August 17, 2016

Jim Freeburg
Office of the Insurance Commissioner
PO Box 40258
Olympia, WA 98504

Delivered via electronic mail
Attention: Rules Coordinator

RE: Rule Number 2016-19 Prior Authorization Processes

Dear Mr. Freeburg,

Thank you for the opportunity to review the stakeholder draft of Rule number 2016-19 regarding Prior Authorization Processes. On behalf of Molina Healthcare, please find the following comments for consideration.

WAC 284-43-0160
Definition of "Expedited prior authorization request"

Molina's Comments:
The proposed rule sets forth a definition for "expedited prior authorization request" which uses the same verbiage as the definition for "urgent care review request" currently found in WAC 284-43-2000. This may create a conflict as the two terms appear to have differing turnaround time requirements. Our recommendation would be to mirror existing requirements, language and turnaround times.

WAC 284-43-2050
(1)(a) "The decision must include the name and credentials of the individual who had the authorizing authority to approve or deny the request."

Molina's Comments:
Molina believes this requirement may create a personal safety risk to the authorizing individual for no clear benefit to the member. Molina has received threats to harm or kill made against staff in the past as a result of denials; therefore, we request that this requirement be removed from the draft rule. However, we recognize the need for

providers to be able to reach a direct contact; we suggest replacing the language to require including a phone number to the applicable department.

WAC 284-43-2050
(2) "Issuers that require prior authorization for any covered service must accept and process a prior authorization request from participating providers at any time, including outside normal business hours"

Molina's Comments:
Molina believes that clarification on the intent and meaning of "process" is needed. Currently, Molina has the ability to "accept" a prior authorization request through our provider portal, as well as via fax or email 24 hours a day/7 days a week. The authorization request is then reviewed within the required timeframes. Molina's recommendation is to remove "process" from this section. If the intent of this section extends beyond having the functionality for providers to submit prior authorizations outside of business hours, we would have additional concerns.

WAC 284-43-2050
(6) "Timeframes for issuer review determination and notification are as follows"

Molina's Comments:
For Managed Care Organizations, this draft rule creates a fourth standard for timeframes; other standards include the National Committee for Quality Assurance, Centers for Medicare & Medicaid Services and the Health Care Authority. To create administrative simplification, Molina respectfully requests that the OIC align the timeframes set forth in this rule with another recognized industry standards.

WAC 284-43-2050
(7) "Prior authorization determinations shall expire no sooner than 45 days from date of approval. "

Molina's Comments:
Molina believes additional clarification is needed for this section to address members who are within a grace period due to non-payment of premiums.

WAC 284-43-2050
(8)(c) "Not routinely require providers or facilities to numerically code diagnosis or procedures to be considered for authorization, but may request such codes, if available; (d) Not routinely, require request copies of medical records to render authorization"

Molina's Comments:

Molina requests that this provision be removed. Codes are needed to clarify the services requested within a Prior Authorization request, without these codes the request can be too vague. Additionally, Molina's technical system to log the Prior Authorization is built around diagnosis and procedure codes.

WAC 284-43-2050
(9) "Each issuer must reimburse reasonable costs of medical record duplication for reviews."

Molina's Comments:
Molina requests that this provision be removed. The added cost to the issuer is not reasonable. Furthermore, Molina's contracts with participating providers are inclusive of any record duplication fees.

WAC 284-43-2050
(11) "In limited circumstances when enrollees have to change plans due to an issuer's market withdrawal, subsequent issuers must recognize the prior authorization of the previous issuer and ensure that the enrollee receives the services that were previously authorized as an in-network covered service."

Molina's Comments:
Molina respectfully requests that this requirement be removed and to be replaced with a section directing continuity of care practices to be followed as appropriate. Molina has concerns with abiding by potentially substandard prior authorization decisions made by previous issuers.

WAC 284-43-2050
(12) "A carrier need not use medical evidence or standards in its prior authorization of religious nonmedical treatment or religious nonmedical nursing care."

Molina Comments:
Molina believes this section needs additional clarity including the definition of "religious nonmedical treatment" and "religious nonmedical nursing care" and which services would fall under those categories.

We appreciate the opportunity to work collaboratively with the OIC in proposed rulemaking. We also would like to thank you for the opportunity to participate in the Stakeholder Meeting held on August 10th. We found it extremely valuable and provided additional context around the OIC's intent in Rule making, which we found very helpful.

Thank you for your consideration of Molina's comments, and if there are any questions we would be happy to discuss if needed.

Sincerely,

Gretchen Gillis
Manager of Government Contracts
Molina Healthcare of Washington

CC:
Julie Lindberg, VP of Healthcare Services
Will Rivera, Director of Healthcare Services
Lisa Moore, Contract Specialist