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June 15, 2016

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

RE: Comments Regarding Prior Authorization Requirements

Dear Mr. Freeburg,

On behalf of Seattle Children's Hospital, we want to thank you for an opportunity to provide input regarding potential rulemaking by the Office of the Insurance Commissioner regarding insurance company prior authorization requirements in Washington State.

Suzanne Vanderwerff, Sr. Director of Revenue Cycle, and I attended the meeting you hosted at the offices of the OIC on November 2,2015, where WSHA member representatives expressed significant concerns regarding narrow networks and the growing administrative and financial burden facilities bear to meet payer prior authorization requirements. Our experience reflects that since the passage of the Affordable Care Act, payers have significantly increased the types of services that require authorization, and have made obtaining authorizations more time consuming. Our data reflect a 36% increase in the number of patient encounters that requiried pre-authorization from 2013 to 2015, yet only .6% of these encounters were denied after all appeal options were exhausted. We conclude that prior authorization for the pediatric population that we serve is not value added, and does not save patients families, payers or employers from incurring unnecessary costs. Instead, the prior authorization requirements delay access to necessary care and raises the cost of care.

We urge you to adopt the recommendations outlined by Claudia Sanders and Andrew Busz of the Washington State Hospital Association in their June 8th letter. We agree with all of the recommendations. As the region's largest provider of pediatric quaternary care, we also have specific challenges obtaining prior authorization for children. Attached is the document WSHA submitted with recommendations for rule making, edited with additional comments intended to highlight how children are negatively affected by the insurers who cover them.

I will be in attendance at the follow up stakeholder meeting on June 28th you are hosting at the offices of the OIC, and would be happy to elaborate further on any of the points provided. I look forward to the meeting, and collaborating with your office.

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Sincerely,

Lori Kapp
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Specific WSHA Comments for OIC Consideration for Rulemaking (text in black) with additional comments to illustrate unique challenges for quaternary specialty pediatric care, where appropriate, in red text.

Transparency

We request that the rules require carriers to provide 24 hour online access to:

- An online, updated listing of all services that require prior authorization. Services requiring prior authorization should be identifiable by both its English nomenclature description and the full range of CPT codes for the service. For each service that following should be available:
    - Clinical criteria (diagnoses and indications) needed to establish medical necessity
    - Any pre-service requirements (trial of more conservative treatment, etc.)
    - Specific information (test results, etc.) needed to submit for review
    - Clearly defined deviations of the prior authorization rules for pediatric patients when they are different, unnecessary, or not applicable

- The health plan's approval mechanism must provide an online confirmation for the provider. This is needed as plans may not honor an approval that was relied upon by the provider but was given by phone or other means of communication.

- Services where authorizations are provided on the health plans' behalf by a benefit manager, third-party administrator, or other contracted utilization management entity should be seamlessly incorporated into the health plan's process. The plan's prior authorization request process should identify and link to the appropriate entity. In addition, a prior authorization approval by any of these entities on behalf of the plan should be considered binding on the plan. Some plans have indicated the OIC should not have direct regulatory authority over such entities as they are under the responsibility of the health plan. At the same time, often there is little accountability for the decisions of these entities, or ensuring providers are aware of processes or requirements involving these entities. Often, the burden and risk is placed on the provider to determine if and where to submit a prior authorization request. SCH has learned through many denial appeals that the TPA's do not have evidence based guidelines for pediatric services. For example, a newborn child with a congenital heart defect requires frequent

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echocardiograms while cardiologists monitoring the condition prior to surgery. The TPA's only authorize 1 echocardiogram every 2 years, based on adult cardiac health utilization criteria. Each denial appeal requires the cardiologist to speak with a TPA medical director. The denial almost always is overturned, but the TPA's do not update their authorization algorithms to reflect the unique needs of pediatric patients. The patient's next scheduled echo gets denied again, and the process repeats. We encourage the OIC to establish rules to ensure prior authorization is a uniform and seamless, evidence based process, regardless of the number of different entities involved.

- In addition to the prior authorization, health plans should allow for a pre-determination process. As a research and teaching hospital and leading provider of pediatric quaternary specialty care, not all of the services provided at SCH have been accounted for by health plans. Many plans have no process to review a service involving new therapies or technology that have moved beyond the research or experimental phase, which are FDA approved but may not be covered by the plan and denied through the claim submission process. We urge the OIC to require health plans to have a pre-service predetermination process for unique or not yet standard of care procedures.

- In addition to services requiring prior authorization, plans should integrate online capability to view medical criteria and pre-service requirements for any services that do not require an advance prior authorization but are still subject to the carrier's retrospective medical necessity review. We have heard many occasions where providers were told a service was not subject to prior authorization, only to have the service denied upon the plan's retrospective review based on uncommunicated medical necessity criteria.

Communication of New Requirements

- We ask that the rules make clear that changes to prior authorization requirements are considered material changes to payment or delivery of care and subject to notification requirements under WAC 284-171-421 (6) (60 days) and treated in a similar manner to other amendments to contract (such as notification sent to the contracting contact at the hospital or physician group). Many plans provide no notification of new requirements other than an update to their website or an online newsletter. Often times these newsletters only vaguely reference that a change is coming, but not what the specific change is, making it impossible to plan for and resource the new requirement. Since

these changes have significant impact on the payment and service delivery for specific services, they should be communicated the same as other changes to the contract to ensure the provider has appropriate opportunity to respond contractually before the change takes place.

> *(6) An issuer must make all documents, procedures, and other administrative policies and programs referenced in the contract available for review by the provider or facility prior to contracting. An issuer may comply with this subsection by providing electronic access.*
>
> *(a)* ***Participating providers and facilities must be given reasonable notice of not less than sixty days of changes that affect provider or facility compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.***
>
> *(b)(i) Subject to any termination and continuity of care provisions of the contract, a provider or facility may terminate the contract without penalty if the provider or facility does not agree with the changes, subject to the requirements in subsection (9) of this section.*
>
> *(ii) A material amendment to a contract may be rejected by a provider or facility. The rejection will not affect the terms of the existing contract. A material amendment has the same meaning as in RCW 48.39.005.*
>
> *(c) No change to the contract may be made retroactive without the express written consent of the provider or facility.*

- We also recommend OIC consider regulating 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 Bree Collaborative.

Timeliness of Response /Extenuating Circumstances/ Expedited Approval

- We ask that the OIC consider more aggressive response timeliness requirements than currently exists in WAC 284-43-2000. The WAC does provide shorter timelines for immediate and urgent conditions, yet delays in care due to prior authorization requirements create delays in care that has significant cost to patients and providers. SCH also urges the OIC to define the term "urgent". Health plans define urgent as the risk to "life or limb". This definition is unworkable when treating pediatric cancer patients, or newborn with rare metabolic conditions or rare conditions that have not been diagnosed but require testing. One of the goals of SB 5346 is to "foster a continuous quality improvement cycle to simplify health care administration". We think it is unacceptable that currently the bulk of services requiring prior authorization can be subject to waiting periods of up to five days or longer. We believe a carrier should have the capability to respond on an immediate basis for any services it chooses to subject to prior authorization and ask that OIC consider this requirement in its rulemaking.

- The rules should require plans to have a process to review and cover services that are retrospectively determined to meet the stated clinical criteria even in cases where no prior authorization was submitted in advance, 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. Currently many services that meet medical necessity criteria are denied as a result of "administrative denials" due to the process. As a regional provider of quaternary specialty pediatric care for the entire state of Washington, we frequently serve families who travel great distances for a specialty consult. When a specialty provider orders a diagnostic study based on his or her findings from the patient's history and exam, that patient should not have to travel back at an undetermined time later in the month to allow the prior authorization process to occur. This barrier to care directly conflicts with the Institute of Medicine pillars of quality related to timely and efficient care.

- WSHA recommends that the OIC promote uniformity in handling of extenuating circumstances by requiring carriers to implement, at a minimum, the *Best Practice Recommendation for Extenuating Circumstances around Pre-Authorization and Admission Notification* developed by OneHealthPort. While the best practice recommendations are well-though out, it assumes that providers can always know the plan's requirement prior to the billing of the service, which may not be the case if the plan's criteria is not transparent and not known at the time of service. We ask the BPR

requirement be modified to expand the time period for consideration, requiring the health plan to retrospectively consider services for payment that meet the clinical criteria for the service, so long as the request for consideration is made within a reasonable timeframe once the requirement is known.

Medical Necessity for New Requirements

- We ask that OIC require prior authorization requirements to be based on demonstrated reasonable medical necessity based on current medical literature or consensus of recognized UM organizations, including community based standards such as those created by the Robert Bree Collaborative. When evidence based consensus for standard of care does not exist, as often is the case for treating very rare pediatric cancers or other conditions in the pediatric population, we ask that OIC require health plans to authorize the standard of care in the local community. Our members see a lot of variety in requirements in services requiring prior authorization between plans. In some cases the requirement seems to be little more than an attempt to create a barrier to medically necessary services. The prior authorization request process creates significant administrative cost for providers. The OIC should require that for new prior authorization requirements by health plans, the health plan must demonstrate in a transparent fashion through medical literature or other means that the new requirement would result in significant savings due to reduction in non-medically necessary services.

- Ultimately, we believe adoption of a set of common clinical standards among plans will aid adoption of evidence-based medicine. We recommend the OIC, either internally, or through a designee, create a mechanism for review of new requirements to ensure they meet medical necessity and financial requirements.

- If a plan's medical necessity requirements and limitations are applied to specific sites of service, the plan should also be required to demonstrate sufficient network access and have a robust mechanism to retrospectively identify and allow cases where alternative access does not exist or is determined not to be medically prudent due to the patient's age or condition. An example is cases where a health plan requires infusion services to be provided in a non-hospital setting. There need to be mechanisms in place to ensure patients have reasonable access to the care in the alternative setting and a mechanism

to ensure the plan will pay regular benefits for the service if due to the patient's age or condition, the services are provided in the hospital setting.

- Due to the medical and psycho-social complexity of managing chronic conditions in the pediatric population, SCH urges the OIC to adopt rules to require health plans to cover hospital based infusions for specialty medicines for pediatric patients aged 18 and under, unless the health plan specifically partners with the family to coordinate the transfer of care to a provider who can and will order the medication infusions at a stand alone infusion center.

Alternative Arrangements to Prospective Prior Authorization

- Prior authorization is only one of several ways that a plan's clinical and preservice requirements can be communicated and enforced. We do not believe it is the best way because the inherent lags and delays to care involved. We ask that the OIC preserve the ability for health plans and providers to enter into arrangements that allow a mutually agreed-upon alternative to traditional prior authorization processes. One form of arrangement is to require a provider to incorporate the clinical criteria and preservice requirements into their care delivery, with a retrospective verification process. As these arrangements ensure services are provided in accordance with plan's clinical and pre-service requirements, there is no difference to patient benefits or qualification for services compared to those whose providers are under a standard prior authorization program. The service are merely authorized in a less costly and more efficient manner. We believe these arrangements are a valid path to broader adoption of evidence-based medicine at the provider level and should be encouraged.