THE POLYCLINIC

August 16, 2016

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

Dear Mr. Freeburg:

The Polyclinic is an independent, physician-owned multispecialty clinic serving more than 240,000 patients in the Seattle metropolitan area. Our first priority, each day, is the health and safety of those patients.

We appreciate the opportunity to comment on this important rule, and commend the OIC on the spirit in which the draft language is written: clearly to improve patient care and remove waste from the system.

In addition to the important points made by the Washington State Medical Association (WSMA) and other provider groups, The Polyclinic offers three points to ensure the OIC's rule is effective in improving patient care:

1. **Modify drug pre-authorizations to ensure patients get timely treatment.**
   a. Chemotherapy
      Cancer patients are experiencing delays to life-saving treatment due to pre-authorization requirements. As you can imagine, speed and consistent therapy can be critical to giving a patient the best chance of survival or a prolonged life**.** Current processes can delay treatment for weeks or more.

      We recommend the rule state that if providers are prescribing medications within National Comprehensive Cancer Network (NCCN) guidelines that no pre-authorization is required. And when a drug needs to be prescribed outside its indicated use, review and approval of the authorization must be swift, aided by online portal use as described in point #2 below.

   b. Denials
      Last week, one of our oncologists attempted to appeal a denial for a standard chemotherapy drug through a peer-to-peer process. The problem that exists in these situations is that the peer at the insurance company is not an expert in the relevant medical specialty, and in the instance last week The Polyclinic oncologist tried to explain to the insurance reviewer that the patient has metastatic cancer and that neither adjuvant treatment nor neo-adjuvant treatment is appropriate. *The patient's treatment has now been delayed three weeks, and we are still waiting for a ruling from the peer-to-peer process.*

We ask that when denials are made, the insurance company representative participating in a peer-to-peer discussion is a board certified physician in the relevant field of medicine. Further, our first recommendation allowing drugs be administered in patient care without pre-authorization if they meet NCCN guidelines would have eliminated the dangerous situation this patient now faces, because the requested chemotherapy drug is standard, and adheres to NCCN guidelines.

c. Inexpensive drug therapies

Often the process of obtaining pre-authorization for a drug is more expensive than the drug itself. An example is testosterone therapy. Typically, this therapy is given to the patient in the office based on tests indicating the patient's levels that day. It is best for the patient to get the injection immediately, but pre-authorization can cause the patient to come back to the office after the authorization is obtained.

We are typically paid about $50 per testosterone injection, which does not cover the cost of the drug, the medical care and the administration needed to prepare the pre-authorization. Certainly, it costs the insurer as well.

We recommend that drugs under a certain cost not be subject to pre-authorization to ensure patients do not experience unnecessary delay of treatment and to reduce waste from the entire system.

2. Ensure all pre-authorization processes are through online portals, not via telephone.

The OIC's draft language aptly calls for insurers to provide pre-authorization through online portals. While some online tools currently exist, it is important to point out that often a request starts in an online format, but at some point the provider office is asked to call a phone number to proceed. Currently, a single request can take hours to complete, with provider staff tied up on the phone with insurers.

We request that language regarding online portals be very specific – that the entire process must be able to be completed in an online format, with no telephone interaction needed.

Additionally, as the WSMA requests, **a single portal** through which providers can request pre-authorization, using objective and standard requirements, would create the most value for the patient and purchasers of health care.

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3. **Expand the scope of services for which providers do not need prior authorization if they meet specified requirements.**
   Currently a large scope of procedures and drugs are subject to pre-authorization, with a high percentage – in the 90s - that are approved in the first round of authorization. The staff time on both the provider and insurer side, as well as delay in patient care, can be eliminated by reducing the scope of care that needs to be pre-authorized.

   We recommend the rule specifically identify criteria that would, if met, require payors to grant providers an expanded menu of services that don't require pre-authorization.

Mr. Freeburg, again we thank you for the opportunity to submit comments on this important rule, and support the OIC's efforts to bring pre-authorization practices in line with safe, timely, and cost-efficient care.

Please contact me if I can provide further information that is helpful in your efforts; I would be happy to speak with you.

Sincerely,

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