Providence Health & Services
1801 Lind Avenue SW, #9016
Renton, WA 98057-9016
www.providence.org

October 14, 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 multiple stakeholder meetings, and in response to the second 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 care1 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 and August 17th letters:

- 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.

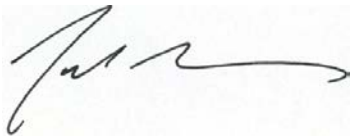
Section of proposed rule	PH&S Comments
New definitions - WAC 284-43-0160 - "Prior authorization"	Providence appreciates the OIC's attention here to medical necessity, appropriateness, and level of care, which we believe is intended to ensure the patients' best interests are at the center of this process. 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**?

Utilization Review and Prior Authorization - WAC 284-43- 2050 – subsection D part (2)	We request clarification regarding the exception for use of medical evidence when dealing 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 (3)	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 (11) (c)	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 (11) (d)	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 (13)	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 (20)	We have two concerns with this section: 1. 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. 2. 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.***

Again, we thank you for the opportunity to provide our comments on the issues under consideration. We look forward to continuing to partner on this work. For more information or if you have questions, please contact Lauren Platt, State Advocacy Program Manager, at (425) 525-5734 or lauren.platt@providence.org.

Sincerely,



Joel Gilbertson

Senior Vice President, Community Partnerships and External Affairs
Providence Health & Services