From:	Sydney Zvara
To:	OIC Rules Coordinator; Freeburg, Jim (OIC)
Subject:	AWHP Ltr Re: Proposed rulemaking on prior authorization processes and transparency (R2016-19)
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Attachments:	08-09-16 OIC Prior Auth Draft Rule - Comment Ltr.pdf

The Association of Washington Healthcare Plans

August 9, 2016 Transmitted electronically to
rulescoordinator@oic.wa.gov

Jim Freeburg
Special Assistant to the Commissioner
Washington Office of the Insurance Commissioner
5000 Capitol Blvd. SE
P.O. Box 40258
Olympia WA 98504-0258
Re: Proposed rulemaking on prior authorization processes and transparency (R2016-19)

Dear Jim,

On behalf of Association of Washington Healthcare Plan (AWHP) member healthcare plans, thank you for the opportunity to provide input regarding the Washington Office of the Insurance Commissioner's (OIC) draft rule related to prior authorization processes and transparency.

First of all, we want to express our appreciation for the OIC's recognition of prior authorization as an important utilization management tool to help ensure safe, appropriate, high-quality care for patients, and the wise use of health care resources. We also appreciate the process used by the OIC to make sure all voices and perspectives have a chance to be heard on this proposed rulemaking topic.

Keeping in mind the vital role that prior authorization plays in serving the best interests of consumers, we hope your office will strongly consider the following key points and recommendations.

- **What specific administrative and transparency problems are believed to exist and how are the proposed regulatory changes intended to fix them?** It is difficult to evaluate the potential effectiveness of the proposed requirements without first understanding the specific problems or barriers at which they are targeted. This is especially pertinent because the proposed rules appear to go well beyond the stated intent. We ask that the OIC clarify

what specific problems it is seeking to fix and how the proposed requirements will resolve them.

- **Streamlining of the prior authorization process cannot be achieved by carriers alone, but rather requires a collaborative effort on the part of both providers and carriers.** The burden for ensuring a streamlined and efficient process cannot be imposed on one side of the equation only. We are concerned that the proposed rules place the majority of the administrative burden on carriers. The proposed rules require carriers to conduct the intake review for all requests, as well as provide notification about deficiencies, within a very short timeframe. This accomplishes nothing in the way of encouraging complete, well-documented review requests from providers. Instead, this one-sided burden rewards poorly supported, incomplete requests and penalizes the enrollee by increasing carriers' administrative costs. We recommend amending the proposed rules to create a more balanced approach that encourages provider submission of well-documented, well-supported prior authorization requests and provides for more equalized turnaround requirements.

- **WAC 284-43-0160 (New Definitions)** The proposed rule creates a redundant and confusing set of definitions. The proposed new definition of "Standard prior authorization request" is the same as the definition of "Nonurgent preservice review request" in 284-43-2000. This is confusing because a single type of request will be defined twice, and will have requirements in two different rules under two different names. We also note that contractually required prior authorizations are already subject to several stringent federal and state rules, in particular for "pre-service claims." Sweeping voluntary prior authorization requests into the same category for turnaround times and other requirements creates confusion about which rules apply. It also increases administrative burdens and costs.

  Definition conflicts also appear when the proposed draft definitions are compared against the current review definitions in WAC 284-43-2000. They do not match and create confusing consequences. By way of example, subsection (1) (b) does not take into consideration that a facility for a proposed service may not yet be known. This is even more significant in draft subsection (4) where the enrollee may not yet have been seen by the specialist.

  We recommend that the OIC resolve the above definition issues and conflicts.

- **WAC 284-43-2050 (New Section)**

  (1)(a) The proposed requirement for carriers to supply the provider and enrollee with the name and credentials of the person approving or denying their request is burdensome and inappropriate. It is unclear why the OIC would require the identity of the person making the prior authorization decision and what the OIC would gain as a result of obtaining that information. For integrated care delivery systems, this requirement has an additional unintended consequence because the

administrative reviews are done by actively practicing physicians within those integrated care delivery systems. If provided this additional level of detail, patients may directly reach out to the reviewing physicians rather than using the appeals process. We request elimination of this requirement.

(2) Emergency medical care does not require prior authorization. Accordingly, we strongly object to the proposed requirement for 24/7 reviewer staff availability. This increased administrative cost for non-emergency, preplanned medical services is unnecessary and will significantly increase carrier administrative costs which will ultimately be borne by consumers in the form of premiums. WAC 284-43-2000(6)(b) (iv) currently allows five calendar days for a routine pre service claim determination which is a more reasonable time period for making routine prior authorization determinations. We urge the OIC to eliminate the 24/7 reviewer availability requirement for non-emergency medical services.

(3) Especially considering that this rule is still in the Stakeholder Draft stage, January 1, 2017 is a very short timeframe for requiring creation of an interactive prior authorization website by carriers who do not already have this capability in place or are not using OneHealthPort. It is also unclear as to what specifically is meant by "interactive." We recommend the OIC provide more reasonable lead time, such as requiring the interactive website by July 1, 2017. In the event the OIC sees pressing reasons for a January 1, 2017 date, we would appreciate understanding what those pressing reasons might be; and would suggest adding a provision to allow carriers to apply for a grace period/safe harbor for building the interactive website. Also, please clarify OIC expectations related to an interactive website. Further, while carriers support electronic solutions, some have found the provider community reluctant or unwilling to implement them. If carriers are required to uniformly implement a costly web-based prior authorization tool, carriers should have the authority to require participating providers to use the tool.

(4) Asking carriers to give prior authorizations for courses of treatment without assessing medical necessity before the specialist even sees the enrollee is problematic. It is reasonable to expect that, upon seeing the enrollee, the specialist may determine that a different course of treatment is advisable. We recommend eliminating this requirement from the proposed rule.

(6)(a)(ii) To align with NCQA definitions, we recommend adding language to clarify that 24 hours = 1 calendar day.

(7) The proposed 45-day validity period for prior authorization means an individual could have dropped coverage and not paid premiums for two months and yet still is entitled to receive benefits for the pre-authorized services --- including for voluntary benefit determinations. It also does not take into consideration circumstances in which the enrollee may have changed carriers. Please clarify

whether this is consistent with the OIC's intent for this rulemaking. We recommend at least adding a provision to this section that address loss of eligibility under the plan, as well as a change in carriers, and allows a carrier to revoke the prior authorization in these instances.

(8)(c) The proposed rule prohibits the routine collection of diagnosis and procedure codes to be considered for authorization. It is important for carriers to know and understand precisely which procedure is being performed and the diagnosis and condition. This is necessary to conduct a medical necessity review and it helps facilitate payment of claims after the authorization has been approved. The use of diagnosis and procedure codes provides clarity for the provider and carrier and ensures both the parties have the same understanding of the proposed treatment. Simply relying on narrative descriptions can result in unintentional miscommunications and incorrect decisions by both parties. We recommend eliminating this prohibition.

(8)(f) The proposed rule requires review determinations to be based solely on the medical information obtained by the carrier at the time of the review. This is not in the best interest of the enrollee's safety and well-being. Carrier's routinely use all available information in the member's file to make prior authorization determinations. Furthermore, if a carrier is prohibited from using valid information that is already contained in its file, then this could lead to delays and unnecessary request for additional information from the provider. We recommend removing this limitation.

(9) The proposed rule requires a carrier to reimburse reasonable cost of medical record duplication fees. Reimbursement for cost of medical records is often addressed in the provider's network participation agreement. We suggest this requirement be removed when the contracting parties have already reached a contractual agreement on the methodology for payment of medical records.

(11) The proposed rule does not make clear who is responsible for determining the services were pre-authorized and for furnishing the documentation and details. To help avoid confusion, we recommend clarifying these responsibilities.

Of greater concern is the requirement to provide such pre-authorized services as being in-network. The new carrier's network may not include all the same providers as the previous plan's network, thus necessitating a change in providers; if the enrollee chooses not to make such a change, the carrier cannot ensure in-network coverage. Additionally, the new carrier should be allowed to apply reasonable criteria in evaluating a previous carrier's prior authorization. We recommend narrowing the scope of the requirements related to honoring a previous carrier's prior authorization.

(14) Requiring a carrier to amend its provider agreements every time its prior

authorization procedures change is unreasonably broad and incredibly burdensome. Details of prior authorization procedures are not included in carrier provider agreements. Also of concern is the implication that making any changes to prior authorization procedures will require OIC approval because carriers have to file provider contract changes with the OIC. Accordingly, anytime the OIC creates a prior authorization rule, this means all carriers would have to refile contract templates. Another consequence might be that benefit coverage for newly available medical treatments that warrant prior authorization will be delayed until it is practical to amend the provider contracts. For these reasons, we recommend eliminating this proposed requirement.

We look forward to further discussion and working collaboratively with you on this rulemaking effort. In the interim, please do not hesitate to contact me if I can be of assistance.

Sincerely,

Sydney Smith Zvara
Executive Director

Association of Washington Healthcare Plans
7252 Fairway Ave SE, Snoqualmie, WA 98065
Tel: 425-396-5375 Fax 425-396-5372 www.AWHP-Online.com

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