Group Health Cooperative
Group Health Headquarters
Legal Department
320 Westlake Avenue N.
Suite 100
Seattle, WA 98109

www.ghc.org

August 17, 2016

Jim Freeburg
Special Assistant to the Commissioner
Washington Office of the Insurance Commissioner
500 Capitol Blvd. SE
Olympia, WA 98504-0258
Submitted electronically via: rulesc@oic.wa.gov

Re: **Proposed rulemaking on prior authorization processes and transparency (R2016-19)**

Dear Mr. Freeburg:

Group Health Cooperative – a not-for-profit, tax-exempt integrated health system providing coverage and care to approximately 600,000 people across Washington State and Northern Idaho – appreciates the opportunity to provide comments in response to the Office of the Insurance Commissioner's ("OIC") July 15, 2016 stakeholder draft rules.

We offer the following in reference to subsections of OIC's proposed Subchapter D, WAC 284-43-2050:

- (1) – Please provide clarification on how "sufficient" will be defined. We have concerns this standard could change between different issuers and providers.

- (1)(a) – Would this allow for electronic notices? Many providers opted out of paper "written" notices; we recommend continuing this electronic option and extending it to members. We do not currently have the option for members to receive electronic notices, but could.
    - The subsection requires notification to the "provider" and does not specify if this should be the referring/ordering or the approved/denied provider.
    - We share concerns with releasing the name and credentials of the authorizing authority; this creates safety concerns for our staff, would allow direct access to reviewers (thus circumventing regulatory appeals and grievance processes), would lead to difficulty in hiring and retaining reviewers, and would deviate from national standards. We request that this requirement be removed.

- (1)(b) – We suggest this notification only apply where an authorization determines in- or out-of-network benefits; member and providers currently have options to determine if a provider or facility is out-of-network. Many of our coverage determinations are not impacted by the prescriber being in or out of network.

- (2) – A 24/7 requirement would create a significant burden by necessitating additional staffing and associated costs; where authorization timeframes are met, there is no need to process requests outside of normal business hours. To the extent a 24/7 requirement is proposed herein, we request such proposal be removed.

- (3) – Additional lead-time is requested for any interactive online requirement; we suggest a January 1, 2018 deadline or a similar grace period. Creating such a website is a large undertaking and could not be completed by January 1, 2017.

- (4) – Allowing a specialist to request services based solely on review of medical records has potential for unnecessary and expensive services, and leaves the primary care physician out of the care plan. This creates problems with coordination of patient care. Furthermore, many prior authorization criteria require the provider to conduct an assessment or provide rationale that is dependent on an established relationship and physical assessment of the member – compliance would be difficult under this proposed subsection. We recommend removing this subsection.

- (6) – The suggested timeframes are very short for any clinical review, differ from industry standards, and are misaligned with accreditation bodies (including the OIC, CMS, and NCQA). Our review processes include consultation and review of several sources, which requires more than a 24-hour turnaround. The proposed shortened timeframes will affect the ability to undertake proper reviews and will result in increased denials, while decreasing abilities to create efficiencies and cost-effective care.
    - We often do not receive adequate information from providers (we currently make up to 3 requests) and, based on experience, do believe many providers will not be able to provide sufficient information within the proposed "second request" timeframes. This will result in increased denials, causing delays in care.
    - We recommend adoption of common regulatory timeframes, or of those adopted as best practices through the OneHealthPort Administrative Simplification workgroup.

- (7) – There is rarely a justified need for an end-date 45-days from approval. Authorizations should terminate based on the type of service. If such a standard authorization is required, inpatient and administrative (non-clinical) pre-authorizations must be excluded.

- (8)(c) – Diagnosis and service codes are necessary for proper, full review; we recommend removing this subsection.

- (8)(d) – Similar to diagnosis and service codes, medical records are often necessary for proper, full review; we recommend removing this subsection.

- (9) – Our provider contracts contain standard language addressing this issue. In most cases we are allowed to request copies of records (usually one), with subsequent record requests reimbursable. This subsection would make our provider contracts non-complaint and could have a large financial impact if "reasonable costs" is defined similar to "reasonable fee" in RCW 70.02.010 and WAC 246-08-400. We request removal of this subsection or, if not, clarification on "reasonable costs."

- (10) – We request clarification on what an issuer is responsible for under this subsection, as most of the proposed rules are aimed directly at issuers. For example, could we satisfy this subsection by including language in our provider contracts requiring compliance by any subcontractors?

- (11) – Our experience shows most insurers are unwilling to provide such information. This would render compliance with the subsection difficult. What recourse would insurers have if such information/data is not provided? Would this leave an insurer liable for decisions made by a prior insurer? Problems will arise where the two insurers operate under differing criteria, such as when one insurer covers a service the other does not.
    - Regarding drug formularies, recognizing authorizations from a prior insurer interferes with our strategic design and management of our drug formulary – which is aimed at providing safe, effective, and affordable care. This subsection would inhibit our intent and prohibit proper review for ensuring the most appropriate prescription to treat a member's condition.

- (14) –One requirement of WAC Chapter 284-170 is to provide 60 days' notice to providers of certain changes to a contract and/or conditions for compensation – is this the intent of the subsection? We request clarification on the specific requirements proposed by this subsection and the cited WAC.

On behalf of Group Health Cooperative, I thank you for the opportunity to comment on the stakeholder draft rules. Please feel free to contact me directly with any questions, concerns, or if there is anything else I can assist with.

Sincerely,

Cesar J. Lopez
Senior Regulatory Affairs Consultant
Group Health Cooperative