Providence Health & Services
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August 17th, 2016

Jim Freeburg
Washington State Office of the Insurance Commissioner
P.O. Box 40258
Olympia, WA 98504-0255
Submitted via email: rulescoordinator@oic.wa.gov

Dear Mr. Freeburg:

Re: Request for Public Comment on Prior Authorization Process, Stakeholder Draft Rules

On behalf of Providence Health & Services, I want to thank you for the opportunity to provide comments on the prior authorization process. As previously stated, we appreciate the effort staff is undertaking to get multiple perspectives on opportunities to streamline prior authorization through this stakeholder engagement process, as this issue is of great importance to our caregivers and patients. Upon participation in the June 28th and August 10th stakeholder meetings, and in response to the first stakeholder draft language, we offer the following comments so that they may be considered as this work moves forward.

Providence Health & Services ("Providence") is a not-for-profit Catholic health care ministry committed to providing for the needs of the communities it serves – especially for those who are poor and vulnerable. In Washington state, Providence and our affiliated partners – Swedish Health Services, Pacific Medical Centers and Kadlec – comprise 15 hospitals, 376 physician clinics, senior services, supportive housing, hospice and home health programs, care centers and diverse community services. The combined health system employs more than 40,000 people statewide. In 2015, Providence and our partners provided nearly $450 million in community benefit, including $297 million in unfunded costs of Medicaid and $54 million in free and discounted care[1] for Washingtonians who could not afford to pay. Together, we are working to improve quality, increase access and reduce the cost of care in all of the communities we serve.

After reviewing the language included in the stakeholder draft, we respectfully submit the following questions and information shared by Providence Health & Services (including its affiliates listed above), Providence Health Plan (a registered health care service contractor) and the Providence-Swedish Health Alliance as our Accountable Care Organization (ACO).

Prior to undertaking this review, we have agreed on the following priorities or guiding principles as a system, which we also stated in our June 17th letter:

[1] Data is consolidated for Providence and our affiliates based on financial reporting.

- Improve transparency and encourage seamless processes through better use of technology, while providing flexibility in requirements to acknowledge technological limitations and costs
- Decrease confusion by outlining clear requirements for communicating changes to providers
- Balance the need for expedited approval process in extenuating circumstances with unintended consequences for the patient
- Streamline the appeals process
- Require insurers to consider medical necessity when setting prior authorization policies
- Allow for alternative arrangements between health plans and providers to the traditional prior authorization process, while considering how to mitigate unintended consequences of these arrangements

We believe the stakeholder draft represents significant progress towards a majority of these goals, and applaud the OIC staff for striking a balance between different stakeholder priorities and interests. For details on the priorities above, please refer to our June 17th letter.

One area of note continues to be the appeals process, and in addition to our specific comments provided in the table below, we would like to have a more robust conversation regarding the use of the appeals process and how this may be addressed in further drafts of the prior authorization rules.

Section of proposed rule	PH&S Comments
New definitions - WAC 284-43-0160 - "Prior authorization"	Providence appreciates the OIC's attention here to medical necessity, appropriateness, and level of care, which we believe is intended to ensure the patients' best interests are at the center of this process. We do request clarification on the language "in relation to the applicable health plan." Can the OIC clarify what is meant by this language and what the expectations are for the level of standardization for the process across plans, versus what will be left to the carrier's discretion?
New definitions - WAC 284-43-0160 - "Expedited prior authorization request"	Providence is supportive of this definition, although we do agree, as other stakeholders pointed out during the August 10th meeting, that this definition seems to very closely mirror existing definitions for emergency services which do not (and cannot) require prior authorization. With that in mind, current practice is that the provider usually defines what is expedited, which we believe is preserved in this current definition. As this process moves forward, we want to ensure this definition continues to allow this flexibility for providers to make that determination. In the August 10th stakeholder meeting, the issue was raised that the cases that would meet this definition.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (1)	We support the requirements to ensure information is available online, and submitted comments requesting such language be included in these rules. We do however have concerns with the language "as mutually agreed to by all parties." It is unclear which parties are included in this reference, and if the intent of this paragraph is ultimately to standardize the information available online, we request that this language be stricken from this section as to increase clarity on what is required of insurers.

Section of proposed rule	PH&S Comments
	We have two additional requests for clarification in this section: • "Sufficient information" is undefined – we would prefer there to be clarity on what is expected, and will be exploring whether we have any best practices to share that have worked across our system. • Because out of network benefits require prior authorization as well, we request that the OIC require information is available online to non-participating providers in addition to participating.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (1) (a)	PH&S supports what we believe is the intent of this language; that a patient is able to get ahold of an individual with decision-making authority over prior authorization determinations when needed. However, we have concerns with the language as stated which would require specific identifying information on the individual that a patient could use to harm the staff member who made the determination. To protect against such extreme circumstances, we would prefer that the language be changed to allow for less identifiable information – such as requiring instead the first name and fist letter of the last name for the individual who had the authorizing authority, or their employee number, along with contact information for the specific department making prior authorization decisions. We are also supportive of requiring that the credentials of the individual be included. This ensures patients have access to individuals, rather than a generic help line, that have decision-making authority and also protects our employees against extreme circumstances.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (1) (b)	While we agree with the intent for there to be increased information for patients seeking care that is then out-of-network, we have many concerns with the language as drafted that we think could complicate the process and add significant administrative burden to prior authorization requests without providing significant clarity from a patient perspective. For example, while the provider could be in-network, the facility may not be, and it's possible that the notification would lead a patient to believe that more of the costs would be covered then when the claim is processed. We request that this language be stricken, and that these issues be addressed in the larger conversations that are currently taking place regarding balance billing. We look forward to having further discussions about the intent of this language and possible solutions.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (2)	Providence had previously submitted comments in favor of 24-hour access to some type of submission system whereby forms can be submitted by a provider, but the language as written may be interpreted differently. We believe the intent of this language as written is to ensure 24/7 ***submission*** capability, and we applaud the requirement that there be a way for providers to submit requests 24 hours a day, 7 days a week. However we are concerned about the inclusion of the term "process" which is undefined and could be interpreted to mean requests are reviewed 24 hours a day. For pre-planned services meeting the definition of "standard prior authorization request", 24/7 reviewer availability is not necessary or appropriate, and would add tremendous costs to the health care system. If a services is needed urgently, or is emergency, the service is covered under the Urgent or Emergency

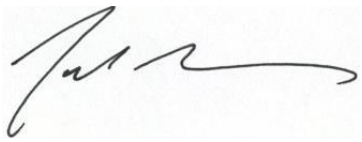
Section of proposed rule	PH&S Comments
	Service benefit. We request that the term "process" be eliminated to avoid this confusion.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (3)	While we are supportive of an online processing mechanism, as demonstrated in our comments to the OIC, the term "interactive process" is undefined, and may be subjective. Are there minimum specifications the OIC will require to meet this regulation?
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (4)	We have two concerns with this section: • Product design requirements could interfere with this statement. Currently, Providence offers products that require referral from a primary care physician or medical home to be on file before a specialist prior authorization is accepted. We request that the language be written to allow for this practice, which we believe is important for continuation of patient choice among different health care options. • We believe there may need to be a small tweak to the language to ensure compliance with HIPPA. How does this statement comply with HIPPA rules since member may not have signed that records could be released to a provider they haven't seen yet? Perhaps the inclusion of "as requested by the enrollee" so the new language would read: *Issuers must have a process that allows specialists the ability to request a prior authorization for a clinically recognized course of treatment based upon a review of medical records in advance of seeing the enrollee and* ***as requested by the enrollee****.*
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (5)	We believe this is a confusing reference in conjunction with subsection (6) of this same section. The "timely manner" appears redundant with the more precise timelines outlined further in the chapter.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (5) (b)	This section outlines that the issuer must "tell" the provider, but no method of communication is specified. Are there minimum standards for this notification or options that the OIC would deem appropriate for this notice?
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (6)	During the August 10th stakeholder meeting, OIC staff clarified that this is meant to be 72 consecutive hours, rather than 72 business hours. We request that this clarification be made explicit in the language. Will there be exceptions made for holidays or weekends? We believe this will require additional resources to implement within our health plan, as we do not currently staff weekends and holidays. However, we are also aware that this may have a positive impact on both our patients and our caregivers. Therefore, we are undergoing financial analysis to attempt to assess both the costs and opportunities associated with this change in timeline on our system, and can provide that information in the next round of stakeholder feedback.
Utilization Review and Prior Authorization - WAC 284-43-	For expedited authorization requests, the language as written would change the allowable time frame from 48 hours to 24 hours. We understand from the August

Section of proposed rule	PH&S Comments
2050 – subsection D part (6) (b)	10th stakeholder meeting that this is 24 consecutive hours. How are weekends and legal holidays to be considered? As with our comments in the previous section, this change would result in a significant administrative burden on our health plan to implement. This comment also applies to the draft language in section (6) part b) ii) and section (6) part b) ii) B).
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (7)	Authorizations are often built based on the time frame provided by the requesting provider and may be 30 days in some cases. In order to allow for this flexibility, we request that the language be changed to read: *"Prior authorization determinations shall expire no sooner than 45 days from date of approval,* ***unless a shorter time frame is requested by the provider submitting the request."***
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (8) (a)	The term "reasonably reliable source" is undefined. We were glad to hear this issue highlighted in the August 10th stakeholder meeting, and understand that this is an issue that warrants further discussion. We are currently examining ways in which this can be defined which we could implement across our system, and can provide that information during the next stakeholder comment period.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (8) (c)	Providence does not have an issue with this current language, as long as it continues to allow for the submission of a written diagnosis from the provider, as this information is a required field to build the authorization for review.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (8) (d)	We request clarity on this section, as we are unsure of the intent. We do currently require clinical documentation to render a clinical decision – would this be interpreted as violating this regulation?
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (8) (e)	We request that the OIC clarify the intent of this language. Does this language also encompass inpatient concurrent reviews?
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (8) (f)	Stakeholders raised the issue that this language may restrict the types of information that are used to get a more complete picture of the patient's needs in a prior authorization determination. We agree that this language here appears to be too restrictive. A patient's medical history, for example, could be important when considering prior authorization for a service.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (9)	We believe this language is not consistent with current practice, which allows this issue to be negotiated through provider specific contracts. How is "reasonable costs" defined? If the documents are part of the original submission, does it count as "duplication"? To avoid this confusion, we recommend that the OIC consider striking this language.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (10)	We appreciate this language and applaud the OIC for including rules that hold third party administrators accountable.
Utilization Review and Prior	We appreciated the robust discussion this issue generated in the stakeholder

Section of proposed rule	PH&S Comments
Authorization - WAC 284-43-2050 – subsection D part (11)	meeting. As mentioned, Providence is supportive of the concept to find a way to hold the patient harmless in this scenario. However, we are concerned that with today's shifting marketplace, the way this is written holds the wrong party accountable for previous decisions made by another plan. Is there a way to require the plan that approved the service to pay for all services approved through a certain date from their exit of the market? If finalized as written, this could put carriers in a precarious market in a risky financial position if required to cover costly services approved by another plan. We would like to continue discussing with the OIC how we may find a solution that would avoid putting the patient at risk and putting the new carrier at a financial disadvantage.
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (12)	We request clarification on what constitutes "reasonable medical evidence" in this scenario. We also request clarification regarding the exception for use of medical evidence when deadline with "prior authorizations of religious nonmedical treatment or religious nonmedical nursing care." What is the intent of this language and how is it applied today according to utilization review regulations?
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (13)	We request clarification as to whether this would require all health plans to be NCQA certified for the state of Washington?
Utilization Review and Prior Authorization - WAC 284-43-2050 – subsection D part (14)	While we are supportive of the intent to require notification of substantive changes to prior authorization, we are concerned that there seems to be no threshold set here for

Again, we thank you for the opportunity to provide our comments on the issues under consideration. This work requires balancing many valid interests and diverse stakeholders, and we look forward to being an effective and engaged partner in the work ahead. For more information, please contact Lauren Platt, State Advocacy Program Manager, at (425) 525-5734 or via e-mail at lauren.platt@providence.org.

Sincerely,



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