S-6182.1

SUBSTITUTE SENATE BILL 6404

State of Washington 66th Legislature 2020 Regular Session

By Senate Health & Long Term Care (originally sponsored by Senators Frockt, O'Ban, Dhingra, Becker, Kuderer, Rivers, Lovelett, Wellman, Pedersen, Nguyen, Darneille, Hasegawa, McCoy, Wilson, C., Das, Conway, and Saldaña)

READ FIRST TIME 02/06/20.

AN ACT Relating to reducing barriers to patient care through appropriate use of prior authorization and adoption of appropriate use criteria; adding a new section to chapter 48.43 RCW; and adding a new section to chapter 70.250 RCW.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43 RCW to read as follows:

(1) By October 1, 2020, and annually thereafter, for health plans issued by a carrier, the carrier shall report to the commissioner the following aggregated and deidentified data related to the carrier's prior authorization practices and experience for the prior plan year:

(a) Lists of the ten inpatient medical or surgical services, which may include mental health and substance use disorders:

(i) With the highest total volume of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each service;

(ii) With the highest number of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each service; and

(iii) With the highest number of prior authorization requests that were initially denied and then subsequently approved on appeal,

including the total number of prior authorization requests for each service;

(b) Lists of the ten outpatient medical or surgical services, which may include mental health and substance use disorders:

(i) With the highest total volume of prior authorization requests during the previous plan year, including the total number of prior authorization requests for each service;

(ii) With the highest number of approved prior authorization requests during the previous plan year, including the total number of prior authorization requests for each service; and

(iii) With the highest number of prior authorization requests that were initially denied and then subsequently approved on appeal, including the total number of prior authorization requests for each service;

(c) The average determination response time in hours for prior authorization requests to the plan with respect to each covered service listed in (a) and (b) of this subsection for each of the following categories:

(i) Urgent concurrent decisions;

(ii) Urgent preservice decisions;

(iii) Nonurgent preservice decisions; and

(iv) Postservice decisions.

(2) The commissioner shall provide the data collected under subsection (1) of this section to the prior authorization work group.

(3) The commissioner shall develop standardized reports of the aggregated and deidentified data submitted under subsection (1) of this section and make the reports available upon request to interested parties.

(4) The commissioner shall post recommendations from the prior authorization work group made under section 2 of this act on the commissioner's web site.

(5) The commissioner may adopt rules to implement this section. In adopting rules, the commissioner must consult stakeholders including carriers, health care practitioners, health care facilities, and patients.

(6) For the purpose of this section, "prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets the requirements for medical necessity, clinical

appropriateness, level of care, or effectiveness in relation to the applicable plan, including any term used by a carrier or its designated or contracted representative to describe this process.

NEW SECTION. **Sec. 2.** A new section is added to chapter 70.250 RCW to read as follows:

(1)(a) The prior authorization work group is created to enhance the understanding and use of prior authorization in Washington state. The prior authorization work group must be hosted and staffed by the collaborative.

(b) By September 1, 2020, the governor shall appoint fifteen members of the prior authorization work group to be comprised of representatives from health care providers, hospitals, clinics, carriers, and the health care authority. All appointed representatives must be clinicians with at least fifty percent representing providers, hospitals, and clinics, and at least twenty-five percent representing carriers. The appointed members of the prior authorization work group shall select the work group chair.

(2)(a) By January 1, 2021, and annually thereafter, the prior authorization work group shall select and review not less than five medical or surgical services, which may include mental health and substance use disorder services, subject to prior authorization by insurance carriers. The prior authorization work group shall conduct its review and issue prior authorization recommendations by December 31st of the year in which the review began.

(b) The prior authorization work group shall establish subcommittees to focus on specific services selected for review. Each subcommittee must be comprised of practicing clinicians with expertise relevant to the specific medical or surgical service selected for review. Each subcommittee must include at least two members of the specialty or subspecialty society most experienced with the service identified for review. Subcommittee members are not required to be members of the prior authorization work group. Each subcommittee shall make recommendations to the prior authorization work group related to the recommendations in subsection (3) of this section.

(c) In 2021 the prior authorization work group shall review, as one of the services selected, noninvasive cardiac diagnostic imaging procedures.

(d) The prior authorization work group shall consider the prior authorization data collected in section 1 of this act and shall select and prioritize services for review based on the following criteria:

(i) The volume of the service as indicated by prior authorization requests;

(ii) Indications based on medical literature that prior authorization is not appropriate for a service;

(iii) The potential for negative impact on patient care caused by prior authorization delays; and

(iv) Input from health care providers, health care facilities, insurance carriers, and health insurance purchasers.

(3) For each service identified in subsection (2) of this section, the prior authorization work group shall assess the following areas and make corresponding recommendations:

(a) Whether the utilization and approval patterns and medical literature justify the use of a prior authorization requirement for the service. If not, the prior authorization work group shall recommend no prior authorization be required for the service;

(b) Whether adoption of uniform appropriate use criteria or evidence-based criteria confirmed through a clinical decision support mechanism for the service in lieu of prior authorization is appropriate. If so, the prior authorization work group shall identify and select appropriate criteria for the service. The prior authorization work group shall consider the availability and cost of the clinical decision support mechanisms and possible alternative methods of validation in its recommendation. If the work group recommends the use of appropriate use criteria related to noninvasive cardiac diagnostic imaging procedures, the work group shall recommend adoption of appropriate use criteria developed by a federally qualified provider led entity pursuant to 42 C.F.R. 414.94 as it existed on February 1, 2020;

(c) Whether an appropriate federal policy or initiative exists for the service. Any recommendations by the prior authorization work group should align with criteria used for federal initiatives and approval mechanisms under the medicare program; and

(d) The prior authorization work group shall consider the services as provided to both adult and pediatric patients and when appropriate, provide separate recommendations regarding the service for adult and pediatric patients.

(4) The prior authorization work group shall review and make updates as necessary to the recommendations made pursuant to subsection (3) of this section based on evidence that a recommendation no longer reflects relevant evidence-based guidelines.

(5) Beginning December 1, 2021, the work group must annually report on its recommendations to the health care committees of the legislature.

(6) For purposes of this section:

(a) "Prior authorization" means a mandatory process that a carrier or its designated or contracted representative requires a provider or facility to follow before a service is delivered, to determine if a service is a benefit and meets requirements for medical necessity, clinical appropriateness, level of care, or effectiveness in relation to the applicable plan, including any term used by a carrier or its designated or contracted representative to describe this process.

(b) "Appropriate use criteria" means criteria developed or endorsed by a provider-led entity to assist health care practitioners in making the most appropriate treatment decision for a specific clinical condition for an individual. To the extent feasible, such criteria must be evidence-based.

(c) "Clinical decision support mechanism" means a tool for use by clinicians that communicates selected appropriate use criteria information to the user and assists clinicians in making the most appropriate treatment decision for a patient's specific clinical condition.

(d) "Provider-led entity" means a professional medical specialty society or organization.

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