The Association of Washington Healthcare Plans

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RE: R-2016-19 Prior Authorization and Transparency
Comments on Stakeholder Draft (September 2016)

Dear Jim,

Thank you for the opportunity to comment on the proposed stakeholder draft issued on September 23, 2016. On behalf of the Association of Washington Health Plans and its constituent members, please accept these comments, which we hope will help the Commissioner arrive at proposed rule language that fulfills the express scope and mission of the CR101: "In an effort to facilitate access to covered services, the Commissioner wishes to standardize the process of prior authorization when such a program is in effect. These rules are intended to streamline the prior authorization process and to ensure it is more transparent for consumers and providers."

Our comments focus on three major aspects of the stakeholder draft. The proposed rules would:

- materially increase administrative costs for both providers and issuers;
- conflict with One Health Port's best practices recommendations and NCQA requirements; and
- create unintended, negative consequences for members, providers and issuers.

While we respect the Commissioner's desire to implement regulations before session, the proposed prior authorization rules have too great an impact on the fundamental business of insurance to be drafted or adopted without sufficient stakeholder review and comment. We believe there is common ground for providers and issuers on this topic, where the Commissioner's stated goals can be met without incurring unnecessary material costs or increasing the complexity of the administrative process. For that reason, we ask that the Commissioner's rules team issue an additional stakeholder draft, and be open to meeting with issuers and providers in smaller groups in order to discuss whether any specific issue sought to be addressed is actually a pervasive problem warranting comprehensive regulation. In particular, we caution against adopting standards containing sweeping generalized requirements to

address specific, potentially unique concerns. Such concerns are more effectively addressed using focused language, which also reduces the likelihood of unintended consequences.

Cost Concerns

1. *The requirement to have an online interactive browser based portal to accept requests and convey information about prior authorization increases costs.* The stakeholder draft requires issuers to either create or significantly change electronic portals for providers to use for prior authorization processes (*See,* section (4) and (5) of September 23, 2016 Stakeholder draft). Not all issuers have a sufficient number of services requiring prior authorization to justify the cost of building an online system to meet this rule section's requirements. This is particularly true for vision and dental issuers.

   For an issuer using prior authorization more frequently as a utilization management tool, most have online materials available to providers today meeting these standards, but most are not "interactive." Since the term is not defined in the draft, the common usage controls. Basic common usage is that an "interactive" site is a site that allows visitors to interact with the content in some way. Each issuer will have varying levels of permitting interaction – and the OIC's goal of streamlining is not met. For example, an interactive site could permit performing transactions via an online form, submission of information, interacting with information and services using calculators, clickable maps or interactive timelines, personalized content and experience based on previous or similar requests, or live chat, popup screens and glossaries. We respectfully request greater clarity in the regulation itself, not in the Concise Explanatory Statement, of the Commissioner's meaning when requiring development of an interactive site for prior authorization. This will allow issuers to have a better idea of the resources and costs required for achieving compliance and a clear standard in the regulation for purposes of evaluating compliance. Understanding what is required will also help us to provide feedback to the Commissioner on reasonable time periods for implementing the new regulation.

   Not all providers have the systems in place to use such a portal, and prefer using fax based transmission. Members of the Association who piloted various interactive programs online report low provider utilization, suggesting that the requirement may be beneficial to facilities and large practice groups, but of less value to other providers. If issuers are asked to invest in such a system, the economy of scale required to support the system would result in abandoning fax based systems and requiring universal electronic submission. The cost of investment is typically recovered through higher reimbursement rates by providers and higher premium rates for issuers. Some AWHP member issuers placed their estimated cost at over $1 million to establish a system compliant with these sections of the rule.

2. *The requirement to establish a system of documenting information and supporting evidence submitted by providers and facilities while requesting prior authorization potentially involves significant cost.* We believe this requirement is related to the complaint of some providers that

they must submit the same record set when a prior authorization request is renewed or that issuers lose records and then the provider must resubmit them. If so, then we suggest removal of the language prior to (6)(a), replaced by the following statement: "An issuer must retain medical records submitted by a provider or facility in support of a prior authorization request until the process of determining authorization is concluded." This prevents the issuer from being required to retain medical records in a repository for each member for an unspecified period of time, which is how many of our member issuers interpreted the prefatory language in (6). Building such a repository would be extremely expensive, as it would need to be coordinated with member enrollment and eligibility status, and would mirror an EMR system.

Further, by requiring written acknowledgment of receipt of any information conveyed by telephone, the OIC is introducing additional process steps, and increasing the cost of transacting insurance, which again is not consistent with the CR101's stated goal of streamlining the process of prior authorization (*See,* section 6(b) of the September 23, 2016 draft).

3. *Decision making timeframes impose additional staffing costs.* Today, if a member's medical needs require a service delivered after business hours or over a weekend, and the service requires prior authorization, most issuers permit post-service submission of the request. When that occurs, the service is reviewed for medical necessity and would not be denied for failure to obtain prior authorization for services from in-network providers.

   The current draft set of rules eliminates any incentive for issuers to continue to permit post-service review. We appreciate the Commissioner's responsiveness in changing the language from the first draft, and limiting the 24/7 requirement to accepting requests. (section 7). Unfortunately, the turnaround timelines for requesting or providing missing information (section 9) eliminates the benefit of that change. Section 9 sets timelines for two categories of prior authorization, immediate and expedited, that require processing of prior authorization requests over weekends and after normal business hours.

   The cost of having medically qualified staff to review requests in order to conduct the triage for additional information will result in issuers limiting post-service review to those situations where a member is receiving a service and additional necessary services are identified, such as during a surgery. Providers and facilities will need to staff to respond to requests over the weekends or after hours as well, in order to avoid denial of the request for failure to provide information.

   At the stakeholder meeting, the providers requesting accommodation after hours or over the weekend were those whose patients need services upon discharge from a hospital. One issuer correctly commented that properly performed discharge planning would have obtained prior authorization for those services concurrently with any service authorization during the hospital stay. Rather than creating general standards adding additional cost to deal with a unique scenario that is most likely infrequent, as Washington state hospitals have skilled staff working

on discharge planning, we recommend that the Commissioner adopt language stating that an issuer must establish a specific process for prior authorization, or in the alternative, post-service review, for those services that must be delivered after normal business hours or on weekends or holidays.

4. *Requiring all prior authorization processes and requirements to be included in provider contracts is inefficient and increases cost.* The requirement in section (18) of the proposed draft, materially increases cost and confusion. Issuers' prior authorization processes and review standards are typically set out in documents that are posted online. If a clinical standard changes, a service is added or dropped, or a process change is implemented, the issuer notifies providers and facilities in advance through known, accepted communication channels. Requiring a contract amendment to change any part of the way prior authorization is conducted results in a need for additional staff to prepare, mail and negotiate these amendments must be added. It also means that the change could not be effectively implemented in an emergent situation, since the notice period for amendments, followed by the Commissioner's contract review deemer period must expire before the amendment could take effect.

   This also means that providers and facilities would need to have their contracts in front of them at all times in order to conduct prior authorization. The language standard for a legal document is different than the language standard for providing instructions to staff submitting documents. While there is an effort to make legal documents clear and simple, some drafting requirements preclude presenting the material as it would be presented in online instructions.

   If the Commissioner is trying to address provider or facility complaints that processes change without notice, we recommend a simpler solution: establish a requirement for issuers to provide advance notice of not less than 30 days through an electronic or written communication to providers and facilities when a change is made to prior authorization processes, standards for review or services subject to prior authorization. Provide an exception to the notice provision when a standard must change due to states of emergency or emergent changes to clinical standards.

5. *Cost to post all prior authorization standards.* For specialized services, such as oncology, issuers may not develop their own clinical standards but purchase them from other entities. Often those entities label the standards as proprietary and preclude release to any but an IRO or a provider for purposes of preparing their submission to the issuer. Others charge fees in order to display the clinical criteria online. We urge the Commissioner to permit issuers to honor contractual arrangements labeling purchased standards as proprietary, and to not require posting where the issuer incurs costs to do so. The alternative is to incur additional costs of hiring medical staff with sufficient expertise to develop those clinical standards of review that are currently purchased from experts.

6. *Cost of reimbursing for medical records.* The Commissioner should place limits on the amount of reimbursement, requiring the level charged to be reasonable or limited to only those records requested more than once.

7. *Cost of bringing the prior authorization completely in-house.* The Commissioner makes the responsibility for prior authorization non-delegable in section (15) of the proposed draft. "Non-delegable" means issuers are no longer able to contract with third party entities to perform prior authorization for them. This would necessitate hiring the equivalent staffing of these organizations by each issuer, again unnecessarily increasing cost and administrative operations. We recommend language similar to that used elsewhere in chapter 284 WAC, stating that "If an issuer contracts with a third party to perform prior authorization functions; the issuer must ensure the third party complies with the requirements of this sub-chapter."

8. *New section WAC 284-43-2060 guarantees higher health care costs for services that may not meet an issuer's quality or utilization standards or services from providers who are out-of-network.* WAC 284-43-2060 provides an exception for providers and facilities to use to avoid having to follow prior authorization requirements. As drafted, issuers are not permitted to assess the validity of the provider's assertion that they didn't have time to submit the prior authorization request; if asserted by a provider, the issuer must authorize the service. This undercuts issuer quality programs, guarding against the provision of unnecessary medical services and removes the ability of issuers to properly manage their members' care. It also fails to take into account health plan designs that require the use of in-network providers in order for non-emergency services to be covered.

9. *Extension of prior authorization to succeeding issuers.* Section (16) requires issuers to honor a prior issuer's prior authorization for 30 days or when the PA expires. For some prescriptions, authorizations can be for as long as 12 months. This binds successor issuers to coverage and costs they did not price for in their rates. While the Commissioner's staff stated in the stakeholder meeting of October 5 that this is intended to only address situations like Moda's recent withdrawal, the rule as drafted does not do that. Instead, the rule references (d) of RCW 48.43.035 and .038, which pertain to market withdrawals approved with 180 days' notice. If members receive six months' notice that their coverage must change, they do not need the protection of this provision, as they have ample time to plan their new coverage and either obtain services before switching coverage, or advise their provider to determine if prior authorization is needed and obtain it within the very short turnaround times in section (9).

10. *Requiring coverage information specific to a provider as part of the on line system will require major IT reprogramming, increasing costs.* The Commissioner in sections (4)-(6) requires issuers to display information that explains how the prior authorization decision impacts the member financially, which provider or facility it pertains to, and how the prior authorization fits with the member's plan. Most issuers perform prior authorization based on medical necessity, and it is not linked to coverage determinations. The prior authorization is also not linked to a specific

provider or location – in network status and tiered status based on site of service are addressed at the time the claim is adjudicated. Finally, prior authorization would not involve a determination of financial impact to the member, as that involves different documents and analysis than a medical necessity determination involves.

It is for this reason that CMS defines prior authorization as a provisional determination of coverage – we urge the Commissioner to do the same, and to remove requirements for inclusion of information in the determination related to provisions in the certificate of coverage or member cost share.

Inconsistency with Best Practice Standards

1. *The rules should not deviate from the best practice standards for prior authorization developed by the OneHealthPort organization.* OneHealthPort convened a multi-stakeholder workgroup to identify best practices for prior authorization. The work group engaged issuers, providers and third party administrators, as well as purchasers of coverage, and the Commissioner's staff. Recent rulemaking (R-2014-13 to implement RCW 48.165.0301 and R-2016-02) addressed streamlining prior authorization, and in one instance focused on prescription drug requests. Both rulemaking efforts adopted the OneHealthPort best practices. This proposed draft deviates, particularly in the language used for "immediate prior authorization" as a category. The deviation results in a category for prior authorization which, if a member requires authorization for a service within 60 minutes, means the member should be sent to the emergency room for the service. No prior authorization is needed in that instance.

   The best practice recommendation is correctly stated in current version, and the version effective 1/1/17, of WAC 284-43-2000, where the period of time to respond to an "immediate prior authorization request" is one day. NCQA applies this time frame as well. Further, the definition of an immediate prior authorization request is incomplete in the draft rules. The definition in the draft rules is indistinguishable from the definition of an expedited prior authorization request situation. We recommend leaving the language in WAC 284-43-2000 alone, and removing the references to immediate prior authorization from the new proposed sections of chapter 284-43 WAC.

2. *The rules should defer to NCQA or URAC accreditation as prima facie demonstration that an issuer has prior authorization program that meets the Commissioner's requirements.* Section (3) of the September 23, 2016 draft requires issuers to meet NCQA standards, or "any other national standards" for accreditation related to prior authorization, in addition to the standards in the rules. This is unreasonably vague for an administrative regulation, as it is not clear what is required for compliance. Neither does the rule provide direction for circumstances where the state standard differs from one of the national standards. We recommend that the Commissioner accept accreditation by URAC, NCQA or AAAHC to establish that an issuer meets

the state's standards for prior authorization or other recognized standards set forth by the Health Care Authority (HCA) or the Centers for Medicaid and Medicare Services (CMS). For issuers who choose not to seek accreditation, the state's standards continue to provide the necessary direction for prior authorization.

Language Suggestions

The language in WAC 284-43-2050 (5)(a) includes a sentence that could be read to infer that health carriers do not use appropriate communication methods and seek to mislead providers and enrollees, creating a need to "resort to additional research." The second sentence of subsection (5) (a) is duplicative of the first sentence. To make the regulation language more neutral, we recommend adding "use simple language" to the first sentence and striking the second sentence so that it reads as follows:

"(5) In addition to other methods to process prior authorization requests, carriers or their designated or contracted representative that require prior authorization for services must have an electronic, interactive process that is browser-based to complete a prior authorization request.
(a) When a provider makes a request for the prior authorization, the response from the carrier or their designated or contracted representative must be clear, use simple language, and explain if it is approved or denied and the justification and basis for the decision including the criteria for the denial. ~~The response must give the true and actual reason in clear and simple language so that the enrollee and the provider will not need to resort to additional research to understand the real reason for the action.~~ Written notice of the decision must be communicated to the provider or facility, and the enrollee. The denial must include the department and credentials of the individual who has the authorizing authority to approve or deny the request. A denial must also include a phone number to contact the authorizing authority and a notice regarding the enrollee's appeal rights and process. "

Unintended Negative Consequences

Issuers are always seeking to apply evidence-based medicine, reduce unwarranted variation in quality and costs, and authorize services that are reflected in each member's benefit plan coverage, as well as those services that are clinically appropriate for individual members. Prior authorization is used to support those efforts. Given differences in networks and populations served, issuers may have different methods of reaching these shared goals. The services requiring prior authorization differ for each issuer.

By developing standards to meet every complaint received by a provider or facility spokesperson, the system becomes more cumbersome and costly. Initially, the complaint about prior authorization was that hospitals and large groups felt they were staffing for prior authorization unnecessarily, since issuers didn't deny their requests. The rules are silent as to that issue, perhaps as a result of the Commissioner's staff engaging in informal discovery with issuers about the "gold-carding" standard.

We urge the Commissioner's staff to review the remaining specific complaints of the varying provider types with issuers to determine if there is a simpler way to address their concerns than establishing

unnecessary sweeping process changes. Our membership is happy to meet with staff to address those concerns and propose alternate language.

Sincerely,

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