SSB 6404 - S AMD **1103**
By Senator Frockt

ADOPTED AS AMENDED 02/18/2020

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** A new section is added to chapter 48.43
4 RCW to read as follows:
5 (1) By October 1, 2020, and annually thereafter, for individual
6 and group health plans issued by a carrier that covers at least one
7 percent of the covered lives in the state, the carrier shall report
8 to the commissioner the following aggregated and deidentified data
9 related to the carrier's prior authorization practices and experience
10 for the prior plan year:
11 (a) Lists of the ten inpatient medical or surgical codes:
12 (i) With the highest total number of prior authorization requests
13 during the previous plan year, including the total number of prior
14 authorization requests for each code and the percent of approved
15 requests for each code;
16 (ii) With the highest percentage of approved prior authorization
17 requests during the previous plan year, including the total number of
18 prior authorization requests for each code and the percent of
19 approved requests for each code; and
20 (iii) With the highest percentage of prior authorization requests
21 that were initially denied and then subsequently approved on appeal,
22 including the total number of prior authorization requests for each
23 code and the percent of requests that were initially denied and then
24 subsequently approved for each code;
25 (b) Lists of the ten outpatient medical or surgical codes:
26 (i) With the highest total number of prior authorization requests
27 during the previous plan year, including the total number of prior
28 authorization requests for each code and the percent of approved
29 requests for each code;
30 (ii) With the highest percentage of approved prior authorization
31 requests during the previous plan year, including the total number of

prior authorization requests for each code and the percent of approved requests for each code; and

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

(c) Lists of the ten inpatient mental health and substance use disorder service codes:

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

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

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

(d) Lists of the ten outpatient mental health and substance use disorder service codes:

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

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

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

(e) The average determination response time in hours for prior authorization requests to the plan with respect to each code listed

in (a) through (d) of this subsection for each of the following categories of prior authorization:

(i) Expedited decisions;

(ii) Standard decisions; and

(iii) Extenuating circumstances decisions.

(2) The commissioner shall provide the data collected under subsection (1) of this section to the prior authorization work group. The data provided to the work group must be aggregated and deidentified, and may not identify the name of the carrier that submitted the data.

(3) In support of the prior authorization work group, the commissioner may request additional information from carriers reporting data under this section.

(4) 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.

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

(6) 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.

(7) 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.

1 (b) By September 1, 2020, the governor shall appoint fifteen
2 members of the prior authorization work group to be comprised of
3 representatives from health care providers, hospitals, clinics,
4 carriers, the office of the insurance commissioner, and the health
5 care authority. Except for the representative of the office of the
6 insurance commissioner, all appointed representatives must be
7 clinicians with at least fifty percent representing providers,
8 hospitals, and clinics, and at least twenty-five percent representing
9 carriers. One representative must be a behavioral health provider or
10 from a behavioral health organization. The appointed members of the
11 prior authorization work group shall select the work group chair.
12 (2)(a) By January 1, 2021, and annually thereafter, the prior
13 authorization work group shall select and review not less than five
14 medical or surgical services, which may include mental health and
15 substance use disorder services, subject to prior authorization by
16 insurance carriers. The prior authorization work group shall conduct
17 its review and issue prior authorization recommendations by December
18 31st of the year in which the review began.
19 (b) The prior authorization work group shall establish
20 subcommittees to focus on specific services selected for review. Each
21 subcommittee must be comprised of practicing clinicians with
22 expertise relevant to the specific medical or surgical service
23 selected for review. Each subcommittee must include at least two
24 members of the specialty or subspecialty society most experienced
25 with the service identified for review. Subcommittee members are not
26 required to be members of the prior authorization work group. Each
27 subcommittee shall make recommendations to the prior authorization
28 work group related to the recommendations in subsection (3) of this
29 section.
30 (c) In 2021 the prior authorization work group shall review, as
31 one of the services selected, noninvasive cardiac diagnostic imaging
32 procedures.
33 (d) The prior authorization work group shall consider the prior
34 authorization data collected in section 1 of this act and shall
35 select and prioritize services for review based on the following
36 criteria:
37 (i) The volume of the service as indicated by prior authorization
38 requests;
39 (ii) Indications based on medical literature that prior
40 authorization is not appropriate for a service;

1 (iii) The potential for negative impact on patient care caused by
2 prior authorization delays; and
3 (iv) Input from health care providers, health care facilities,
4 insurance carriers, and health insurance purchasers.
5 (3) For each service identified in subsection (2) of this
6 section, the prior authorization work group shall assess the
7 following areas and make corresponding recommendations:
8 (a) Whether the utilization and approval patterns and medical
9 literature justify the use of a prior authorization requirement for
10 the service. If not, the prior authorization work group shall
11 recommend no prior authorization be required for the service;
12 (b) Whether adoption of uniform appropriate use criteria or
13 evidence-based criteria confirmed through a clinical decision support
14 mechanism for the service in lieu of prior authorization is
15 appropriate. If so, the prior authorization work group shall identify
16 and select appropriate criteria for the service. The prior
17 authorization work group shall consider the availability and cost of
18 the clinical decision support mechanisms and possible alternative
19 methods of validation in its recommendation. If the work group
20 recommends the use of appropriate use criteria, the work group shall
21 recommend adoption of appropriate use criteria developed by a
22 federally qualified provider-led entity pursuant to 42 C.F.R. 414.94
23 as it existed on February 1, 2020;
24 (c) Whether an appropriate federal policy or initiative exists
25 for the service. Any recommendations by the prior authorization work
26 group should align with criteria used for federal initiatives and
27 approval mechanisms under the medicare program; and
28 (d) The prior authorization work group shall consider the
29 services as provided to both adult and pediatric patients and when
30 appropriate, provide separate recommendations regarding the service
31 for adult and pediatric patients.
32 (4) The prior authorization work group shall review and make
33 updates as necessary to the recommendations made pursuant to
34 subsection (3) of this section based on evidence that a
35 recommendation no longer reflects relevant evidence-based guidelines.
36 (5) Beginning December 1, 2021, the work group must annually
37 report on its recommendations to the health care committees of the
38 legislature.
39 (6) For purposes of this section:

1 (a) "Prior authorization" means a mandatory process that a
2 carrier or its designated or contracted representative requires a
3 provider or facility to follow before a service is delivered, to
4 determine if a service is a benefit and meets requirements for
5 medical necessity, clinical appropriateness, level of care, or
6 effectiveness in relation to the applicable plan, including any term
7 used by a carrier or its designated or contracted representative to
8 describe this process.
9 (b) "Appropriate use criteria" means criteria developed or
10 endorsed by a provider-led entity to assist health care practitioners
11 in making the most appropriate treatment decision for a specific
12 clinical condition for an individual. To the extent feasible, such
13 criteria must be evidence-based.
14 (c) "Clinical decision support mechanism" means a tool for use by
15 clinicians that communicates selected appropriate use criteria
16 information to the user and assists clinicians in making the most
17 appropriate treatment decision for a patient's specific clinical
18 condition.
19 (d) "Qualified provider-led entity" means a professional medical
20 specialty society or organization."

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21 On page 1, line 3 of the title, after "criteria;" strike the
22 remainder of the title and insert "adding a new section to chapter
23 48.43 RCW; and adding a new section to chapter 70.250 RCW."

EFFECT: (1) Applies the reporting requirements only to individual and group health plans issued by a carrier that cover at least one percent of the covered lives in Washington;

(2) Requires carriers to submit lists of medical or surgical codes, instead of medical or surgical services;

(3) Requires submission of lists of codes of the highest total number of prior authorization requests, instead of the highest total volume of requests;

(4) Requires submission of lists of codes of the highest percentage of approved requests and requests that were initially denied and then subsequently approved, instead of the highest number of those requests;

(5) Requires the submission of two additional sets of lists: (a) Ten inpatient mental health and substance use disorder service codes;

and (b) ten outpatient mental health and substance use disorder service codes;

(6) Adjusts the categories of prior authorizations that a carrier must submit average determination response times for from urgent concurrent, urgent preservice, nonurgent preservice, and postservice decisions, to expedited, standard, and extenuating circumstances decisions;

(7) Permits the insurance commissioner to request additional information from carriers;

(8) Adds a representative from the office of the insurance commissioner to the prior authorization work group;

(9) Requires one person on the work group to be a behavioral health provider or a representative from a behavioral health organization; and

(10) Requires that if the work group recommends appropriate use criteria for any service, that the work group recommend adoption of appropriate use criteria developed by a federally qualified provider-led entity, instead of just in instances when the work group recommends appropriate use criteria related to noninvasive cardiac diagnostic imaging procedures.

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