S-5119.1

SENATE BILL 6404

State of Washington 66th Legislature 2020 Regular Session

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 01/16/20. Referred to Committee on Health & Long Term Care.

AN ACT Relating to reducing barriers to patient care through appropriate use of prior authorization and adoption of appropriate use criteria; amending RCW 41.05.074 and 74.09.758; adding new sections 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, for health plans issued by a carrier, the carrier shall report to the commissioner the following information related to the carrier's prior authorization practices and experience for the 2019 plan year:

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

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

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

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

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

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

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

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

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

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

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

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

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

(7) 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.

(8) 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, prior to delivery of a service, to determine if a service is a benefit and meets the applicable medical policy requirements for medical necessity, clinical appropriateness, site of care, level of care, sequence of treatment alternatives, or effectiveness in relation to the applicable plan. Prior authorization includes, but is not limited to, utilization management and medical necessity review processes used by a carrier.

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) 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. The appointed members of the prior authorization work group shall select the work group chair.

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

(b) The prior authorization work group shall establish subcommittees to focus on specific medical or surgical 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 medical or surgical 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 or develop 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;

(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) 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, prior to delivery of a service, to determine if a service is a benefit and meets the applicable medical policy requirements for medical necessity, clinical appropriateness, site of care, level of care, sequence of treatment alternatives, or effectiveness in relation to the applicable plan. Prior authorization includes, but is not limited to, utilization management and medical necessity review processes used by a carrier.

(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.

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

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

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

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

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

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

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

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

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

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

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

(6) <u>Health plans offered to public employees and their covered dependents under this chapter shall adopt the recommendations of the prior authorization work group developed pursuant to section 2 of this act.</u>

<u>(7)</u> For purposes of this section:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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