Managed Care Implementation Update

Engrossed Substitute Senate Bill 5187; Section 211(71)(b); Chapter 475; Laws of 2023

Engrossed Second Substitute House Bill 1357; Section 3; Chapter 382; Laws of 2023

Legislative summary

In 2023 the legislature passed E2SHB 1357, modernizing prior authorization processes for all health carriers including Apple Health (Medicaid) Managed Care Organizations (MCO). The bill requires a reduction in prior authorization turn-around times, creates differing turn-around times for authorization requests received via electronic versus non-electronic methods, establishes requirements for written clinical review criteria, and mandates MCO creation of a prior authorization Application Programming Interface (API) for in-network providers. All requirements of this act went into effect on January 1, 2024, with the exception of API creation which will go into effect January 1, 2026, and implementation of a prescription drug API by January 1, 2027.

Implementation

Health Care Authority (HCA) works closely with our contracted MCOs on the implementation of E2SHB 1357 components through changes in contract language and provision of technical assistance when required.

Electronic vs. Non-Electronic Prior Authorization Request Definition

In partnership with the Office of the Insurance Commissioner (OIC), new definitions were added to the MCO contracts to define when a prior authorization request has been received via electronic means. HCA worked with OIC to ensure consistency across Medicaid and commercial health plans.

Prior Authorization Turn-around Times

The MCO contract requires completion of standard prior authorizations within 3 calendar days when received electronically, or 5 calendar days when received non-electronically. Expedited requests must be completed within 1 calendar day electronic or 2 calendar days non-electronic. Extensions may be granted if additional information is requested from the provider to support the request. This extension allows the provider 2 days to respond for expedited requests, or 4 days to respond for standard requests.

These requirements were updated in the MCO contracts with an effective date of January 1, 2024. HCA worked with MCOs leading up to the go-live date to address perceived barriers and facilitate discussion of strategies for compliance between peer organizations. All MCOs have complied with the reduced turn-around times since the effective date.

Written Clinical Review Criteria Requirements

HCA's contracts with MCOs require them to utilize evidence-based criteria reviewed annually and updated as needed, have a method to provide written criteria to providers or enrollees upon request, and to consider needs of diverse populations. All contracted MCOs utilize a mix of proprietary and nationally

Medicaid Programs Division
P.O. Box 45530
Olympia, WA, 98504-5530
Phone: (360) 725-1709
hca.wa.gov

published clinical criteria (e.g., MCG or Interqual). Nationally published criteria are subject to licensing restrictions which complicate the ability to disclose the full document to enrollees and providers. These criteria are available upon request but cannot be published online due to legal constraints. HCA continues to provide technical assistance to MCOs to navigate these restrictions and ensure MCOs respond promptly to requests for written copies of clinical criteria.

Prior Authorization API

Due to delay in publication of federal rules for API standards, the API portion of E2SHB 1357 does not go into effect until January 1, 2026. Since the spring of 2024, HCA has been proactively working with MCOs on implementation plans though a series of collaborative meetings. This meeting series will continue throughout 2025 to support MCO implementation and compliance with E2SHB 1357 and CMS 0057-F. Ongoing technical assistance will be provided as needs are identified and Centers for Medicare & Medicaid Services (CMS) issues additional guidance. Internal HCA workgroups on the technical specifications of the CMS mandated APIs are underway and will guide additional MCO outreach and technical assistance.

Due to differences in implementation timeframes for state and federal regulations and differences in CMS technical specification guidance, additional work remains to harmonize implementation strategies and comply with both rules.

MCO Compliance

HCA is ensuring MCO compliance with E2SHB 1357 through monitoring of prior authorization samples, prior authorization trends, administrative hearings, and ad-hoc complaints.

- **Monitoring of Prior Authorization Samples**
    - HCA monitors a targeted sample of files from each MCO on an annual basis through our TEAMonitor compliance review program.
    - In addition to our annual review of these items, each MCO must achieve and maintain accreditation through the National Committee for Quality Assurance (NCQA). NCQA reviews individual prior authorization determinations in a similar manner to the reviews performed by HCA's TEAMonitor annual review.
- **Monitoring of Prior Authorization Trends**
    - MCOs are required to submit a quarterly report to HCA containing information on each prior authorization denial, grievance, or appeal request received. These reports are reviewed for trends or patterns.
    - MCOs submit a quarterly report to HCA that monitors compliance with prior authorization turn-around times. MCOs must maintain compliance with timeframes at a rate of >90%. All MCOs are currently in compliance with the required timeframes.
    - MCOs must produce an evaluation of their utilization management programs on an annual basis. This report requires the MCO to reflect on the efficacy and quality of their

utilization management program. HCA reviews these reports for compliance with particular attention to overall rates of denials and approvals as well as utilization of services. This allows HCA to compare MCO denial rates and observe for concerning trends. The format of this data currently varies across MCOs. HCA continues to work on standardization of utilization management reporting from MCOs to ensure the accuracy and quality of analyses are improved over time.

- **Monitoring of Administrative Hearings**
  - HCA clinical staff review all administrative hearing requests to ensure clinically appropriate and contractually compliant decisions were made. This allows our subject matter experts to note any trends in requests for administrative hearings and may guide future technical assistance or increased monitoring in future TEAMonitor reviews.
  - Administrative hearing reviews include a review of Adverse Benefit Determination and Appeal Resolution notices for compliance and ease of understanding.

Next Steps

HCA has worked closely with the Apple Health MCOs to implement changes to prior authorization turnaround times with great success; however, additional work is needed to harmonize the API requirements found in E2SHB 1357 with CMS rule 0057-F and ensure compliance reporting to HCA is reported consistently across MCOs. Contract language is currently being drafted for the API requirements within E2SHB 1357 and HCA is partnering with OIC to facilitate a technical assistance work group for health carriers managing internal implementation efforts. The WA FHIR PA Interoperability Workgroup will cover both HB-1357 PA API and CMS-0057-F PA API requirements that will flex to meet current and changing deadlines. This workgroup is open to impacted WA payers, providers, and their associated vendors

MCOs have raised concerns around API implementation due to the differences between regulations. The state rule requires Prior Authorization API implementation on January 1, 2026, while federal rules for the Prior Authorization API become effective January 1, 2027, causing there to be a discrepancy in standard regulations between state requirements and federal requirements over a one-year span. As currently written, the state rules lack technical guidance on implementation strategies to meet HL7 Fast Healthcare Interoperability Resources (FHIR) API requirements, whereas CMS-0057-F offers a recommendation that utilizes Specific guidelines and templates for consistency

Contact

Karen Buchanan RN, BSN
Medicaid Compliance Review Unit Supervisor
Medicaid Programs Division
Phone: (360) 643-6930
karen.buchanan@hca.wa.gov