Washington State Medical Association
Physician Driven Patient Focused

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

Dear Mr. Freeburg:

On behalf of the Washington State Medical Association and its over 10,000 members, thank you for the opportunity to submit comments on the OIC's CR-102 rulemaking "Prior authorization processes and transparency (R 2016-19)" aimed at streamlining and standardizing prior authorization processes in Washington state.

We applaud the Office of the Insurance Commissioner (OIC) for seeking to improve patient access to medically necessary care by addressing in the CR-102 certain aspects of administratively burdensome prior authorization processes.

In this letter, we have:

- Recognized critical provisions from SB 5346 included in the CR-102.
- Identified WSMA-supported policies that are not present in the CR-102, but should be included in the final rule.
- Provided feedback on specific policy proposals from the CR-102.

Provisions of SB 5346 included in stakeholder draft

In 2009 the legislature passed SB 5346 designed to streamline and standardize administrative interactions between issuers and providers. SB 5346 gives the OIC clear authority to implement through rulemaking the sections of the bill that have not been voluntarily adopted by the industry to date. The WSMA is pleased to see key provisions from SB 5346 included in this rulemaking, including:

Extenuating circumstances

OIC proposal: Requires health issuers and their contracted agents to allow the retrospective review of services when an extenuating circumstance prevents a provider from obtaining a required prior authorization before a service is delivered. An extenuating circumstance is one where an issuer must not deny a provider's claim for lack of prior authorization if the services are otherwise eligible for reimbursement. At a minimum, the health issuer's policy must address:

- A provider or facility is unable to expect the need for the outpatient service in question prior to performing the service;

- The provider or facility is unable to identify from carrier or their designated or contracted representative to request prior authorization
- The provider or facility does not have enough time to request a prior authorization before and while performing a service; and
- The enrollee is discharged from a facility and insufficient time exists for institutional or home health care services to receive approval prior to delivery of the service.

WSMA comment: The WSMA is supportive of this provision, however, we request clarification around why the situation listed in subsection (a) is limited to the outpatient setting. The word "outpatient" should be removed, so that is applicable to all health services, regardless of setting.

We applaud the OIC for including "before and while performing a service" to the following provision: "The provider or facility does not have enough time to request a prior authorization before and while performing a service." It's the WSMA's understanding that this language would allow the extenuating circumstances provision to prohibit the *denial of covered, medically necessary services provided intraoperatively*. As discussed in previous WSMA comment letters in response to this rulemaking, surgeons can request prior authorization for a specific procedure and receive the approval, however, during the actual surgery, the surgeon may discover that an alternative surgical procedure is clinically necessary.

In instances like these, issuers deny payment for the procedure performed as it differs from the procedure initially authorized, and do not typically allow for appropriate latitude in the authorization process that reflects the clinical realities of the case. We applaud the OIC for including an extenuating circumstances policy that would allow for the retroactive approval of services like these.

We urge the OIC to apply the extenuating circumstances policy to all providers giving care to a patient under a carrier's plan, just not those that are in-network.

Capability to submit prior authorization requests electronically

OIC proposal: Requires health issuers and their contracted entities to have an electronic process that is browser-based to upload documentation and complete prior authorization requests.

WSMA comment: With modern electronic medical record technology, the exchange of trusted and vetted clinical information between provider and issuer is achievable and should be the foundation of any future prior authorization process. Efforts should be focused on data exchange and associated standards (such as ASC X12N 278 HIPAA) that would allow for a patient-centric model of prior authorization and place shared accountability for utilization management on both providers and issuers alike.

While requiring health issuers to provide an electronic, browser-based portal to facilitate prior authorization requests has merit as a short-term solution, the policy is shortsighted in light of recently developed clinical decision support and appropriate use criteria tools that are widely recognized as the future of prior authorization, with providers accountable for managing utilization at the point of care within existing practice workflows and processes. The OIC's proposal, if adopted, would require physicians and practice staff to navigate away from their practice management systems and to each issuer's individual webpage, obtain log-in information and learn to operate each unique system.

The WSMA is pleased, however, to see the inclusion in the CR-102, a requirement that the browser-based process be able to "complete" a prior authorization request, as opposed to merely "facilitate" and must allow for the "uploading of documentation." This change helps to address the current reality of web

portals, whereby physicians navigate as far as they can before they are prompted to call 1-800 numbers or fax patient medical records outside of the actual portal.

Timeliness

OIC proposal: Requires health issuers and their contracted agents to have written policies to assure that prior authorization determinations are made within appropriate timeframes for the following:

- Standard prior authorization requests: 5 calendar days after benefits have been verified and sufficient clinical information has been provided to the health issuer.
- Expedited prior authorization requests: 2 calendar days after benefits have been verified and sufficient clinical information has been provided to the health issuer.

WSMA comment: The WSMA is supportive of the standardized timelines under which health issuers must process and make a decision on prior authorization requests proposed in the initial stakeholder draft: 72 hours for *standard prior authorization requests* and 24 hours for *expedited prior authorization requests*.

The WSMA is concerned over the absence of a definition for "sufficient information." As currently proposed, the provision gives health issuers too much latitude in determining what it means for an application to be "sufficient." This is counter to the spirit of standardization and streamlining that the OIC hopes to achieve in this rule. We strongly urge the OIC to call out in this section the need for health issuers and their contracted entities to list all materials that would make a request "sufficient" in the online prior authorization system proposed in Subchapter D of this rule.

OIC proposal: Timeframes must be appropriate to the severity of the enrollee condition and the urgency of the need for treatment, as documented in the prior authorization request.

WSMA comment: We urge the OIC to strike this language in its entirety. In an attempt at standardization across payers, the OIC contemplates acceptable timeframes for approval in this rule. Permitting health carriers and their contracted agents to determine timeframes gives too much room for delayed notification or a determination.

Critical omissions from stakeholder draft that should be present in final rule

Clinical criteria in lieu of prior authorization, where appropriate

OIC proposal: Health issuers and their contracted agents must maintain a documented prior authorization program description and use medically acceptable clinical review criteria. The program must meet national certification standards such as those used by the National Committee for Quality Assurance (NCQA), Joint Commission, URAC and AAAHC in addition to the requirements in the proposed rule. The prior authorization program must include a method for reviewing and updating clinical review criteria.

WSMA comment: The WSMA is supportive of requirements that ensure health issuers are making decisions based on the most current consensus of medical literature.

When a provider can demonstrate, however, that they are utilizing nationally accepted, evidence-based appropriate use criteria or clinical guidelines produced by national specialty societies and nationally recognized utilization management organizations, prior authorizations should not be required.

In addition, health issuers should be required to list which national certification standards (NCQA or otherwise) their prior authorization program meets in the "online prior authorization system" contemplated in subchapter D of the CR-102.

OIC proposals and WSMA comment

Definitions

OIC proposal: Defines the terms *expedited prior authorization request, pre-determination request, pre-service requirement, prior authorization, standard prior authorization request* at WAC 284-43-0160.

WSMA comment: The WSMA supports definitions of *prior authorization* in WAC, and is pleased to see the definitions of *expedited prior authorization request*, *pre-determination request*, *pre-service requirement* and *standard prior authorization* included in this stakeholder draft.

We urge the OIC to strike the word "mandatory" in the first sentence in the definition of "prior authorization," as that word suggests prior authorization is required for all services. It is also redundant as the word "requires" is in the same sentence. Based on summaries of the proposed rule released by the OIC, the definition of prior authorization in this section would require that providers and facilities submit prior authorization requests to issuers, not patients. This is not clear in the rule and might lead to confusion for all parties involved; patients, health issuers, their contracted agents and providers. We caution against restricting the ability of a patient to submit a prior authorization request in situations where the patient might feasibly be able to submit the request more quickly than an administratively overwhelmed physician's office. The WSMA recommends that the OIC not restrict the ability of a patient to submit a prior authorization request.

Predetermination requests

OIC proposal: Requires health carriers and their contracted entities to have a method that allows physicians to request a predetermination when provided for by the plan.

WSMA comment: We encourage the OIC to clarify its intent around "when provided for by the plan" language. As written, this proposal seems to make the requirement to allow for predetermination both a mandate and/or optional at once.

Transparency and communication requirements

OIC proposal: Requires health issuers and their contracted entities to have a "current and accurate" online prior authorization system that is accessible to providers and facilities for the purposes of determining if a service is a covered benefit under the enrollee's health benefit plan and the information necessary to submit a complete a prior authorization request before delivering a service. Specifically, the online system must include sufficient information to determine:

- If a service is a covered benefit under the enrollee's health benefit plan;
- If a prior authorization request is necessary;
- If any preservice requirements apply; and
- If a prior authorization request is necessary, the following information:
    - The clinical criteria used to evaluate the request; and
    - Any required documentation.

WSMA comment: Transparency and communication requirements are critical components for streamlining prior authorization processes. We urge the OIC to strengthen this provision by clarifying that patient-specific formularies and benefit plans are to be made available by inputting a patient's plan identification number.

It is the OIC's obligation to clearly define "sufficient information," as the meaning may be very broadly interpreted.

We urge the OIC to clearly state what "written notification" means for this section. As previously discussed, fax machines should not be considered a sole method for contacting physicians.

We applaud the OIC for including services not requiring a formal prior authorization request, but which are still subject to medical necessity and pre-service criteria in this draft.

The proposal only requires access for "participating providers," when often times non-participating providers need this information before providing a service to an out-of-network patient. We encourage OIC to contemplate how non-participating providers can access this information.

OIC proposal: Requires health issuers to provide a clearly written notice of whether a prior authorization decision was approved or denied, with justification for the decision, including criteria for the denial. Written notice of the decision must give the true and actual reason and must be communicated to the provider or facility and the enrollee in clear and simple language so that the enrollee and the provider or facility will not need to resort to additional research to understand the real reasons for the denial.

WSMA comment: We support the inclusion of requiring a clear, simply written notice of whether a prior authorization decision was approved or denied and the basis for that decision. Key to this process is the requirement that issuers include the clinical criteria used to make the decision and we urge the OIC to keep this requirement in the final rule.

We encourage the OIC to contemplate specific forms of "written communication" that are satisfactory for the purposes for this rule. As example, 1980s technology, such as fax machines should not be utilized by health carriers and their contracted entities as the primary means for communicating with physicians and their staff.

For clarity, we urge the OIC to state in this section that the timeframes for these decision notices are subject to the timeframe requirements contemplated in this rule.

We are pleased to see a proposed requirement that a decision notice must include a phone number to contact the authorizing authority (so that physicians know who to contact to discuss the rationale for denying authorization for the requested service) and notice regarding the patient's appeal rights.

OIC proposal: Requires health issuers to notify providers and enrollees if the authorized facility or practice is out of network.

WSMA comment: We support the inclusion of this proposed communication requirement. Understanding whether a provider is in a patient's network allows patients to make informed decisions about when and where to receive the care they need.

We are supportive of the OIC's proposal to require health issuers to state whether the authorized service may be delivered by an out of network provider or facility, and disclose to the enrollee the financial implications for receiving care from an out of network provider.

Where an out-of-network service is permitted, these prior authorization rules should apply.

OIC proposal: If a prior authorization request from a physician is not accompanied by all necessary information, the issuer must tell the provider what additional information is needed and the deadline for its submission as set forth in the rule.

WSMA comment: The WSMA is supportive of this proposed policy and we urge the OIC to require health issuers to ***clearly*** specify what information is missing from the request at time of notification to the provider.

OIC proposal: Requires health issuers and their contracted agents to maintain a system of documenting information and supporting evidence submitted by providers and facilities while requesting prior authorization. Upon request, health issuers or their contracted agents must remit written acknowledgement of receiving of each document submitted in support of a prior authorization request. When information is transmitted over the telephone, health issuers and their contracted agents must provide written acknowledgement of the information communicated by the provider.

WSMA comment: The WSMA is supportive of policies that reduce administrative burden on providers by requiring health issuers and their agents to track what kind of information has been submitted in relation to a prior authorization request and making that information available to providers upon request.

Ability to submit a prior authorization at any time

OIC proposal: Requires health issuers or their contracted agent to allow a provider or facility to submit a request for prior authorization at any time, including outside normal business hours.

WSMA comment: The WSMA is supportive of this proposal. At the very least, reviews should be accepted during the business hours where the patient is located, not where the issuer or agent is located. Should the OIC adopt this recommendation, we would urge the OIC to require health issuers to begin processing (as opposed to merely accepting) a prior authorization within the business hours where the patient is located, especially for expedited prior authorization requests.

Insufficient information

OIC proposal: If sufficient information has not been provided to the health issuer or contracted agent to make a decision for:

- Standard prior authorization requests: health issuers or contracted agents have 5 calendar days to request additional information from the provider. The provider then has 5 calendar days to submit necessary information. Once a completed application is received, the health issuer or its contracted agent must make a decision and give notification within 4 calendar days
- Expedited prior authorization requests: health issuers or contracted agents have 1 calendar day to request additional information from the provider. The provider then has 2 calendar days to submit necessary information. Once a completed application is received, the health issuer or its contracted agent must make a decision and give notification to the provider within 2 calendar days.
- Extenuating circumstance: If the timeframes for approval of an expedited prior authorization are insufficient for a provider or facility to receive approval prior to the preferred delivery of the service, the prior authorization should be considered an extenuating circumstance as defined in WAC 284-43-2060.

WSMA comment: Requiring providers to respond within a set number of hours or calendar days is problematic, as many medical practices are closed on Saturday and/or Sunday, and up to three days for holiday weekends. As example, if a provider were to submit an expedited request on Friday morning and the issuer responded that the information was incomplete Friday evening, the 2-calendar day clock would have started and ended before the provider even returns to the office. Once the physician receives the notification from the health issuer, they must often review medical records, confer with other members of the care team, and circle back with the patient to collect relevant information. We recommend requiring physicians to respond with additional information within a set number of business days as opposed to hours or calendar days in order to allow the practitioner an appropriate amount of time to collect information.

It is critical that health issuers and their contracted agents be required to list components required to make a request "sufficient" in the online prior authorization contemplated under Subchapter D of this proposed rule.

The WSMA is supportive and appreciates the reference to extenuating circumstances in this section. Clarity around how the standard and expedited prior authorizations, in conjunction with the extenuating circumstances provision cover all patient conditions and circumstances is critical to the success of these rules.

Appeals process

OIC proposal: Prior authorization denials are an adverse benefit determination and are subject to the appeal process.

WSMA comment: An appeals process is a critical avenue for providers and patients to obtain authorization for a covered, medically necessary service after it was initially denied. For clarity, please identify which appeals process the OIC refers to in this instance.

Prior authorization program

OIC proposal: Health issuers must maintain a documented prior authorization program description and written clinical review criteria based on reasonable medical evidence. The program must meet national certification standards such as those used by the NCQA, joint commission, URAC or AAAHC and have staff that are properly qualified, trained, supervised and supported by explicit written clinical review criteria and review procedures.

WSMA comment on program description and written clinical review criteria: So that physicians and issuers alike are making decisions based on the most current consensus of medical literature, issuers should be required to utilize the most recent, nationally accepted, evidence-based appropriate use criteria or clinical guidelines produced by national specialty societies and nationally recognized utilization management organizations, and we are supportive of this provision.

The language in this section reads like health carriers would be required to meet the standards of all accrediting bodies listed in the rule as examples. If this is not the OIC's intent, please make clear that a health carrier must be accredited by only one such entity.

As the stakeholder draft does not contemplate an active enforcement mechanism, we urge the OIC to require that health issuers list which national certification standards their prior authorization program meets in the "online prior authorization system" contemplated in Subchapter D of the stakeholder draft.

We also urge the OIC to fully name the following national accreditation organizations in the statute, as opposed to only referencing their condensed names or acronyms; Joint Commission, URAC, AAAHC.

In addition, the online system must make certain sufficient information available for physicians and patients. This is critical information that physicians need before providing a service or submitting a request for authorization, and we urge the OIC to further streamline and modernize the prior authorization process by requiring health carriers and their contracted entities to provide for searching for specific benefit, formulary and plan information by patient identification number for that plan.

WSMA comment on staff that are properly qualified, trained, supervised: While health issuers would be required to use staff that are properly qualified, trained, supervised and supported by explicit written clinical review criteria and review procedures, the OIC does not expressly state what it means to be properly "qualified, trained and supervised." To ensure a fair process for patients, and continued standardization, we urge the OIC to define these criteria to ensure that qualified professionals are making decisions concerning patients' health care in Washington state.

Medical records

OIC proposal: Prohibits health issuers from routinely requesting copies of medical records, and permits access only to the portion of the medical record necessary in that specific case to certify, for the service requested, the medical necessity, appropriateness of an admission or extension of stay, and frequency or duration of service. Also, each issuer would be required to reimburse reasonable costs of medical record duplication for reviews.

WSMA comment: The WSMA supports this proposal. We urge the OIC to state that this requirement is not waivable by carriers or their contracted entities as part of payment contract negotiations.

Issuer agents

OIC proposal: Clarifies that an issuer's obligation to comply with these requirements is non-delegable; the issuer is not exempt from these requirements because it relies on a third-party vendor or subcontracting arrangement for its prior authorization program.

WSMA comment: The WSMA is supportive of this provision.

Communication of new requirements to physicians and other treating providers

OIC proposal: Treats changes to prior authorization procedures as a change to provider contract as the term is used in Chapter 284-170 WAC and must be made as amendment.

WSMA comment: The WSMA supports this proposal and encourages the OIC to use language that makes clear that changes to prior authorization procedures **are** a change to the provider contract, and therefore **are subject to the requirements** of Chapter 284-170 WAC as opposed to more passive "as the term is used in Chapter 284-170 WAC" language.

In addition, the OIC should specifically refer to the appropriate "hold harmless" provisions at WAC 284-170-421 so that health issuers and providers alike understand obligations of both parties.

Prior authorization expiration

OIC proposal: Prior authorization determinations do not expire for 45 days following the date of approval.

WSMA comment: The WSMA supports standardizing expiration dates across issuers. As some physician specialties have long lead times for scheduling services, the WSMA recommends expanding the expiration to 90 days following date of approval.

OIC proposal: When an enrollee must change plans due to an issuer's market withdrawal, the patient's new issuer must recognize the prior authorization of the previous issuer (for up to 30 days or the expiration of the authorization, whichever is longer), and ensure that the enrollee receive the services that were previously authorized as an in-network covered service.

WSMA comment: The WSMA is supportive of efforts to ensure continuity of care for patients that are forced to change insurance plans due to an issuer's market withdrawal.

OIC proposal: Issuers must have a process that allows specialists the ability to request a prior authorization for diagnostic or laboratory services based upon a review of medical records in advance of seeing the enrollee.

WSMA comment: The WSMA is supportive of this provision that seeks to relieve travel and other kinds of burdens on patients by allowing specialists to order services in advance of seeing a patient, upon review of the medical record.

Enforcement
We recommend that the OIC develop an active enforcement mechanism and standards in order to ensure best application of the rules. Going forward, the industry needs the establishment of uniform standards and monetary penalties for failure to comply.

The WSMA applauds the OIC for seeking to improve patient access to care by addressing administratively burdensome prior authorization processes in Washington state. If finalized as proposed (with necessary clarifications), this rule would be a strong step in the right direction toward making sure consumers of health care have access to the services they purchased and physicians are not unduly burdened in providing that care.

We appreciate your consideration of these comments. For questions, please do not hesitate to contact Jeb Shepard at jeb@wsma.org.

Sincerely,

Jennifer Hanscom, Executive Director/CEO

cc: WSMA Executive Committee
Kathryn Kolan, JD, Director, Legislative and Regulatory Affairs