Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

ESSB 6404

Brief Description: Adopting prior authorization and appropriate use criteria in patient care.

Sponsors: Senate Committee on 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).

Brief Summary of Engrossed Substitute Bill

- Establishes the Prior Authorization Work Group to review prior authorization standards for specific health care services and to make recommendations to the Legislature.
- Requires carriers to submit certain information related to prior authorization practices to the Insurance Commissioner.

Hearing Date: 2/26/20

Staff: Kim Weidenaar (786-7120).

Background:

Prior Authorization.
Prior authorization is the requirement that a health care provider seek approval of a drug, procedure, or test before seeking reimbursement from an insurer. Health carriers may impose different prior authorization standards and criteria for a covered service among tiers of contracting providers. In 2018 the Legislature prohibited health carriers from requiring prior authorization for initial evaluation and management visits, and up to six consecutive treatment visits in a new episode of care of chiropractic, physical therapy, occupational therapy, acupuncture and Eastern medicine, massage therapy, and speech and hearing therapies that meet the standards of medical necessity and are subject to quantitative treatment limits of the health plan.

Bree Collaborative.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

In 2011 the Legislature established the Dr. Robert Bree Collaborative (Collaborative), which identifies health care services that have substantial variations in practice patterns or high utilization trends and investigates evidence-based practices that will improve quality and reduce variation in the use of the services.

Each year, the Collaborative must identify up to three services to address. For each health care service identified, the Collaborative must analyze evidence-based practice approaches to improve quality and reduce variations in service; identify data collection and reporting necessary to develop baseline health service utilization rates and measure the impact of adopted strategies; and identify strategies to increase the use of evidence-based best practice approaches in both state and private health care plans. The Collaborative must report annually to the administrator of the Health Care Authority (HCA), the Legislature, and the Governor, regarding the health service areas it has identified to review and its recommended strategies.

The Collaborative consists of 20 members, appointed by the Governor, including representatives of health carriers, third-party administrators, health maintenance organizations, physicians who represent certain practice areas, self-funded purchasers of health care services, state purchased health care programs, and the Washington Health Alliance. The Collaborative is authorized to include additional members to acquire expertise in the service areas identified for review.

The Collaborative has published reports on topics such as accountable payment models, addiction and dependence treatment, cardiovascular health, obstetrics, potentially avoidable hospital readmissions, and pediatric psychotropic use. All state purchased health care programs must implement evidence-based best practice guidelines or protocols developed by the Collaborative after the HCA administrator, in consultation with participating agencies, has affirmatively reviewed and endorsed the recommendations.

Summary of Bill:

Prior Authorization Work Group.
The Prior Authorization Work Group (Work Group) is established and is to be hosted and staffed by the Bree Collaborative. By September 1, 2020, the Governor must appoint 15 members to the Work Group comprised of representatives from health care providers, hospitals, clinics, carriers, a patient advocacy group, the Office of the Insurance Commissioner (OIC), and the Health Care Authority. Except for the patient advocacy group representative and OIC representative, all representatives must be clinicians with at least 50 percent representing providers, hospitals, and clinics, and at least 25 percent representing carriers. One representative must be a behavioral health provider or from a behavioral health organization. The appointed members of the Work Group must select the chair.

By January 1, 2021, and annually thereafter, the Work Group must select, review, and provide prior authorization recommendations for at least five medical, surgical, mental health, or substance use disorder services, subject to prior authorization. Recommendations require an affirmative vote of 60 percent of the members

The Work Group must establish subcommittees to focus on specific services selected for each review. Each subcommittee must be comprised of practicing clinicians with relevant expertise to

the service being reviewed and must include at least two members of the specialty or subspecialty society most experienced with the identified service.

The Work Group must consider the data collected by the Insurance Commissioner (Commissioner) and must select and prioritize services for review based on:

- the volume of prior authorization requests;
- indications based on medical literature that prior authorization is not appropriate for a service;
- the potential for negative impact on patient care cause by prior authorization delays; and
- input from health care providers, facilities, carriers, and health insurance purchasers.

In 2021 the Work Group must review noninvasive cardiac diagnostic imaging. For each service reviewed, the Work Group must assess the following areas and make corresponding recommendations:

- whether the utilization and approval patterns and medical literature justify the use of a prior authorization requirement for the service and, if not, the Work Group should recommend no prior authorization be required for the service;
- 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; and
- whether an appropriate federal policy or initiative exists for the service, and if so, any recommendations should align with the federal criteria.

The Work Group must:

- consider the services as provided to both adult and pediatric patients and provide separate recommendations, when appropriate;
- review and update the recommendations based on evidence that a recommendation no longer reflects relevant evidence-based guidelines; and
- beginning December 1, 2021, and annually, report its recommendations to the Legislature.

Insurance Commissioner Duties.

By October 1, 2020, and annually thereafter, for health plans issued by a carrier, a carrier must report the following deidentified and aggregated data to the Commissioner for the prior plan year:

- lists of the 10 inpatient and 10 outpatient medical or surgical codes, and lists of the 10 inpatient and 10 outpatient mental health and substance use disorder codes:
    - with the highest total number of prior authorization requests, including the number of requests and percent of approved requests for each code;
    - with the highest percentage of approved prior authorization requests, including the number of requests and percent of approved requests for each code; and
    - with the highest percentage or prior authorization requests that were initially denied and then subsequently approved on appeal, including the number of requests and the percent of requests initially denied and then subsequently approved for each code;
- the average determination response time in hours for prior authorization requests to the plan with respect to each covered service included in the lists for each of the following prior authorization categories:

- expedited decisions;
- standard decisions; and
- extenuating circumstances decisions.

The Commissioner must:

- develop standardized reports of the data and make the reports available to interested parties;
- post the Work Group's recommendations on the Commissioner's website; and
- provide the data collected from the carriers to the Work Group in an aggregated and deidentified format that does not identify the carrier.

The Commissioner may request additional data from carriers and adopt rules.

"Prior authorization" is defined as 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.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.