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Technical Assistance Advisory 2023-04[1]

TO: Health carriers that offer health plans, as defined in RCW 48.43.005

FROM: Insurance Commissioner Mike Kreidler

DATE: December 20, 2023

SUBJECT: Implementation of Engrossed Second Substitute House Bill 1357 in the matter of modernizing the prior authorization process

The Office of the Insurance Commissioner (OIC) is issuing this Technical Assistance Advisory (TAA) to provide guidance concerning the new requirements adopted in RCW 48.43.830 for health carriers that utilize prior authorization processes for either health care services or prescription drug services in their health plans. This guidance is designed to help carriers understand their compliance obligations to the extent the new statute conflicts with existing OIC rules.

Background

The Washington State Legislature passed Engrossed Second Substitute House Bill 1357 (E2SHB 1357 (2023)), subsequently codified as RCW 48.43.830 and effective for health plans issued or renewing on or after January 1, 2024. The OIC's rulemaking "Revising the prior authorization process" (R2023-02) will address the new law and make updates to

[1]This advisory is a policy statement released to advise the public of OIC's current opinions, approaches, and likely courses of action. It is advisory only. RCW 34.05.230(1).

Subchapter D of Chap. 284-43 WAC.[2] Because the prior authorization rulemaking process will extend into 2024, the OIC is providing guidance in this TAA on how to comply with the law to the extent current OIC rules are inconsistent with the deadlines and requirements of the new statute.

RCW 48.43.830 changed current prior authorization requirements through four major components:

- Shortens prior authorization determination timelines;
- Requires carriers to communicate prior authorization criteria clearly and share it electronically;
- Adds standards for clinical review criteria used in prior authorization determinations; and
- Requires carriers to upgrade prior authorization processes to standardized interoperability.

OIC Implementation and Enforcement of New Statutory Prior Authorization Requirements and Application Programming Interface (API) Upgrades

OIC will enforce most of the provisions of E2SHB 1357, codified as RCW 48.43.830, beginning on January 1, 2024, as required by the statute and described below. To the extent there is a conflict between the current OIC rules and the newly codified RCW 48.43.830, the new statute overrides the OIC rule. Specifically, enforcement will relate to the following:

New Prior Authorization Timelines

RCW 48.43.830(1)(a)-(c) establishes different timelines for standard and expedited prior authorization determinations. The new timelines apply to health care and prescription drug services and vary based upon whether the requests are submitted in electronic or non-electronic format. The OIC will enforce the new statutory prior authorization timelines that apply to both health care services and prescription drugs within health plans issued on or after January 1, 2024.

[2] Because WAC 284-170-130, the Health Benefit Plan Management Subchapter A, General Provisions, Definitions section was opened within the "Consolidated health care rulemaking" (2023-7), the expedited and standard prior authorization request definitions in RCW 48.43.830(4) were included in that rulemaking process.

For electronic standard prior authorization requests, the timeline for determinations will be within three calendar days of the prior authorization submission, excluding holidays. For electronic expedited prior authorization requests, the timeline for determinations will be within one calendar day of the prior authorization submission. If more information is needed to make a prior authorization decision for either an electronic standard or an electronic expedited request, the carrier must request additional information within one calendar day of the prior authorization submission.

For nonelectronic standard prior authorization requests, the timeline for determinations will be within five days of the submission. If more information is needed to make a prior authorization decision for a nonelectronic standard prior authorization request, the carrier must request additional information within five calendar days of the submission. For nonelectronic expedited prior authorization requests, the timeline for determinations will be within two calendar days of the submission. If more information is needed to make a prior authorization decision for a nonelectronic expedited request, the carrier must request additional information within one calendar day of the submission.

Within any of the above timeframes, if a carrier still has insufficient information to make a prior authorization determination, the carrier can establish a specific reasonable time frame for additional information submission.[3] The carrier must communicate the additional information request and the time frame to the provider and to the enrollee.[4]

New Prior Authorization Communication and Clinical Review Requirements

RCW 48.43.830(1)(d) also outlines new standards for how prior authorization requirements are communicated, developed, and reviewed. The OIC will enforce these new prior authorization requirements that apply to both health care services and prescription drugs within health plans issued or renewed on or after January 1, 2024.[5] The detailed changes require carriers to:

- Describe their prior authorization requirements in detailed, easily understandable language;
- Make their current prior authorization requirements and restrictions, including written clinical review criteria, electronically available to providers and facilities upon request;

[3] RCW 48.43.830(1)(c).
[4] *Id.*
[5] RCW 48.43.830(1)(d).

- Base their prior authorization requirements on peer-reviewed, evidence-based clinical review criteria;
- Ensure that their clinical review criteria accommodate new and emerging information related to the appropriateness of clinical criteria with respect to black and indigenous people, other people of color, gender, and underserved populations; and
- Evaluate and update the clinical review criteria at least annually, if necessary.

New Application Programming Interface (API) Upgrades

Finally, RCW 48.43.830(2)(a)-(d) requires health carriers to automate prior authorization requests and determination processes through an API or an interoperable electronic process (IEP). The timelines and procedures for Washington's prior authorization process automation requirements are aligned with proposed rules issued by the federal Centers for Medicare and Medicaid Services (CMS) Rulemaking for Advancing Interoperability and Improving Prior Authorization Processes (CMA-0057-P). The initial API upgrades must support prior authorization requests and determinations for health care services beginning on January 1, 2026.[6] The API or IEP upgrades for prescription drug prior authorization requests are on a January 1, 2027 timeline. Therefore the OIC will enforce the requirement to provide this interface for health care service prior authorizations beginning on January 1, 2026. The OIC will enforce the requirement to provide this interface for prescription drug prior authorizations beginning on January 1, 2027.

Please direct any questions about this advisory to Joyce Brake, Policy and Rules Manager, who may be contacted at joyce.brake@oic.wa.gov or (360) 725-7041.

[6] Per RCW 48.43.830(2)(c), the initial API upgrade requirements in RCW 48.43.830(2)(a) will not be enforced until this date because CMS did not finalize the federal rules related to API standards in prior authorization settings by September 13, 2023.