December 29, 2016 submitted electronically to: rulesc@oic.wa.gov

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Re: Proposed Prior Authorization and Transparency Rule CR-102 (R 2016-19)

Dear Jim,

Thank you for consideration of our comments on the proposed Prior Authorization and Transparency Rule CR-102 (R 2016-19). 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 regarding this proposed rule. In particular, we affirm AHWP's recommendations regarding withdrawing, revising and limiting the scope of the proposed CR-102.

However, we also want to call attention to a few specific items. Please find our comments and questions regarding specific code sections below.

WAC 284-43-0160 Definitions. (Amendatory)

(10) *Expedited prior authorization request* – The phrase "any request by a provider or facility for approval of a service 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. We propose replacing "the passage of time" with "following the standard timeframe", so that the section reads, "any request by a provider or facility for approval of a service where following the standard timeframe could seriously jeopardize the life or health of the enrollee . . ."

(37) *Standard prior authorization request* – This definition is overly broad, as it encompasses all types of prior authorization requests, including expedited. It should include language that differentiates standard prior authorization requests from other types of requests.

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

(1) An effective date of January 1, 2018 is too soon because complying with the proposed process requirements 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. We would propose a 24 month timeframe, with an effective date of January 1, 2019, to implement this rule as proposed.

(3) What is the actual requirement here? Is the requirement to meet accreditation standards of any single national accreditation organization? Does meeting the requirements of a national accreditation organization establish a compliant prior authorization program?

(4) & (5)
As referenced above in (1), implementation of an online prior authorization system that can access and compile data from various sources in order to meet the proposed requirements will be expensive due to the significant amount of time and increased staffing required. As proposed, such a system will prove particularly inefficient and costly to issuers, as well as consumers, because providers are not required to adopt or use the proposed online system. Thus, the costs and administrative burden of implementation and maintenance will be in addition to—instead of replacing—whatever prior authorization system issuers currently maintain.

(5)(a) To add clarity and remove the disparaging insinuation regarding the motives of issuers, the second sentence should be simplified: "The response must provide the reason for the decision in clear and simple language."

(9) This is a 24/7 requirement, which is especially problematic over weekends and holidays when coupled with the proposed issuer and provider response timeframes. This requirement would increase costs through additional administrative expense, as well as the hiring and training of new staff.

(19) Mandating that all prior authorization procedures become part of the provider contract, and that any prior authorization procedure change requires a contract amendment, is an incredible burden to the development and maintenance of an adequate provider network. In addition to delaying the contract negotiation process through increased OIC contract filings and approvals, this requirement promotes fragmentation of prior authorization standards—contrary to this rule's stated goal—because prior authorization procedures will become, in effect, bargaining chips to be negotiated according to each provider's specific preferences during the contracting and amendment process.

Further, the requirement that all prior authorization procedure changes require contractual amendment creates a barrier to readily updating authorization requirements in response to changing medical evidence. This seems inconsistent with the intent of the legislature because lawmakers, in enacting RCW 48.43.016, expressed a preference for a more dynamic, web-

based method of disclosing such information. Specifically, see RCW 48.43.016(3), which requires that prior authorization information be posted on an issuer's website and upon request.

WAC 284-43-2060 Extenuating circumstances (New)

(2) In the second sentence, what constitutes an extenuating circumstance is mischaracterized as the intended result of an extenuating circumstance—"an extenuating circumstance means a situation where a carrier must not deny a provider or facility's claim for lack of prior authorization if the services are otherwise eligible for reimbursement." This adds confusion to the whole code section.

Thank you for the opportunity to provide these comments. We look forward to further discussion of this important topic.

Sincerely,

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