
SENATE BILL 5324

State of Washington

69th Legislature

2025 Regular Session

By Senators Cleveland, Muzzall, Nobles, and Slatter

Read first time 01/17/25. Referred to Committee on Health & Long-Term Care.

1 AN ACT Relating to aligning the implementation of application
2 programming interfaces for prior authorization with federal
3 guidelines; and amending RCW 48.43.830, 41.05.845, and 74.09.840.

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

5 **Sec. 1.** RCW 48.43.830 and 2023 c 382 s 1 are each amended to
6 read as follows:

7 (1) Each carrier offering a health plan issued or renewed on or
8 after January 1, 2024, shall comply with the following standards
9 related to prior authorization for health care services and
10 prescription drugs:

11 (a) The carrier shall meet the following time frames for prior
12 authorization determinations and notifications to a participating
13 provider or facility that submits the prior authorization request
14 through an electronic prior authorization process, as designated by
15 each carrier:

16 (i) For electronic standard prior authorization requests, the
17 carrier shall make a decision and notify the provider or facility of
18 the results of the decision within three calendar days, excluding
19 holidays, of submission of an electronic prior authorization request
20 by the provider or facility that contains the necessary information
21 to make a determination. If insufficient information has been

1 provided to the carrier to make a decision, the carrier shall request
2 any additional information from the provider or facility within one
3 calendar day of submission of the electronic prior authorization
4 request.

5 (ii) For electronic expedited prior authorization requests, the
6 carrier shall make a decision and notify the provider or facility of
7 the results of the decision within one calendar day of submission of
8 an electronic prior authorization request by the provider or facility
9 that contains the necessary information to make a determination. If
10 insufficient information has been provided to the carrier to make a
11 decision, the carrier shall request any additional information from
12 the provider or facility within one calendar day of submission of the
13 electronic prior authorization request.

14 (b) The carrier shall meet the following time frames for prior
15 authorization determinations and notifications to a participating
16 provider or facility that submits the prior authorization request
17 through a process other than an electronic prior authorization
18 process:

19 (i) For nonelectronic standard prior authorization requests, the
20 carrier shall make a decision and notify the provider or facility of
21 the results of the decision within five calendar days of submission
22 of a nonelectronic prior authorization request by the provider or
23 facility that contains the necessary information to make a
24 determination. If insufficient information has been provided to the
25 carrier to make a decision, the carrier shall request any additional
26 information from the provider or facility within five calendar days
27 of submission of the nonelectronic prior authorization request.

28 (ii) For nonelectronic expedited prior authorization requests,
29 the carrier shall make a decision and notify the provider or facility
30 of the results of the decision within two calendar days of submission
31 of a nonelectronic prior authorization request by the provider or
32 facility that contains the necessary information to make a
33 determination. If insufficient information has been provided to the
34 carrier to make a decision, the carrier shall request any additional
35 information from the provider or facility within one calendar day of
36 submission of the nonelectronic prior authorization request.

37 (c) In any instance in which a carrier has determined that a
38 provider or facility has not provided sufficient information for
39 making a determination under (a) and (b) of this subsection, a
40 carrier may establish a specific reasonable time frame for submission

1 of the additional information. This time frame must be communicated
2 to the provider and enrollee with a carrier's request for additional
3 information.

4 (d) The carrier's prior authorization requirements must be
5 described in detail and written in easily understandable language.
6 The carrier shall make its most current prior authorization
7 requirements and restrictions, including the written clinical review
8 criteria, available to providers and facilities in an electronic
9 format upon request. The prior authorization requirements must be
10 based on peer-reviewed clinical review criteria. The clinical review
11 criteria must be evidence-based criteria and must accommodate new and
12 emerging information related to the appropriateness of clinical
13 criteria with respect to black and indigenous people, other people of
14 color, gender, and underserved populations. The clinical review
15 criteria must be evaluated and updated, if necessary, at least
16 annually.

17 (2) (a) Each carrier shall ~~((build and maintain a prior~~
18 ~~authorization application programming interface that automates the~~
19 ~~process for in-network providers to determine whether a prior~~
20 ~~authorization is required for health care services, identify prior~~
21 ~~authorization information and documentation requirements, and~~
22 ~~facilitate the exchange of prior authorization requests and~~
23 ~~determinations from its electronic health records or practice~~
24 ~~management system. The application programming interface must support~~
25 ~~the exchange of prior authorization requests and determinations for~~
26 ~~health care services beginning January 1, 2025, and must:~~

27 ~~(i) Use health level 7 fast health care interoperability~~
28 ~~resources in accordance with standards and provisions defined in 45~~
29 ~~C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);~~

30 ~~(ii) Automate the process to determine whether a prior~~
31 ~~authorization is required for durable medical equipment or a health~~
32 ~~care service;~~

33 ~~(iii) Allow providers to query the carrier's prior authorization~~
34 ~~documentation requirements;~~

35 ~~(iv) Support an automated approach using nonproprietary open~~
36 ~~workflows to compile and exchange the necessary data elements to~~
37 ~~populate the prior authorization requirements that are compliant with~~
38 ~~the federal health insurance portability and accountability act of~~
39 ~~1996 or have an exception from the federal centers for medicare and~~
40 ~~medicaid services; and~~

1 ~~(v) Indicate that~~) establish and maintain a prior authorization
2 application programming interface that is consistent with final rules
3 issued by the federal centers for medicare and medicaid services and
4 published in the federal register, and that indicates that a prior
5 authorization denial or authorization of a service less intensive
6 than that included in the original request is an adverse benefit
7 determination and is subject to the carrier's grievance and appeal
8 process under RCW 48.43.535. The implementation of the application
9 programming interface must align with federal effective dates,
10 including enforcement delays and suspensions, issued by the federal
11 centers for medicare and medicaid services.

12 (b) Each carrier shall establish and maintain an interoperable
13 electronic process or application programming interface that
14 automates the process for in-network providers to determine whether a
15 prior authorization is required for a covered prescription drug. The
16 interoperable electronic process or application programming interface
17 must support the exchange of prior authorization requests and
18 determinations for prescription drugs, including information on
19 covered alternative prescription drugs, beginning January 1, 2027,
20 and must:

21 (i) Allow providers to identify prior authorization information
22 and documentation requirements;

23 (ii) Facilitate the exchange of prior authorization requests and
24 determinations from its electronic health records or practice
25 management system(~~(, and may include the necessary data elements to~~
26 ~~populate the prior authorization requirements that are compliant with~~
27 ~~the federal health insurance portability and accountability act of~~
28 ~~1996 or have an exception from the federal centers for medicare and~~
29 ~~medicaid services)); and~~

30 (iii) Indicate that a prior authorization denial or authorization
31 of a drug other than the one included in the original prior
32 authorization request is an adverse benefit determination and is
33 subject to the carrier's grievance and appeal process under RCW
34 48.43.535.

35 (c) If federal rules related to standards for using an
36 application programming interface to communicate prior authorization
37 status to providers are not finalized by the federal centers for
38 medicare and medicaid services by September 13, 2023, the
39 requirements of (a) of this subsection may not be enforced until

1 ((January 1, 2026)) final rules published by the federal government
2 take effect.

3 ~~(d) ((i) If a carrier determines that it will not be able to~~
4 ~~satisfy the requirements of (a) of this subsection by January 1,~~
5 ~~2025, the carrier shall submit a narrative justification to the~~
6 ~~commissioner on or before September 1, 2024, describing:~~

7 ~~(A) The reasons that the carrier cannot reasonably satisfy the~~
8 ~~requirements;~~

9 ~~(B) The impact of noncompliance upon providers and enrollees;~~

10 ~~(C) The current or proposed means of providing health information~~
11 ~~to the providers; and~~

12 ~~(D) A timeline and implementation plan to achieve compliance with~~
13 ~~the requirements.~~

14 ~~(ii) The commissioner may grant a one-year delay in enforcement~~
15 ~~of the requirements of (a) of this subsection (2) if the commissioner~~
16 ~~determines that the carrier has made a good faith effort to comply~~
17 ~~with the requirements.~~

18 ~~(iii) This subsection (2)(d) shall not apply if the delay in~~
19 ~~enforcement in (c) of this subsection takes effect because the~~
20 ~~federal centers for medicare and medicaid services did not finalize~~
21 ~~the applicable regulations by September 13, 2023.~~

22 ~~(e))~~ By September 13, 2023, and at least every six months
23 thereafter until September 13, 2026, the commissioner shall provide
24 an update to the health care policy committees of the legislature on
25 the development of rules and implementation guidance from the federal
26 centers for medicare and medicaid services regarding the standards
27 for development of application programming interfaces and
28 interoperable electronic processes related to prior authorization
29 functions. The updates should include recommendations, as
30 appropriate, on whether the status of the federal rule development
31 aligns with the provisions of chapter 382, Laws of 2023. The
32 commissioner also shall report on any actions by the federal centers
33 for medicare and medicaid services to exercise enforcement discretion
34 related to the implementation and maintenance of an application
35 programming interface for prior authorization functions. The
36 commissioner shall consult with the health care authority, carriers,
37 providers, and consumers on the development of these updates and any
38 recommendations.

39 (3) Nothing in this section applies to prior authorization
40 determinations made pursuant to RCW 48.43.761.

1 (4) For the purposes of this section:

2 (a) "Expedited prior authorization request" means a request by a
3 provider or facility for approval of a health care service or
4 prescription drug where:

5 (i) The passage of time:

6 (A) Could seriously jeopardize the life or health of the
7 enrollee;

8 (B) Could seriously jeopardize the enrollee's ability to regain
9 maximum function; or

10 (C) In the opinion of a provider or facility with knowledge of
11 the enrollee's medical condition, would subject the enrollee to
12 severe pain that cannot be adequately managed without the health care
13 service or prescription drug that is the subject of the request; or

14 (ii) The enrollee is undergoing a current course of treatment
15 using a nonformulary drug.

16 (b) "Standard prior authorization request" means a request by a
17 provider or facility for approval of a health care service or
18 prescription drug where the request is made in advance of the
19 enrollee obtaining a health care service or prescription drug that is
20 not required to be expedited.

21 **Sec. 2.** RCW 41.05.845 and 2023 c 382 s 2 are each amended to
22 read as follows:

23 (1) A health plan offered to public employees, retirees, and
24 their covered dependents under this chapter issued or renewed on or
25 after January 1, 2024, shall comply with the following standards
26 related to prior authorization for health care services and
27 prescription drugs:

28 (a) The health plan shall meet the following time frames for
29 prior authorization determinations and notifications to a
30 participating provider or facility that submits the prior
31 authorization request through an electronic prior authorization
32 process:

33 (i) For electronic standard prior authorization requests, the
34 health plan shall make a decision and notify the provider or facility
35 of the results of the decision within three calendar days, excluding
36 holidays, of submission of an electronic prior authorization request
37 by the provider or facility that contains the necessary information
38 to make a determination. If insufficient information has been
39 provided to the health plan to make a decision, the health plan shall

1 request any additional information from the provider or facility
2 within one calendar day of submission of the electronic prior
3 authorization request.

4 (ii) For electronic expedited prior authorization requests, the
5 health plan shall make a decision and notify the provider or facility
6 of the results of the decision within one calendar day of submission
7 of an electronic prior authorization request by the provider or
8 facility that contains the necessary information to make a
9 determination. If insufficient information has been provided to the
10 health plan to make a decision, the health plan shall request any
11 additional information from the provider or facility within one
12 calendar day of submission of the electronic prior authorization
13 request.

14 (b) The health plan shall meet the following time frames for
15 prior authorization determinations and notifications to a
16 participating provider or facility that submits the prior
17 authorization request through a process other than an electronic
18 prior authorization process described in subsection (2) of this
19 section:

20 (i) For nonelectronic standard prior authorization requests, the
21 health plan shall make a decision and notify the provider or facility
22 of the results of the decision within five calendar days of
23 submission of a nonelectronic prior authorization request by the
24 provider or facility that contains the necessary information to make
25 a determination. If insufficient information has been provided to the
26 health plan to make a decision, the health plan shall request any
27 additional information from the provider or facility within five
28 calendar days of submission of the nonelectronic prior authorization
29 request.

30 (ii) For nonelectronic expedited prior authorization requests,
31 the health plan shall make a decision and notify the provider or
32 facility of the results of the decision within two calendar days of
33 submission of a nonelectronic prior authorization request by the
34 provider or facility that contains the necessary information to make
35 a determination. If insufficient information has been provided to the
36 health plan to make a decision, the health plan shall request any
37 additional information from the provider or facility within one
38 calendar day of submission of the nonelectronic prior authorization
39 request.

1 (c) In any instance in which the health plan has determined that
2 a provider or facility has not provided sufficient information for
3 making a determination under (a) and (b) of this subsection, the
4 health plan may establish a specific reasonable time frame for
5 submission of the additional information. This time frame must be
6 communicated to the provider and enrollee with the health plan's
7 request for additional information.

8 (d) The prior authorization requirements of the health plan must
9 be described in detail and written in easily understandable language.
10 The health plan shall make its most current prior authorization
11 requirements and restrictions, including the written clinical review
12 criteria, available to providers and facilities in an electronic
13 format upon request. The prior authorization requirements must be
14 based on peer-reviewed clinical review criteria. The clinical review
15 criteria must be evidence-based criteria and must accommodate new and
16 emerging information related to the appropriateness of clinical
17 criteria with respect to black and indigenous people, other people of
18 color, gender, and underserved populations. The clinical review
19 criteria must be evaluated and updated, if necessary, at least
20 annually.

21 (2)(a) Each health plan offered to public employees, retirees,
22 and their covered dependents under this chapter shall ~~((build and~~
23 ~~maintain a prior authorization application programming interface that~~
24 ~~automates the process for in-network providers to determine whether a~~
25 ~~prior authorization is required for health care services, identify~~
26 ~~prior authorization information and documentation requirements, and~~
27 ~~facilitate the exchange of prior authorization requests and~~
28 ~~determinations from its electronic health records or practice~~
29 ~~management system. The application programming interface must support~~
30 ~~the exchange of prior authorization requests and determinations for~~
31 ~~health care services beginning January 1, 2025, and must:~~

32 ~~(i) Use health level 7 fast health care interoperability~~
33 ~~resources in accordance with standards and provisions defined in 45~~
34 ~~C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);~~

35 ~~(ii) Automate the process to determine whether a prior~~
36 ~~authorization is required for durable medical equipment or a health~~
37 ~~care service;~~

38 ~~(iii) Allow providers to query the health plan's prior~~
39 ~~authorization documentation requirements;~~

1 ~~(iv) Support an automated approach using nonproprietary open~~
2 ~~workflows to compile and exchange the necessary data elements to~~
3 ~~populate the prior authorization requirements that are compliant with~~
4 ~~the federal health insurance portability and accountability act of~~
5 ~~1996 or have an exception from the federal centers for medicare and~~
6 ~~medicaid services; and~~

7 ~~(v) Indicate that))~~ establish and maintain a prior authorization
8 application programming interface that is consistent with final rules
9 issued by the federal centers for medicare and medicaid services and
10 published in the federal register, and that indicates that a prior
11 authorization denial or authorization of a service less intensive
12 than that included in the original request is an adverse benefit
13 determination and is subject to the health plan's grievance and
14 appeal process under RCW 48.43.535. The implementation of the
15 application programming interface must align with federal effective
16 dates, including enforcement delays and suspensions, issued by the
17 federal centers for medicare and medicaid services.

18 (b) Each health plan offered to public employees, retirees, and
19 their covered dependents under this chapter shall establish and
20 maintain an interoperable electronic process or application
21 programming interface that automates the process for in-network
22 providers to determine whether a prior authorization is required for
23 a covered prescription drug. The interoperable electronic process or
24 application programming interface must support the exchange of prior
25 authorization requests and determinations for prescription drugs,
26 including information on covered alternative prescription drugs,
27 beginning January 1, 2027, and must:

28 (i) Allow providers to identify prior authorization information
29 and documentation requirements;

30 (ii) Facilitate the exchange of prior authorization requests and
31 determinations from its electronic health records or practice
32 management system(~~(, and may include the necessary data elements to~~
33 ~~populate the prior authorization requirements that are compliant with~~
34 ~~the federal health insurance portability and accountability act of~~
35 ~~1996 or have an exception from the federal centers for medicare and~~
36 ~~medicaid services)); and~~

37 (iii) Indicate that a prior authorization denial or authorization
38 of a drug other than the one included in the original prior
39 authorization request is an adverse benefit determination and is

1 subject to the health plan's grievance and appeal process under RCW
2 48.43.535.

3 (c) If federal rules related to standards for using an
4 application programming interface to communicate prior authorization
5 status to providers are not finalized by the federal centers for
6 medicare and medicaid services by September 13, 2023, the
7 requirements of (a) of this subsection may not be enforced until
8 ~~((January 1, 2026))~~ final rules published by the federal government
9 take effect.

10 ~~((d)(i) If the health plan determines that it will not be able
11 to satisfy the requirements of (a) of this subsection by January 1,
12 2025, the health plan shall submit a narrative justification to the
13 authority on or before September 1, 2024, describing:~~

14 ~~(A) The reasons that the health plan cannot reasonably satisfy
15 the requirements;~~

16 ~~(B) The impact of noncompliance upon providers and enrollees;~~

17 ~~(C) The current or proposed means of providing health information
18 to the providers; and~~

19 ~~(D) A timeline and implementation plan to achieve compliance with
20 the requirements.~~

21 ~~(ii) The authority may grant a one-year delay in enforcement of
22 the requirements of (a) of this subsection (2) if the authority
23 determines that the health plan has made a good faith effort to
24 comply with the requirements.~~

25 ~~(iii) This subsection (2)(d) shall not apply if the delay in
26 enforcement in (c) of this subsection takes effect because the
27 federal centers for medicare and medicaid services did not finalize
28 the applicable regulations by September 13, 2023.)~~

29 (3) Nothing in this section applies to prior authorization
30 determinations made pursuant to RCW 41.05.526.

31 (4) For the purposes of this section:

32 (a) "Expedited prior authorization request" means a request by a
33 provider or facility for approval of a health care service or
34 prescription drug where:

35 (i) The passage of time:

36 (A) Could seriously jeopardize the life or health of the
37 enrollee;

38 (B) Could seriously jeopardize the enrollee's ability to regain
39 maximum function; or

1 (C) In the opinion of a provider or facility with knowledge of
2 the enrollee's medical condition, would subject the enrollee to
3 severe pain that cannot be adequately managed without the health care
4 service or prescription drug that is the subject of the request; or

5 (ii) The enrollee is undergoing a current course of treatment
6 using a nonformulary drug.

7 (b) "Standard prior authorization request" means a request by a
8 provider or facility for approval of a health care service or
9 prescription drug where the request is made in advance of the
10 enrollee obtaining a health care service that is not required to be
11 expedited.

12 (5) This section shall not apply to coverage provided under the
13 medicare part C or part D programs set forth in Title XVIII of the
14 social security act of 1965, as amended.

15 **Sec. 3.** RCW 74.09.840 and 2023 c 382 s 3 are each amended to
16 read as follows:

17 (1) Beginning January 1, 2024, the authority shall require each
18 managed care organization to comply with the following standards
19 related to prior authorization for health care services and
20 prescription drugs:

21 (a) The managed care organization shall meet the following time
22 frames for prior authorization determinations and notifications to a
23 participating provider or facility that submits the prior
24 authorization request through an electronic prior authorization
25 process, as designated by each managed care organization:

26 (i) For electronic standard prior authorization requests, the
27 managed care organization shall make a decision and notify the
28 provider or facility of the results of the decision within three
29 calendar days, excluding holidays, of submission of an electronic
30 prior authorization request by the provider or facility that contains
31 the necessary information to make a determination. If insufficient
32 information has been provided to the managed care organization to
33 make a decision, the managed care organization shall request any
34 additional information from the provider or facility within one
35 calendar day of submission of the electronic prior authorization
36 request.

37 (ii) For electronic expedited prior authorization requests, the
38 managed care organization shall make a decision and notify the
39 provider or facility of the results of the decision within one

1 calendar day of submission of an electronic prior authorization
2 request by the provider or facility that contains the necessary
3 information to make a determination. If insufficient information has
4 been provided to the managed care organization to make a decision,
5 the managed care organization shall request any additional
6 information from the provider or facility within one calendar day of
7 submission of the electronic prior authorization request.

8 (b) The managed care organization shall meet the following time
9 frames for prior authorization determinations and notifications to a
10 participating provider or facility that submits the prior
11 authorization request through a process other than an electronic
12 prior authorization process described in subsection (2) of this
13 section:

14 (i) For nonelectronic standard prior authorization requests, the
15 managed care organization shall make a decision and notify the
16 provider or facility of the results of the decision within five
17 calendar days of submission of a nonelectronic prior authorization
18 request by the provider or facility that contains the necessary
19 information to make a determination. If insufficient information has
20 been provided to the managed care organization to make a decision,
21 the managed care organization shall request any additional
22 information from the provider or facility within five calendar days
23 of submission of the nonelectronic prior authorization request.

24 (ii) For nonelectronic expedited prior authorization requests,
25 the managed care organization shall make a decision and notify the
26 provider or facility of the results of the decision within two
27 calendar days of submission of a nonelectronic prior authorization
28 request by the provider or facility that contains the necessary
29 information to make a determination. If insufficient information has
30 been provided to the managed care organization to make a decision,
31 the managed care organization shall request any additional
32 information from the provider or facility within one calendar day of
33 submission of the nonelectronic prior authorization request.

34 (c) In any instance in which a managed care organization has
35 determined that a provider or facility has not provided sufficient
36 information for making a determination under (a) and (b) of this
37 subsection, a managed care organization may establish a specific
38 reasonable time frame for submission of the additional information.
39 This time frame must be communicated to the provider and enrollee

1 with a managed care organization's request for additional
2 information.

3 (d) The prior authorization requirements of the managed care
4 organization must be described in detail and written in easily
5 understandable language. The managed care organization shall make its
6 most current prior authorization requirements and restrictions,
7 including the written clinical review criteria, available to
8 providers and facilities in an electronic format upon request. The
9 prior authorization requirements must be based on peer-reviewed
10 clinical review criteria. The clinical review criteria must be
11 evidence-based criteria and must accommodate new and emerging
12 information related to the appropriateness of clinical criteria with
13 respect to black and indigenous people, other people of color,
14 gender, and underserved populations. The clinical review criteria
15 must be evaluated and updated, if necessary, at least annually.

16 (2) (a) Each managed care organization shall (~~build and maintain~~
17 ~~a prior authorization application programming interface that~~
18 ~~automates the process for in-network providers to determine whether a~~
19 ~~prior authorization is required for health care services, identify~~
20 ~~prior authorization information and documentation requirements, and~~
21 ~~facilitate the exchange of prior authorization requests and~~
22 ~~determinations from its electronic health records or practice~~
23 ~~management system. The application programming interface must support~~
24 ~~the exchange of prior authorization requests and determinations for~~
25 ~~health care services beginning January 1, 2025, and must:~~

26 ~~(i) Use health level 7 fast health care interoperability~~
27 ~~resources in accordance with standards and provisions defined in 45~~
28 ~~C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);~~

29 ~~(ii) Automate the process to determine whether a prior~~
30 ~~authorization is required for durable medical equipment or a health~~
31 ~~care service;~~

32 ~~(iii) Allow providers to query the managed care organization's~~
33 ~~prior authorization documentation requirements;~~

34 ~~(iv) Support an automated approach using nonproprietary open~~
35 ~~workflows to compile and exchange the necessary data elements to~~
36 ~~populate the prior authorization requirements that are compliant with~~
37 ~~the federal health insurance portability and accountability act of~~
38 ~~1996 or have an exception from the federal centers for medicare and~~
39 ~~medicaid services; and~~

1 ~~(v) Indicate that~~) establish and maintain a prior authorization
2 application programming interface that is consistent with final rules
3 issued by the federal centers for medicare and medicaid services and
4 published in the federal register, and that indicates that a prior
5 authorization denial or authorization of a service less intensive
6 than that included in the original request is an adverse benefit
7 determination and is subject to the managed care organization's
8 grievance and appeal process under RCW 48.43.535. The implementation
9 of the application programming interface must align with federal
10 effective dates, including enforcement delays and suspensions, issued
11 by the federal centers for medicare and medicaid services.

12 (b) Each managed care organization shall establish and maintain
13 an interoperable electronic process or application programming
14 interface that automates the process for in-network providers to
15 determine whether a prior authorization is required for a covered
16 prescription drug. The interoperable electronic process or
17 application programming interface must support the exchange of prior
18 authorization requests and determinations for prescription drugs,
19 including information on covered alternative prescription drugs,
20 beginning January 1, 2027, and must:

21 (i) Allow providers to identify prior authorization information
22 and documentation requirements;

23 (ii) Facilitate the exchange of prior authorization requests and
24 determinations from its electronic health records or practice
25 management system(~~(, and may include the necessary data elements to~~
26 ~~populate the prior authorization requirements that are compliant with~~
27 ~~the federal health insurance portability and accountability act of~~
28 ~~1996 or have an exception from the federal centers for medicare and~~
29 ~~medicaid services)); and~~

30 (iii) Indicate that a prior authorization denial or authorization
31 of a drug other than the one included in the original prior
32 authorization request is an adverse benefit determination and is
33 subject to the managed care organization's grievance and appeal
34 process under RCW 48.43.535.

35 (c) If federal rules related to standards for using an
36 application programming interface to communicate prior authorization
37 status to providers are not finalized by September 13, 2023, the
38 requirements of (a) of this subsection may not be enforced until
39 ((January 1, 2026)) final rules published by the federal government
40 take effect.

1 ~~((d)(i) If a managed care organization determines that it will~~
2 ~~not be able to satisfy the requirements of (a) of this subsection by~~
3 ~~January 1, 2025, the managed care organization shall submit a~~
4 ~~narrative justification to the authority on or before September 1,~~
5 ~~2024, describing:~~

6 ~~(A) The reasons that the managed care organization cannot~~
7 ~~reasonably satisfy the requirements;~~

8 ~~(B) The impact of noncompliance upon providers and enrollees;~~

9 ~~(C) The current or proposed means of providing health information~~
10 ~~to the providers; and~~

11 ~~(D) A timeline and implementation plan to achieve compliance with~~
12 ~~the requirements.~~

13 ~~(ii) The authority may grant a one-year delay in enforcement of~~
14 ~~the requirements of (a) of this subsection (2) if the authority~~
15 ~~determines that the managed care organization has made a good faith~~
16 ~~effort to comply with the requirements.~~

17 ~~(iii) This subsection (2)(d) shall not apply if the delay in~~
18 ~~enforcement in (c) of this subsection takes effect because the~~
19 ~~federal centers for medicare and medicaid services did not finalize~~
20 ~~the applicable regulations by September 13, 2023.)~~

21 (3) Nothing in this section applies to prior authorization
22 determinations made pursuant to RCW 71.24.618 or 74.09.490.

23 (4) For the purposes of this section:

24 (a) "Expedited prior authorization request" means a request by a
25 provider or facility for approval of a health care service or
26 prescription drug where:

27 (i) The passage of time:

28 (A) Could seriously jeopardize the life or health of the
29 enrollee;

30 (B) Could seriously jeopardize the enrollee's ability to regain
31 maximum function; or

32 (C) In the opinion of a provider or facility with knowledge of
33 the enrollee's medical condition, would subject the enrollee to
34 severe pain that cannot be adequately managed without the health care
35 service or prescription drug that is the subject of the request; or

36 (ii) The enrollee is undergoing a current course of treatment
37 using a nonformulary drug.

38 (b) "Standard prior authorization request" means a request by a
39 provider or facility for approval of a health care service or
40 prescription drug where the request is made in advance of the

1 enrollee obtaining a health care service or prescription drug that is
2 not required to be expedited.

--- **END** ---