
HOUSE BILL 2568

State of Washington

66th Legislature

2020 Regular Session

By Representatives Slatter, Harris, Cody, Schmick, Leavitt, Kloba, Tharinger, Pollet, and Macri

Read first time 01/15/20. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to reducing barriers to patient care through
2 appropriate use of prior authorization and adoption of appropriate
3 use criteria; amending RCW 41.05.074 and 74.09.758; adding new
4 sections to chapter 48.43 RCW; and adding a new section to chapter
5 70.250 RCW.

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

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

9 (1) By October 1, 2020, for health plans issued by a carrier, the
10 carrier shall report to the commissioner the following information
11 related to the carrier's prior authorization practices and experience
12 for the 2019 plan year:

13 (a) A list of all covered services subject to prior authorization
14 requirements under the plan during the previous plan year;

15 (b) The total number of prior authorization requests during the
16 previous plan year for each covered service listed in (a) of this
17 subsection;

18 (c) The number and percentage of prior authorization requests
19 approved during the previous plan year with respect to each covered
20 service listed in (a) of this subsection;

1 (d) The number of prior authorization requests that were
2 initially denied and then subsequently appealed during the previous
3 plan year, and the number and percentage for covered services with
4 overturn rates in excess of seventy-five percent;

5 (e) The number and percentage of claims that were denied due to
6 absence of an approved prior authorization with respect to each
7 covered service listed in (a) of this subsection; and

8 (f) The average and median determination response time in hours
9 for prior authorization requests to the plan with respect to each
10 covered service listed in (a) of this subsection.

11 (2) By October 1, 2021, and annually thereafter, for health plans
12 issued by a carrier, the carrier shall report to the commissioner any
13 new or adjusted prior authorization requirements imposed for the
14 preceding plan year. Carriers must report this information to the
15 commissioner within ninety days of imposing the new requirement. The
16 commissioner shall provide this information to the prior
17 authorization work group on an ongoing basis.

18 (3)(a) The commissioner may, at its discretion, request the
19 information in subsection (1) of this section for the most recently
20 completed plan year.

21 (b) Carriers shall report to the commissioner the information
22 requested by the commissioner pursuant to this subsection.

23 (c) The insurance commissioner may not make requests under this
24 subsection more frequently than once every three years.

25 (4) The commissioner shall compile and provide data to the prior
26 authorization work group pursuant to section 2 of this act.

27 (5) The commissioner shall develop standardized reports of
28 aggregated and deidentified data submitted pursuant to subsections
29 (1) through (3) of this section and make the reports available upon
30 request to interested parties.

31 (6) The commissioner shall post recommendations from the prior
32 authorization work group made under section 2 of this act, including
33 the specific decision-making criteria selected, on the commissioner's
34 web site.

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

39 (8) For the purpose of this section, "prior authorization" means
40 a mandatory process that a carrier or its designated or contracted

1 representative requires a provider or facility to follow, prior to
2 delivery of a service, to determine if a service is a benefit and
3 meets the applicable medical policy requirements for medical
4 necessity, clinical appropriateness, site of care, level of care,
5 sequence of treatment alternatives, or effectiveness in relation to
6 the applicable plan. Prior authorization includes, but is not limited
7 to, utilization management and medical necessity review processes
8 used by a carrier.

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

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

15 (b) The governor shall appoint fifteen members of the prior
16 authorization work group to be comprised of representatives from
17 health care providers, hospitals, clinics, carriers, and the health
18 care authority. All appointed representatives must be clinicians with
19 at least fifty percent representing providers, hospitals, and
20 clinics. The appointed members of the prior authorization work group
21 shall select the work group chair.

22 (2)(a) No later than January 1, 2021, and annually thereafter,
23 the prior authorization work group shall select and review not less
24 than five medical or surgical services subject to prior authorization
25 by insurance carriers. The prior authorization work group shall
26 conduct its review and issue prior authorization recommendations no
27 later than December 31st of the year in which the review began.

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

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

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

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

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

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

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

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

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

23 (b) Whether adoption of uniform appropriate use criteria or
24 evidence-based criteria confirmed through a clinical decision support
25 mechanism for the service in lieu of prior authorization is
26 appropriate. If so, the prior authorization work group shall identify
27 and select or develop appropriate criteria for the service. The prior
28 authorization work group shall consider the availability and cost of
29 the clinical decision support mechanisms and possible alternative
30 methods of validation in its recommendation;

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

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

39 (4) The prior authorization work group shall review and make
40 updates as necessary to the recommendations made pursuant to

1 subsection (3) of this section based on evidence that a
2 recommendation no longer reflects relevant evidence-based guidelines.

3 (5) For purposes of this section:

4 (a) "Prior authorization" means a mandatory process that a
5 carrier or its designated or contracted representative requires a
6 provider or facility to follow, prior to delivery of a service, to
7 determine if a service is a benefit and meets the applicable medical
8 policy requirements for medical necessity, clinical appropriateness,
9 site of care, level of care, sequence of treatment alternatives, or
10 effectiveness in relation to the applicable plan. Prior authorization
11 includes, but is not limited to, utilization management and medical
12 necessity review processes used by a carrier.

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

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

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

25 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43
26 RCW to read as follows:

27 (1) Carriers shall adopt prior authorization standards, as
28 required by the commissioner in rule.

29 (2) The commissioner shall adopt rules incorporating the prior
30 authorization work group recommendations, developed under section 2
31 of this act, as prior authorization standards.

32 (a) The commissioner shall update the rules based on changes to,
33 or the addition of, recommendations by the prior authorization work
34 group under section 2 of this act.

35 (b) The commissioner may decline to adopt a recommendation of the
36 prior authorization work group only if experts in the field offer
37 clear evidence that the standard conflicts with relevant evidence-
38 based guidelines.

1 **Sec. 4.** RCW 41.05.074 and 2019 c 308 s 20 are each amended to
2 read as follows:

3 (1) A health plan offered to public employees and their covered
4 dependents under this chapter that imposes different prior
5 authorization standards and criteria for a covered service among
6 tiers of contracting providers of the same licensed profession in the
7 same health plan shall inform an enrollee which tier an individual
8 provider or group of providers is in by posting the information on
9 its web site in a manner accessible to both enrollees and providers.

10 (2) The health plan may not require prior authorization for an
11 evaluation and management visit or an initial treatment visit with a
12 contracting provider in a new episode of chiropractic, physical
13 therapy, occupational therapy, acupuncture and Eastern medicine,
14 massage therapy, or speech and hearing therapies. Notwithstanding RCW
15 48.43.515(5), this section may not be interpreted to limit the
16 ability of a health plan to require a referral or prescription for
17 the therapies listed in this section.

18 (3) The health care authority shall post on its web site and
19 provide upon the request of a covered person or contracting provider
20 any prior authorization standards, criteria, or information the
21 health plan uses for medical necessity decisions.

22 (4) A health care provider with whom the administrator of the
23 health plan consults regarding a decision to deny, limit, or
24 terminate a person's covered health care services must hold a
25 license, certification, or registration, in good standing and must be
26 in the same or related health field as the health care provider being
27 reviewed or of a specialty whose practice entails the same or similar
28 covered health care service.

29 (5) The health plan may not require a provider to provide a
30 discount from usual and customary rates for health care services not
31 covered under the health plan, policy, or other agreement, to which
32 the provider is a party.

33 (6) Health plans offered to public employees and their covered
34 dependents under this chapter shall adopt the recommendations of the
35 prior authorization work group developed pursuant to section 2 of
36 this act.

37 (7) For purposes of this section:

38 (a) "New episode of care" means treatment for a new or recurrent
39 condition for which the enrollee has not been treated by the provider

1 within the previous ninety days and is not currently undergoing any
2 active treatment.

3 (b) "Contracting provider" does not include providers employed
4 within an integrated delivery system operated by a carrier licensed
5 under chapter 48.44 or 48.46 RCW.

6 **Sec. 5.** RCW 74.09.758 and 2019 c 325 s 5029 are each amended to
7 read as follows:

8 (1) The authority and the department may restructure medicaid
9 procurement of health care services and agreements with managed care
10 systems on a phased basis to better support integrated physical
11 health, mental health, and substance use disorder treatment,
12 consistent with assumptions in Second Substitute Senate Bill No.
13 6312, Laws of 2014, and recommendations provided by the behavioral
14 health task force. The authority and the department may develop and
15 utilize innovative mechanisms to promote and sustain integrated
16 clinical models of physical and behavioral health care.

17 (2) The authority and the department may incorporate the
18 following principles into future medicaid procurement efforts aimed
19 at integrating the delivery of physical and behavioral health
20 services:

21 (a) Medicaid purchasing must support delivery of integrated,
22 person-centered care that addresses the spectrum of individuals'
23 health needs in the context of the communities in which they live and
24 with the availability of care continuity as their health needs
25 change;

26 (b) Accountability for the client outcomes established in RCW
27 71.24.435 and 71.36.025 and performance measures linked to those
28 outcomes;

29 (c) Medicaid benefit design must recognize that adequate
30 preventive care, crisis intervention, and support services promote a
31 recovery-focused approach;

32 (d) Evidence-based care interventions and continuous quality
33 improvement must be enforced through contract specifications and
34 performance measures that provide meaningful integration at the
35 patient care level with broadly distributed accountability for
36 results;

37 (e) Active purchasing and oversight of medicaid managed care
38 contracts is a state responsibility;

1 (f) A deliberate and flexible system change plan with identified
2 benchmarks to promote system stability, provide continuity of
3 treatment for patients, and protect essential existing behavioral
4 health system infrastructure and capacity; and

5 (g) Community and organizational readiness are key determinants
6 of implementation timing; a phased approach is therefore desirable.

7 (3) The principles identified in subsection (2) of this section
8 are not intended to create an individual entitlement to services.

9 (4) The authority shall require managed care organizations that
10 provide services to clients under this chapter to adopt the
11 recommendations of the prior authorization work group developed
12 pursuant to section 2 of this act upon initiation or renewal of a
13 contract with the authority following the recommendation.

14 (5) The authority shall increase the use of value-based
15 contracting, alternative quality contracting, and other payment
16 incentives that promote quality, efficiency, cost savings, and health
17 improvement, for medicaid and public employee purchasing. The
18 authority shall also implement additional chronic disease management
19 techniques that reduce the subsequent need for hospitalization or
20 readmissions. It is the intent of the legislature that the reforms
21 the authority implements under this subsection are anticipated to
22 reduce extraneous medical costs, across all medical programs, when
23 fully phased in by fiscal year 2017 to generate budget savings
24 identified in the omnibus appropriations act.

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