Washington State Hospital Association

August 10, 2016

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

Re: Comments Regarding Prior Authorization Stakeholder Draft

Dear Mr. Freeburg,

On behalf of our 101 hospital and health system members, the Washington State Hospital Association appreciates the opportunity to comment regarding potential rulemaking by the Office of the Insurance Commissioner (OIC) on prior authorization practices in this state.

We are pleased that the OIC is willing to consider rulemaking regarding prior authorizations. There has been a tremendous increase in the number of prior authorizations required by health plans. Our hospitals believe that many of these are not evidence- based or aimed at reducing unnecessary costs, but simply adding to administrative burden.

We have attached specific comments on the draft, in the order of the current draft. Thank you for addressing a number of issues raised in our previous comments. We hope, though, you will also consider addressing some of the additional concerns. We recognize that some of our issues may have not been addressed simply because of timing issues with the issuance of this version of the draft

Thank you for considering our additional comments. If you have questions, please contact Andrew Busz, WSHA Policy Director, Finance at andrewb@wsha.org or (206) 216-2533.

Claudia Sanders
Senior Vice President
Policy Development

Andrew Busz
Policy Director, Finance

Specific WSHA Comments Regarding Current Stakeholder Draft Rules

Our comments are presented using the order the items appear in the draft rules. Our comments refer to but do not repeat the detailed comments we previously provided.

New Definitions

'Expedited Prior Authorization Request". We believe the list of circumstances where a request for expedited review must be honored by a plan is much too limited. Delays in care due to prior authorization requirements impede the flow of care and have significant cost to patients and providers. We restate our previous comments and request that the OIC: 1) expand the set of circumstances requiring expedited review, 2) provide a retrospective review process for cases where services needed to be provided before authorization could be obtained, and 3) require a standardized process and criteria for consideration of extenuating circumstances.

Utilization Review and Prior Authorization

Online access to criteria. The proposed language requires that "Issuers must make sufficient information available online to participating providers or as mutually agreed to by all parties so that, prior to delivering a service, providers will be able to determine whether a service is subject to prior authorization." This requirement is limited to requiring transparency of what services require review. We ask that the language for this section be modified to reflect the requirements of House Bill 1471, which requires that effective January 1, 2017, "A health carrier shall post on its web site and provide upon the request of a covered person or contracting provider any prior authorization standards, criteria, or information the health plan uses for medical necessity decisions." Please see our detailed comments submitted previously.

The proposed language requires "When a provider makes a request for the prior authorization, the notice must be clear and explain if it is approved or denied and the justification for the decision, for example the prior authorization is denied because the service is a non-covered benefit." We would appreciate additional clarity. If a request is denied due to not meeting medical necessity criteria, we think the OIC should require that the issuer provide an explanation of the specific criteria the service failed to meet.

Response time frames for expedited review. We appreciate the OIC's efforts to establish reasonable time frames for responses for expedited review requests. An expedited process prevents risks of delays to care. The OIC process includes a step where the issuer requests additional information and specifies that the additional information must be provided within 24 hours. We are concerned that in some circumstances it may be difficult for providers to have any additional information related to an expedited request within this time frame. It may be particularly difficult if the criteria were not available from the issuer prior to the request, or if the provider must obtain information related to prior services from other providers. The failure for a provider to meet this time limit may result in cancellation of expedited requests by the issuer. We ask that instead, providers be required to make a best effort to provide the additional information as soon as possible, generally within 24 hours of the request from the issuer. The issuer would then make a decision within 24 hours of receipt of the additional information.

As mentioned in the new definitions section, there are cases where services must be provided before an expedited or standard prior authorization review process can be completed. We ask that in these cases, services be covered if determined that the medical necessity criteria was met. Please see our previous comment letter.

Limits to information requested for review. We appreciate the language that limits issuers to requesting only the specific information needed to make a determination of the prior authorization request. Historically this has been a significant issue as some issuers have been reluctant to disclose their medical necessity criteria and pre-service requirements. We believe this limitation is good and consistent with the expectations under House Bill 1471.

Accountability for benefit manager and vendor review arrangements. We are pleased with OIC's interest in making issuers more accountable for authorizations obtained through third-party vendors, review organizations, or benefit managers. We believe the draft language is confusing. We believe the language should be modified to say, "An issuer must ensure *that its subcontractors* comply with the requirements of this section. An issuer's obligation to comply with these requirements is non-delegable; the issuer is not exempt from these requirements because it relied upon third-party vendor or subcontracting arrangement."

Transferability of prior authorizations. We support the proposed provision that in the limited cases where enrollees must change plans due to an issuer's market withdrawal, the new issuer must honor any authorizations made by the previous issuer. We would like more information on how the OIC would interpret and enforce this provision, as there may be differences in opinion regarding what situations would constitute a market withdrawal. For example, would this would apply if an issuer were to stop offering a particular policy type or a program affecting enrollees, but remained in the market? There is a level of risk for both patients and providers if services are provided in good faith, but the authorization is not honored by the successor issuer.

Requirements for prior authorization programs. We appreciate the proposed language requiring that an issuer's prior authorization program description and written clinical review criteria be based on reasonable medical evidence. We believe, however, that this still gives issuers too much latitude in establishing requirements that may not be medically justified. We are concerned about the proliferation of new requirements that appear to do little more than add administrative burden and delay care. We again request a requirement that issuers demonstrate that any new requirement is needed and would reduce non-medically necessary services. See our previous comment letter for more detail.

Contractual notification. We appreciate the proposed language that clarifies that the imposition of new prior authorization requirements is a material change to payment and service delivery and subject to the notification requirements governing changes to provider contracts.