October 14, 2016 Sent via email to: rulesc@oic.wa.gov

Jim Freeburg
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Re: 2nd Stakeholder Draft of Proposed Prior Authorization Process and Transparency Rule (R 2016-19)

Dear Jim,

Thank you for your consideration of our comments on the second stakeholder draft of proposed Prior Authorization Rule 2016-19, released September 23, 2016.

As you know, carriers typically employ a number of strategies to coordinate care for our members. One of the tools frequently used is a prior authorization process. While we understand and appreciate the need to ensure that members can access needed services, we believe the rule as proposed significantly limits our ability to utilize prior authorization as a way to better manage and coordinate the care of our members.

Coordinated Care is a member of the Association of Washington Healthcare Plans (AWHP), and we support all the concerns and suggestions raised in their letter. However, we wanted to call attention to a few additional ítems. Please find comments regarding specific code sections below.

WAC 284-43-0160 (New definitions)

Expedited prior authorization request – The phrase "where the passage of time could seriously jeopardize the life or health of the enrollee" could be construed very broadly to include any period of time, and, accordingly, could be applied to almost any situation.

Immediate prior authorization request – Without guidance as to the length of time, the phrase "where the passage of time without treatment would, in the judgement of the provider, result in an imminent emergency room visit or hospital admission, and deterioration of the enrollee's health status" can also be broadly construed. Clarification as to the intent of the last sentence, "Immediate prior authorization requests includes 'urgent prior authorization requests,'" would be helpful.

Standard prior authorization request – This definition is overly broad. Construed literally, it encompasses all types prior authorization requests.

WAC 284-43-2050 Prior authorization processes (New section)

(1) An effective date of January 1, 2018 is too soon because complying with these process requirements (as proposed) will require issuers, at a minimum, to: hire and train new staff; create and maintain new administrative systems; and draft and implement new policies and procedures.

(3) This section seems to require issuers to meet all "accepted national certification standards" simultaneously. What if standards conflict?

(4) As referenced above in (1), implementation of an online prior authorization system will take issuers time, as well as increase costs.

(c) Clarification as to the meaning of "preservice requirements" would be helpful. Examples?

(5) Need clarification as to the meaning of "interactive process."

(a) To add clarity and remove insinuation, the second sentence could be simplified: "The response must provide the reason for the decision in clear and simple language."

(7) This is still a 24/7 requirement, which is especially problematic over weekends and holidays, when coupled with the issuer and provider response timeframes required in (9).

This requirement would increase costs through additional administrative expense, as well as the hiring and training of new staff.

(9)

(a) The One Health Port best practice recommendation for immediate requests is a decision within 60 minutes "or a mutually agreeable timeframe," not "or as stated in the provider contract." As written, this would burden the contract negotiation process because negotiated timeframes would have to be filed with the OIC for approval prior to use.

(13) When read in conjunction with (16), these sections could create situations where insurers are required to cover services beyond those justified when setting the premium rate.

(16) See (13).

(18) In addition to delaying and burdening the contract negotiation process through increased OIC contract filings, this requirement promotes fragmentation of prior authorization standards—contrary to this rule's stated goal—because prior authorization procedures negotiated during the contracting process will become, in effect, bargaining chips.

WAC 284-43-2060 Extenuating circumstances (New section)

(2)

(c) "The provider does not have enough time to request a prior authorization" is overly broad, and could be applied to almost any situation.

Thank you for the opportunity to provide these comments. We encourage the OIC to look at the specific complaints and/or problems surrounding prior authorization that prompted this rule-making, and to craft this rule to specifically address those concerns. We believe the rule as drafted is overly broad and will have unintended negative consequences. We look forward to further discussion of this important topic.

Sincerely,

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