that the BD/UR agency must do due diligence to identify those relevant to the criteria being developed or reviewed
ii. Definitions will be further explained in the regulation or in filing instructions

f. Beacon asks what happens if different agencies have different stakeholder lists
    i. OHIC clarified that it is dependent on the type of criteria and also reactive vs. proactive measures
g. BCBSRI states that stakeholder participation is expansion on current statutory requirements, and believes that this should be left up to the carriers
    i. OHIC agrees that it was expanded upon for this Workgroup because within the homework descriptions insurers stated they acquire member input through complaint and appeal process that carriers currently utilize, but does not agree that this expands on statute
    ii. NHPRI agreed that stakeholder groups vary from member and is a different than what NHP was viewing this topic as, NHP refers to RIGL 27-18.7, which does not specifically include member
    iii. OHIC reiterated that we're not being prescriptive with specific mechanisms for member and provider input
        a. Also, that members sometimes rely on the consumer advocacy groups to speak on their behalf
        b. If we're looking for minimum standards, we could leave that discretion and design up to the carriers
        c. OHIC also refers to the policies and procedures portion in the Health Plan Act for seeking member input
    iv. Delta Dental voiced agreement with BCBSRI regarding legal teams' perception of RIGL 27-18.7
h. MHARI thinks stakeholder is better than member specifically regarding BH consumers- that local providers does not get to the consumer

At this session, a representative from Change Healthcare, the organization that creates the nationally-recognized InterQual Criteria, attended as a public guest. Laura Coughlin, VP of InterQual Development and Clinical Strategy, gave the Workgroup an overview of their criteria development and review process in relation to Admin Simp's topic of soliciting, considering and incorporating input. Coughlin spoke about how their process is evidenced-based and how they study, consider, and incorporate input into InterQual Criteria.

Coughlin said that InterQual has been operating in RI for 14 years, and through the local provider input process, has only received 4 comments from publishing for public comment.

OHIC uses the example of "lack of progress" as an example of using InterQual and utilizing local variations due to RI's rules and regulations. InterQual allows for the denial of continued clinically appropriate care if the patient is showing a "lack of progress." OHIC forbids the use of lack of progress in utilization review, as it is not in the best interest of consumers, especially when used in behavioral health settings, where "lack of progress" may be due to the underlying symptoms. Thus, UR agents using InterQual for utilization review in RI need to have supplemental clinical criteria to allow for the approval of claims that would be otherwise denied based on InterQual's lack of progress criteria.

Consideration/ Incorporation Parameters

- **The HCE/UR agents must have a documented process to consider all objections, comments and recommendations concerning the criteria that is received from local providers and stakeholders' input.**
- **In addition to a required annual review of the clinical criteria, there must be means for ongoing receipt of objections, comments and recommendations from providers and stakeholders. (e.g. feedback form on website, the complaint & grievance process)**

The group largely supported these two parameters but requested more definitions and further clarity. The Workgroup asked for a definition of "documented" process. MHARI suggested that the feedback form on organizations' websites be universal. OHIC explained that forms don't have to be identical, but maybe could be titled similarly to achieve some percent of standardization.

Discussion followed about the availability of the forms and criteria to the public. OHIC clarified that this requirement is just about the availability of feedback/input forms and submission process for stakeholders and providers, not the posting of the full clinical criteria.

Feedback Parameters

- **Prior to the annual effective date of criteria adoption or revision, HCE/UR agents must document a summary of the principal reasons for adopting or rejecting any revisions resulting from the objections, comments or recommendations made by providers and other stakeholders.**
- **The updated description of clinical criteria must be available to all beneficiaries and providers, and OHIC upon request. It must also be made readily available and accessible on the health care entity or the review agent's website**

The Workgroup asked if responses to comments need to be public information. OHIC responded that the expectation would be that commenters receive a direct follow-up response and that a summary be provided to OHIC upon request. Group members expressed that individual responses may not be manageable. OHIC then discussed possibility of grouping comments into categories and doing a broad statement response. OHIC further clarified that due to confidentiality and case specific information, it wouldn't be plausible to have public responses to all comments received. This type of analysis is why OHIC will not be prescriptive in its parameters. UR agents must balance meaningful feedback closure, with processes that are feasible.

Questions were posed about timeline for getting updates on the websites. How long would agencies have to post updates? OHIC responded that no specific timeline has been determined and we will take that under consideration when drafting the BD/UR regulations.

At the close of this session OHIC asked Workgroup to submit comments on the revised parameters by November 8, 2018 so we can document and re-send to the group for their review before the final Workgroup meeting.

Recommendations/Options

At the final Workgroup meeting on November 30th, OHIC welcomed back Workgroup members and discussed a change to the plan for the final meeting. Because OHIC respects members time and viewpoints, we clarified the different options and plan to present them all to the Commissioner for her consideration, instead of building consensus on proposed parameters.

OHIC then discussed the edits that were based on group input, and then implemented into the parameter document. The new document outlines the different options under the Matrix categories (1) Solicitation (2) Consideration/Incorporation, and (3) Feedback closure.

In relation to Parameter A's sample string of stakeholders, OHIC explained that because the group felt "medical professional associations" was not inclusive of behavioral health and substance use, it was changed to "professional healthcare associations". RIMS raised the issue that this type of organization is different from a professional consumer organization, and MHARI also asked that we define consumer advocacy groups. OHIC explained that this would be taken into consideration when drafting the BD/UR regulations' definitions. OHIC also addressed SUMHLCRI's written question about OHIC's monitoring of supplemental criteria. OHIC responded that all criteria must meet approval of the Commissioner, and monitoring occurs during Network Plan certification, BD/UR certification, Market Conduct Exams and tracking of complaints and grievances.

As in prior sessions Parameter A sparked the most discussion of opposing views.

Parameter A: Agencies conducting Benefit Determination/ Utilization Review(BD/UR) shall establish a reasonable process to solicit input from Rhode Island participating providers and stakeholders, including but not limited to local consumer advocacy groups, healthcare professional associations, chronic disease associations concerning clinical criteria. This process must include mechanisms to improve the input process to increase transparency of stakeholder engagement

RIPIN provided written comment in support of Parameter A's expansion of the statute. They stated that "regarding RIGL § 27-18.9-7(b)(7)(iii), in that subsection the use of the words "without limitation" indicates that the subsequent language, specifically "a process to incorporate input from local participating providers," is illustrative rather than exhaustive. Therefore, OHIC is permitted to establish additional regulatory requirements to define contours of that "process to incorporate and consider local variations."

BCBSRI interprets the term "without limitation" differently. They believe that without limitation refers to the review agent, not the local participating providers. Representatives from BCBSRI re-stated their opposition to the addition of stakeholders. They stated that "adding stakeholders is an expansion of RIGL § 27-18.9 and should not be required. While stakeholder feedback may be valuable it is not required by statute. OHIC can recommend that agencies include stakeholders in this process but should not require more than what is required under the statute."

Workgroup members appear to be split down the middle, half supporting Option 1 and the other half Option 2. OHIC reiterated that both options and rationales will be presented to the Commissioner through this report.

Parameter B: BDUR agents shall not be required to solicit local participating provider and stakeholder input when relying solely on an unaltered national clinical criterion set that is acceptable to the Commissioner.

Discussion then moved to Parameter B's two options: (1) Nationally recognized criteria is not subject to local level of review, or (2) Both national criteria and supplemental criteria should be subject to local level review. Workgroup members in support of Option 1 feel that National criteria has gone through a comprehensive, evidence-based evaluation process and referenced Laura Coughlin's information regarding InterQual's local provider input solicitation barriers.

Those supporting Option 2 believe that national criteria do not always take into consideration the local variations, and because of that, review agents should seek input from local participating providers and stakeholders. Again, these two options along with suggestion that OHIC needs to review interpretation of statute in this matter will be presented to the Commissioner.

Parameter C: BD/UR agents using a supplemental clinical criterion to national criteria must establish and employ a reasonable process to solicit, consider, and incorporate local variations to national standards and criteria identified herein including without limitation, a reasonable process to solicit, consider, and incorporate, as appropriate, input from local participating providers and stakeholders.

Parameter C states that the development and review of Supplemental criteria should include local level of input. Members did agree on this factor that Supplemental criteria does need to be subject to local level input.

Before moving on, OHIC asked Workgroup about the view that Supplemental criteria should not only be subject to local input, but also to national input. Workgroup members mostly felt that local variations are best left to local providers, as they know the matter best. Some members, however, felt that it is a moot point since they interpret the statute as requiring national provider feedback.

Beacon asked for clarity about input that could potentially harm the consumer. OHIC explained that, like with everything we do, the impact on the consumers need to be priority– not every variation suggested is going to be one that is best to be incorporated. Due to the outcome of this discussion, "as appropriate" was added after incorporation of input.

Parameter D: BD/UR agents shall have a reasonable process for ongoing receipt of feedback (e.g. form on website, complaint and grievance process) and consideration of all input concerning the criteria that is received from local participating providers and stakeholders. Feedback shall be incorporated as appropriate.

The Workgroup discussed that most insurers and review agents are already employing this passive form of receiving input. OHIC further clarified that this ongoing means should be available regardless of the criteria in question, national or supplemental. RIMS asked about OHIC's monitoring and required reporting. OHIC explained that evidence of agent's means for ongoing receipt of input shall be asked for in certification review, and review agents BD/UR quarterly reports.

Parameter E: BD/UR agents shall complete an annual review of the clinical criteria as described in parameter "C" above.

Members agreed that most, if not all, are already conducting annual reviews of criteria. BCBSRI added clarification that a review occurs more frequently, if necessary (e.g. FDA approval of a new drug, a new statutory ruling, new regulations, etc.)

Parameter F: BD/UR agents shall document a summary of the principal reasons for adopting or rejecting any revisions resulting from the input made by participating providers and other stakeholders

In discussion, some Workgroup members advised that organizations need to avoid proverbial loop of review process vs. adjudication. As mentioned in the former session, we aren't going to be too prescriptive about the means to execute this parameter, but some members would like "documented" to be clearer.

Parameter G: The updated description of clinical criteria shall be available to all beneficiaries, participating providers, and OHIC upon request. It shall also be made readily available and accessible on the health care entity or the review agent's website prior to use

NHPRI did provide a written comment regarding Parameter G. Because of IQ proprietary nature they could not meet this requirement. They recommend striking or modifying this factor of the parameter. OHIC clarified that this is statutory language and wanted to clarify that only a description of updates to criteria, not the entire clinical criteria shall be uploaded to their websites.

At the close of the last session, OHIC thanked the group for their collaboration in this year's Administrative Simplification Workgroup and asked for any final dissent, comments, or support by December 7, 2018 so that OHIC may begin drafting the final report to submit to the Commissioner.

Final Comments

SUMHLC sent a comment in support of Parameter A's 3rd option. They believe that "often advocates representing behavioral health are not included as it is assumed that they are represented by other providers". SUMHLC also reiterated the recommendation that the term "reasonable" be better defined.

Member, Pat Quinlan, representing RI Dental Association, RI Society of Anesthesiologists, RI Radiological Society, and RI Chapter of American Academy of Physician Assistants submitted the following comment: "With regard to the seven lettered subsections of the parameters, we support the adoption of "Option 2" in parameter A, parameter B, parameter C, parameter D, parameter E, and parameter F." Mr. Quinlan also strongly suggested that time frames and notice periods be incorporated into any regulatory document and appreciates the inclusion of parameter D that requires a reasonable process for ongoing receipt and consideration of input.

NHPRI provided final comments regarding the requirement to seek stakeholder input. Neighborhood does not support this expansion of health plan regulatory requirements, because the change will increase, not simplify, administrative requirements for plans, and

may distract, and potentially dilute the important role of providers in the process as required by OHIC's statute. Neighborhood suggests removing 'stakeholders' from the Workgroup's parameters.

Finally, CVS, Delta Dental, and BCBSRI submitted a joint legal memo regarding the Admin Simp parameters. The memo outlines their opposition to expanding the review agents input process to include stakeholders' input. In the parameters the "broad references to non-provider stakeholders exceed the letter, scope, and intent of the statute."

Conclusion

OHIC believes that the 2018 Administrative Simplification Workgroup process was effective for several reasons. First, the Workgroup was asked to share information about their clinical criteria development and review process, in particular, the process to solicit, consider and incorporate input from local participating providers and stakeholders. This information proved to be critical in the process of developing effective parameter recommendations for the Commissioner.

Second, OHIC requested that participating organizations send representatives who have first-hand knowledge of the current processes and who could represent the views of their organization. The members involved in the Workgroup did prove to be subject matter experts and provided varying perspectives that allowed for a collaborative, effective Workgroup.

Third, while the Workgroup engagement was time limited, OHIC feels that all members made the best of the time that was allotted.

Finally, OHIC staff provided the Workgroup members with documents for review and input, rather than asking the Workgroup to develop them. As a result, OHIC obtained important feedback on the proposed parameters, and options for the Commissioner to consider for incorporating into the BD/UR regulations.