



June 17, 2016

Virginia Mason
Finance & Administration
P.O. Box 900, Mail Stop M6-FNADM
Seattle, WA 98111

Mr. Jim Freeburg
Washington State Office of the Insurance Commissioner
PO Box 40255
Olympia, WA 98504-0255

Dear Mr. Freeburg,

Virginia Mason Medical Center (“Virginia Mason”) submits the following comments on potential rulemaking by the Office of the Insurance Commissioner (OIC) on prior authorization practices in this state. We are pleased that the OIC is considering rulemaking and support the concept of administrative action on this significant practice and public policy issue.

Virginia Mason is a nonprofit regional health system which employs approximately 5,500 people in the Puget Sound area. In this region, we operate a 336-bed acute-care hospital, employ more than 500 physicians in a multispecialty group practice offering both primary and specialty care, and have a network of eight medical centers, along with Bailey-Boushay House, a skilled-nursing facility and chronic care management program for people with HIV/AIDS. We are internationally known for utilizing the Virginia Mason Production System, which applies lean manufacturing principles to health care to improve quality and patient safety.

Virginia Mason has had ongoing unfavorable experiences with the prior authorization processes required by the Commercial Health Insurers doing business in Washington State. Current prior authorization requirements are extremely wasteful, inefficient and neither transparent nor reasonable.

At present, Virginia Mason is subjected to seeking prior authorization for at least 364 unique services. Virginia Mason employs 28 FTEs to assist with this process. Prior authorization can result in the undesirable interruption of necessary care delivery. When we are required to seek prior approval by payers, **more than 95 percent of Virginia Mason’s initial requests are approved. When resubmitting our requests, more than half of those initial rejections are then approved.**

Measures to ensure appropriate use of medical resources is important to ensure both safety and affordability of medical care. This goal is shared by purchasers, providers, health plans, regulators and individual patients. Unfortunately, health plans in Washington State and across the country increasingly are relying on prior authorization to manage access to many types of medical services and procedures. This results in an ever-increasing cost burden to health care providers and significant, unnecessary frustration for patients, who often do not fully understand why prior authorizations are required and are often left out of the conversation when denials occur.

The OIC clearly has the authority and expertise to act on this issue of prior authorization. Senate Bill 5346, which was signed into law in 2009, gives the OIC authority to implement through rulemaking the sections of the bill that have not been voluntarily adopted by the industry. We believe the OIC should either establish minimum requirements for the use of prior authorization or help develop a desirable alternative to the practice.

Virginia Mason believes that a combination of regulatory and market-based initiatives can address concerns regarding prior authorization, utilizing administrative simplification at a reduced cost for all stakeholders and resulting in an improvement in both the quality and timeliness of care for patients. We have identified four areas of concern and made proposed recommendations to address those concerns, as noted below.

1. Unscheduled material changes to business agreements

Health plans unilaterally introduce large numbers of prior authorization requirements at a rapid rate. New prior authorization requirements introduced outside of the “contracting cycle” add unanticipated costs for providers and represent unregulated “material changes” in financial agreements.

We recommend regulating the timing of new prior authorization requirements to correspond with contracting cycles. The exceptions would be limited to important new findings related to patient safety or efficacy as judged by a neutral party, such as the Health Care Authority, the Quality Improvement Committee of the Washington Health Alliance, the Health Technology Assessment Program, or a committee of the Robert Bree Collaborative.

2. Financial standards to justify preauthorization

Of the numerous prior authorization requirements introduced by health plans, there is a considerable administrative cost burden passed on to health care providers in order to manage prior authorization requests with those health plans. We believe there should be a financial standard for introducing new prior authorization requirements.

We recommend that the OIC adopt a financial standard for introducing new prior authorization requirements. We further recommend that the OIC regulate the introduction of new prior authorization requirements from health plans by requiring that the plans demonstrate -- in a transparent fashion -- that the new requirement has a significant financial benefit to the purchasers.

3. Clinical standards to justify preauthorization

The clinical standards upon which prior authorization is required are often based on lists of medical references, with no appraisal to indicate quality of the science behind the recommendation. Standards used by the state Health Technology Assessment Program and the Robert Bree Collaborative are examples of publically reported, standardized evidence appraisals that are open to public comment. (See http://www.breecollaborative.org/wp-content/uploads/evidencetables_tkrthr_final.pdf).

We recommend that the OIC require health plans to submit appraisals in advance to the Insurance Commissioner or a designee to validate the scientific basis for prior authorization according to industry standards for evidence appraisal.

4. Community standard for clinical decision rules

Evidence-based clinical decision rules are based on a limited number of well-known research studies available to all. A community standard for clinical decision rules to limit variation -- developed collaboratively among stakeholders -- would remove immense administrative waste and cost for all. The Robert Bree Collaborative has established hundreds of evidence-based decision rules in its bundled payment initiative and is well-positioned to create such a statewide standard.

We recommend approaching the Robert Bree Collaborative to establish a set of evidence-based decision rules for procedures or medical interventions requiring prior authorizations.

We look forward to participating with the OIC and other interested entities on addressing this issue.

Please do not hesitate to contact me, or our public policy director, Ross Baker (Ross.Baker@VirginiaMason.org; 206.399.4481), if you have questions or comments concerning our position and proposals.

Sincerely,

Bill Poppy
Senior Vice President of Provider Contracting and Chief Information Officer
Bill.Poppy@VirginiaMason.org
(206) 223-6606