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June 17th, 2016

Jim Freeburg
Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0255
Submitted via email: rulescoordinator@oic.wa.gov

Dear Mr. Freeburg:

Re: Request for Public Comment on Prior Authorization Process

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide comments on the prior authorization process. We appreciate the effort staff is undertaking to get multiple perspectives on opportunities to streamline prior authorization through this first stakeholder engagement process, as this issue is of great importance to our caregivers and patients. We are looking forward to participating in the June 28th stakeholder meeting scheduled, and offer the following comments in advance of that discussion so that they may be considered as this stakeholder assessment moves forward.

Providence Health & Services ("Providence") is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. In Washington state, Providence and our affiliated partners – Swedish Health Services, Pacific Medical Centers and Kadlec – comprise 15 hospitals, 376 physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services. The combined health system employs more than 40,000 people statewide. In 2015, Providence and our partners provided nearly $450 million in community benefit, including $297 million in unfunded costs of Medicaid and $54 million in free and discounted care[1] for Washingtonians who could not afford to pay. Together, we are working to improve quality, increase access and reduce the cost of care in all of the communities we serve.

After reviewing the current prior authorization rules, we respectfully submit the following priorities and principles shared by Providence Health & Services (including its affiliates listed above), Providence Health Plan (a registered health care service contractor) and the Providence-Swedish Health Alliance as our Accountable Care Organization (ACO). As a system, we agree on the following priorities, which are elaborated on below:

- Improve transparency and encourage seamless processes through better use of technology, while providing flexibility in requirements to acknowledge technological limitations and costs
- Decrease confusion by outlining clear requirements for communicating changes to providers

[1] Data is consolidated for Providence and our affiliates based on financial reporting.

- Balance the need for expedited approval process in extenuating circumstances with unintended consequences for the patient
- Streamline the appeals process, and allow for appeals to address situations where coverage for the patient has changed
- Require insurers to consider medical necessity when setting prior authorization policies
- Allow for alternative arrangements between health plans and providers to the traditional prior authorization process, while considering how to mitigate unintended consequences of these arrangements

Improve transparency and encourage seamless processes through better use of technology, while providing flexibility in requirements to acknowledge technological limitations and costs

In general, we are supportive of the intent for 24 hour access to information regarding prior authorization process requirements, though we want to be careful that this requirement does not unreasonable increase in exchange for little marginal benefit to those accessing the information.

Currently, Providence Health Plan (PHP) provides 24 hour online access to the services which require prior authorization and any specific information required by the insurer to submit a request. For many other health plans that our providers interact with, however, our provider groups have shared that while information is usually available online, it is not always located in a convenient location. This can lead to confusion on the part of those submitting information which often results in claim denials if providers are submitting a request based off of inaccurate or out-of-date information. In fact, one of our leaders in our system Revenue Cycle Division shared that mistakes resulting in authorization issues are the 2nd highest reason for denials, amounting to $206 million in prior authorization denials in Washington last year.

As the OIC and stakeholders consider the opportunities current technology presents for modernization of the prior authorization process, Providence advocates for flexibility, within reason, as to where exactly this information is provided online and how often it is update (see section below for recommendations on transparency of changes to the process). While PHP currently has an online portal to make online submissions easier and more accessible, we would like the rules in this area to be written with flexibility so that insurers are directed to include this information in an easy-to-access online format, but not be required to be integrated within a submission portal/web tool itself, as that presents significantly higher costs to maintain than a separate website. While PHP's portal includes clinical criteria for many of the most common services that require prior authorization, we would be concerned with any language that would require that all clinical criteria be built in to the web portal, as it would be unduly burdensome to provide this documentation in all cases.

Additional rules that we believe would support increased transparency include:

- If using an online submission process, the tool should also provide an online confirmation for the provider indicating that submitted materials can be considered received by the insurer.
- Where prior authorizations are provided on the plans' behalf by a benefit manager, third-party administrator, or other contracted utilization manager are required to be included into the

process. A prior authorization approval by any of these entities on behalf of the plan should be considered binding on the plan.

- Plans should provide similar online capability for any services that do not require PA but are subject to retrospective medical necessity review.

Decrease confusion by outlining clear requirements for communicating changes to providers

Providence recommends that changes to prior authorization requirements be considered material changes to payment or delivery of care, and therefore be subject to the same notification requirements as currently exist under WAC 284-171-421 (6) – which requires 60 days notification – and treated in a similar manner to other amendments to contract. This would include requiring that notification be sent to the contracting contact at the hospital or physician group. This is currently the practice at the Providence Health Plan for outpatient services, and we believe 60 days is a reasonable requirement for notification and allows sufficient time to train staff on changes as necessary.

Balance the need for retroactive approval process in extenuating circumstances with unintended consequences for the patient

Providence supports the use of best practices whereby plans have a process to review and cover inpatient services that are retrospectively determined to meet the stated clinical criteria, if in the provider's opinion, a delay in diagnosis or treatment could result in deterioration of patient's condition or result in significant financial or travel hardship for patient. We are, however, concerned that the more circumstances in which retrospective review is *required* to be allowed, the increased potential there is that patients could be held responsible for payment of services provided to them that did not meet all authorization requirements if providers use retrospective review as a fallback.

Currently, PHP uses retrospective authorizations for inpatient services, as we believe this supports timely provision of patient care. Our provider groups report that PHP processes in this regard assists them in providing the best patient care possible, and can help avoid the need for additional costly services that become necessary if patient care is interrupted while awaiting prior authorization approvals.

To minimize this risk to the patient while encouraging insures to create expedited review or retrospective review processes, we recommend that retroactive reviews be allowed.

Streamline the process for addressing administrative errors

Our providers have noticed a disturbing trend, whereby appeals processes are increasing in number and complexity. This puts an increasing burden on providers and is not sustainable. Many plans are even requiring that the provider go through a formal appeals process when errors are made on the payor side, such as losing a fax that was preciously sent by a provider. We urge the OIC to consider policies that would limit the use of the appeals process when there has been a clear administrative or technological error. As the OIC considers rules to improve the technological side of the prior authorization process, it is important to guard against an unintended consequence where the formal appeals process becomes the default fallback for every glitch that may occur with an online system.

Require insurers to consider medical necessity when setting prior authorization policies

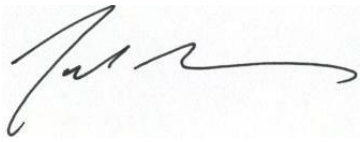
Providence recommends that prior authorization requirements be based on demonstrated reasonable medical necessity according to current medical literature or consensus of recognized UM organizations. If medical necessity requirements and limitations are applied to specific sites of service, such as carving out infusion services and mandating that they only be provided in a specified local setting (such as a specific chain drug store), then the insurer should be required to demonstrate sufficient network access. There should also be a mechanism to retrospectively recognize alternative sites of service where reasonable access did not exist or it is otherwise determined to be medically prudent due to the patient's condition.

Allow for alternative arrangements between health plans and providers to the traditional prior authorization process, while considering how to mitigate unintended consequences of these arrangements

Providence is generally supportive of preserving the ability for health plans and providers to enter into mutually agreed-upon alternative arrangements to the traditional prior authorization process. The agreed on alternative arrangement would ensure services are provided in accordance with the plan's clinical and pre-service requirements through an initial review process of the provider's policies. The alternative arrangement could also include periodic audits to retrospectively ensure that services provided under this express pathway still adhere to the plan's requirements. This would minimize lags and disruption to patient care. Our one caveat is that these alternative arrangements must not create different standards of care for similarly situated patients. For example, alternative authorization arrangements could lead to inconsistencies and unfairness for patients where an insurer is able to authorize services via this express process for commercial members but not for Medicare beneficiaries.

Again, we thank you for the opportunity to provide our comments on the issues under consideration. This work requires balancing many valid interests and diverse stakeholders, and we look forward to being an effective and engaged partner in the work ahead. For more information, please contact Lauren Platt, State Advocacy Program Manager, at (425) 525-5734 or via e-mail at lauren.platt@providence.org.

Sincerely,



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