

August 16, 2016

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

Re: Stakeholder Draft on Prior Authorization Process Rule (R 2016-19)

Dear Mr. Freeburg:

Thank you for the recent publication of the stakeholder draft for the Office of the Insurance Commissioner's (OIC) proposed prior authorization rule (R 2016-19). It is a great comfort to know that Washington State is leading the nation's efforts to ensure consumers and providers are part of a more transparent and streamlined process. These efforts are truly in the best interest of both doctors and patients.

I am the Chief Executive Officer of National Decision Support Company (NDSC), a globally-recognized provider of innovative clinical decision support (CDS) solutions widely adopted by healthcare providers and integrated with leading Electronic Health Record (EHR) vendors. We offer a scalable, cloud-based architecture for delivering actionable CDS based on nationally-recognized guidelines into provider workflows. Through production and delivery of our flagship solution, ACRselect, as well as appropriate use criteria from the American College of Cardiology and the National Comprehensive Cancer Network, NDSC has developed a proven process for digitizing consensus medical guidelines and delivering them at the point-of-care.

I appreciate the release of the stakeholder draft, and the opportunity to provide comments. Overall, we think the implementation of the Prior Authorization Process Rule will secure Washington State's continued leadership in increasing efficiency and transparency in health care, and assist in cost containment. With that in mind, I would like to offer a few suggestions that NDSC believes could further strengthen the state's regulation of prior authorization practices, including: 1) clarifying standards for the electronic submission of prior authorization requests; 2) further strengthening clinical criteria review; 3) taking steps to avoid unnecessary prior authorization delays and 4) ensuring additional transparency throughout the process.

Electronic Submission of Prior Authorization Requests

We thank you for your focus on requiring issuers and their designated benefit managers to accept electronic submissions of prior authorization requests. This is an important step towards minimizing the barriers created by issuer prior authorization practices. However, in order to truly ease the burden to doctors posed by prior authorization, **we believe the state should do more to encourage common standards and interoperability with EHRs**. The current telephone and paper based processes deployed for prior authorization were developed in the 1980's, before the internet was widely used. Today, clinicians are placing orders electronically in their Meaningful

Use Certified EMRs. These systems are capable of transacting prior authorization requests as a part of the provider's normal ordering transaction. The OIC could require interoperability and seamless prior authorization requests in the provider's normal ordering workflow in several ways. First, the OIC could endorse standards such as those currently being promoted by the Workgroup for Electronic Data Interchange (WEDI) and the Medical Group Management Association (MGMA). Second, the OIC could mandate that prior authorization requests occur using transaction rules including HIPAA standard ASC X12N 278. In addition, the OIC could sponsor a statewide prior authorization portal, ensuring that all insurers in the state use the same methodology. No matter which path the state were to choose, helping doctors quickly and efficiently submit prior authorization requests will help decrease response times, significantly improve overall patient care and alleviate an unnecessarily costly burden for all stakeholders in the process.

Clinical Criteria Review

We thank you for your focus on requiring documented and “written clinical review criteria based on reasonable medical evidence.” Strong, evidence-based standards are a key to protecting the clinical integrity of a prior authorization requirement, and to ensuring that patient care, rather than financial considerations, are the primary motive in avoiding overutilization. NDSC believes that more narrowly defined “review criteria” and “reasonable medical evidence” would enhance the effectiveness of the rule. We encourage the OIC to consider requiring issuers to utilize evidence-based appropriate use criteria (AUC) developed by nationally-recognized specialty societies. These criteria are available for a wide range of specialties, and are developed in a transparent manner, drawing upon providers' expertise delivering top quality care and have been proven to reduce inappropriate utilization.

Ensuring that Washington doctors follow clinical recommendations grounded in collaboratively developed appropriate use criteria still protects insurers against over-utilization, while protecting patients against decisions based on financial, rather than health, grounds. This is a model that several states, as well as the federal Centers for Medicare and Medicaid Services (CMS) have followed. For advanced diagnostic imaging, for instance, CMS has stated that, “experience and published studies alike show that results are best when AUC are built on an evidence base that considers patient health outcomes, weighing the benefits and harms of alternative care options, and are integrated into broader care management and continuous quality improvement (QI) programs. Successful QI programs in turn have provider-led multidisciplinary teams that... develop bottom-up, evidence-based AUC or guidelines that are embedded into clinical workflows.”¹ NDSC believes that Washington should consider taking further steps towards ensuring that prior authorization decisions are always guided by the most comprehensive, up-to-date, and clinically relevant criteria possible.

Further Reduction in Review Determination Timeframe

The stakeholder draft makes positive strides towards reducing wait times for doctors and patients who have submitted prior authorization requests. The proposed 72 hour wait period for standard prior authorization requests, however, still represent a potential significant barrier to care. NDSC

¹ “Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016,” 80 Federal Register 220 (16 November 2015), p. 71102. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-11-16/pdf/2015-28005.pdf>

would encourage the OIC to further reduce the review timeline, as well as examine alternative methods of reducing waits for doctors and patients, including automated authorizations in real time for certain services or providers, and exempting from prior authorization requirements providers using certified appropriate use criteria accessed via an electronic platform like CDS. By providing options to comply with the intentions of the prior authorization process, while avoiding long and often unnecessary delays, the OIC would continue to encourage appropriate utilization, while reducing bureaucracy and some of the headaches that providers currently face.

Additional Transparency Throughout the Process

NDSC believes that transparency is potentially the most important element for ensuring a fair and open prior authorization process. The stakeholder draft makes significant strides towards improving transparency throughout the prior authorization process, such as requiring the name of the individual denying a claim to be disclosed. The OIC could enhance this section, however, by following the model of many other states, which require the individuals reviewing prior authorization requests to be licensed practitioners, both in that state, as well as in the medical specialty being reviewed. In the interest of openness and transparency, we also believe these details should be fully disclosed to requesting physicians.

Further, we believe the OIC should consider requiring the written clinical review criteria to be readily available online to all stakeholders, not just providers. This disclosure should include information on the evidence-based methods in which the criteria are created, as well as information as to how the criteria are interpreted and applied, we believe the information that to be disclosed should include at a minimum:

- what services require prior authorization;
- the specific review criteria for each test or treatment requiring prior authorization;
- the process for appealing a denied prior authorization request;

Requiring this information to be made available to subscribers will both increase transparency, as well as reduce the overwhelming burden that is often placed on the subscriber as they navigate medical treatment.

Thank you for the opportunity to submit these commits, and for your continued commitment to improve health care for all Washingtonians. We appreciate your consideration, and would be happy to answer any questions you may have. I can be reached at mmardini@nationaldecisionsupport.com, or 855-475-2500.

Sincerely,



Michael Mardini
Chief Executive Officer
National Decision Support Company