

CERTIFICATION OF ENROLLMENT

**SUBSTITUTE HOUSE BILL 1706**

69th Legislature  
2025 Regular Session

Passed by the House March 4, 2025  
Yeas 97 Nays 0

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**Speaker of the House of  
Representatives**

Passed by the Senate March 26, 2025  
Yeas 49 Nays 0

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**President of the Senate**

Approved

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**Governor of the State of Washington**

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **SUBSTITUTE HOUSE BILL 1706** as passed by the House of Representatives and the Senate on the dates hereon set forth.

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**Chief Clerk**

FILED

**Secretary of State  
State of Washington**

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**SUBSTITUTE HOUSE BILL 1706**

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Passed Legislature - 2025 Regular Session

**State of Washington**

**69th Legislature**

**2025 Regular Session**

**By** House Health Care & Wellness (originally sponsored by Representative Simmons)

READ FIRST TIME 02/21/25.

1       AN ACT Relating to aligning the implementation of application  
2 programming interfaces for prior authorization with federal  
3 guidelines; and amending RCW 48.43.830, 41.05.845, and 74.09.840.

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

5       **Sec. 1.** RCW 48.43.830 and 2023 c 382 s 1 are each amended to  
6 read as follows:

7       (1) Each carrier offering a health plan issued or renewed on or  
8 after January 1, 2024, shall comply with the following standards  
9 related to prior authorization for health care services and  
10 prescription drugs:

11       (a) The carrier shall meet the following time frames for prior  
12 authorization determinations and notifications to a participating  
13 provider or facility that submits the prior authorization request  
14 through an electronic prior authorization process, as designated by  
15 each carrier:

16       (i) For electronic standard prior authorization requests, the  
17 carrier shall make a decision and notify the provider or facility of  
18 the results of the decision within three calendar days, excluding  
19 holidays, of submission of an electronic prior authorization request  
20 by the provider or facility that contains the necessary information  
21 to make a determination. If insufficient information has been

1 provided to the carrier to make a decision, the carrier shall request  
2 any additional information from the provider or facility within one  
3 calendar day of submission of the electronic prior authorization  
4 request.

5 (ii) For electronic expedited prior authorization requests, the  
6 carrier shall make a decision and notify the provider or facility of  
7 the results of the decision within one calendar day of submission of  
8 an electronic prior authorization request by the provider or facility  
9 that contains the necessary information to make a determination. If  
10 insufficient information has been provided to the carrier to make a  
11 decision, the carrier shall request any additional information from  
12 the provider or facility within one calendar day of submission of the  
13 electronic prior authorization request.

14 (b) The carrier shall meet the following time frames for prior  
15 authorization determinations and notifications to a participating  
16 provider or facility that submits the prior authorization request  
17 through a process other than an electronic prior authorization  
18 process:

19 (i) For nonelectronic standard prior authorization requests, the  
20 carrier shall make a decision and notify the provider or facility of  
21 the results of the decision within five calendar days of submission  
22 of a nonelectronic prior authorization request by the provider or  
23 facility that contains the necessary information to make a  
24 determination. If insufficient information has been provided to the  
25 carrier to make a decision, the carrier shall request any additional  
26 information from the provider or facility within five calendar days  
27 of submission of the nonelectronic prior authorization request.

28 (ii) For nonelectronic expedited prior authorization requests,  
29 the carrier shall make a decision and notify the provider or facility  
30 of the results of the decision within two calendar days of submission  
31 of a nonelectronic prior authorization request by the provider or  
32 facility that contains the necessary information to make a  
33 determination. If insufficient information has been provided to the  
34 carrier to make a decision, the carrier shall request any additional  
35 information from the provider or facility within one calendar day of  
36 submission of the nonelectronic prior authorization request.

37 (c) In any instance in which a carrier has determined that a  
38 provider or facility has not provided sufficient information for  
39 making a determination under (a) and (b) of this subsection, a  
40 carrier may establish a specific reasonable time frame for submission

1 of the additional information. This time frame must be communicated  
2 to the provider and enrollee with a carrier's request for additional  
3 information.

4 (d) The carrier's prior authorization requirements must be  
5 described in detail and written in easily understandable language.  
6 The carrier shall make its most current prior authorization  
7 requirements and restrictions, including the written clinical review  
8 criteria, available to providers and facilities in an electronic  
9 format upon request. The prior authorization requirements must be  
10 based on peer-reviewed clinical review criteria. The clinical review  
11 criteria must be evidence-based criteria and must accommodate new and  
12 emerging information related to the appropriateness of clinical  
13 criteria with respect to black and indigenous people, other people of  
14 color, gender, and underserved populations. The clinical review  
15 criteria must be evaluated and updated, if necessary, at least  
16 annually.

17 (2) (a) Each carrier shall ~~((build and maintain a prior~~  
18 ~~authorization application programming interface that automates the~~  
19 ~~process for in-network providers to determine whether a prior~~  
20 ~~authorization is required for health care services, identify prior~~  
21 ~~authorization information and documentation requirements, and~~  
22 ~~facilitate the exchange of prior authorization requests and~~  
23 ~~determinations from its electronic health records or practice~~  
24 ~~management system. The application programming interface must support~~  
25 ~~the exchange of prior authorization requests and determinations for~~  
26 ~~health care services beginning January 1, 2025, and must:~~

27 ~~(i) Use health level 7 fast health care interoperability~~  
28 ~~resources in accordance with standards and provisions defined in 45~~  
29 ~~C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);~~

30 ~~(ii) Automate the process to determine whether a prior~~  
31 ~~authorization is required for durable medical equipment or a health~~  
32 ~~care service;~~

33 ~~(iii) Allow providers to query the carrier's prior authorization~~  
34 ~~documentation requirements;~~

35 ~~(iv) Support an automated approach using nonproprietary open~~  
36 ~~workflows to compile and exchange the necessary data elements to~~  
37 ~~populate the prior authorization requirements that are compliant with~~  
38 ~~the federal health insurance portability and accountability act of~~  
39 ~~1996 or have an exception from the federal centers for medicare and~~  
40 ~~medicaid services; and~~

1 ~~(v) Indicate that))~~ establish and maintain a prior authorization  
2 application programming interface that is consistent with final rules  
3 issued by the federal centers for medicare and medicaid services and  
4 published in the federal register, and that indicates that a prior  
5 authorization denial or authorization of a service less intensive  
6 than that included in the original request is an adverse benefit  
7 determination and is subject to the carrier's grievance and appeal  
8 process under RCW 48.43.535.

9 (b) Each carrier shall establish and maintain an interoperable  
10 electronic process or application programming interface that  
11 automates the process for in-network providers to determine whether a  
12 prior authorization is required for a covered prescription drug. The  
13 interoperable electronic process or application programming interface  
14 must support the exchange of prior authorization requests and  
15 determinations for prescription drugs, including information on  
16 covered alternative prescription drugs, beginning January 1, 2027,  
17 and must:

18 (i) Allow providers to identify prior authorization information  
19 and documentation requirements;

20 (ii) Facilitate the exchange of prior authorization requests and  
21 determinations from its electronic health records or practice  
22 management system(~~(, and may include the necessary data elements to~~  
23 ~~populate the prior authorization requirements that are compliant with~~  
24 ~~the federal health insurance portability and accountability act of~~  
25 ~~1996 or have an exception from the federal centers for medicare and~~  
26 ~~medicaid services))~~; and

27 (iii) Indicate that a prior authorization denial or authorization  
28 of a drug other than the one included in the original prior  
29 authorization request is an adverse benefit determination and is  
30 subject to the carrier's grievance and appeal process under RCW  
31 48.43.535.

32 (c) (~~(If)~~) Regardless of whether federal rules related to  
33 standards for using an application programming interface to  
34 communicate prior authorization status to providers are revoked,  
35 delayed, suspended, or not finalized by the federal centers for  
36 medicare and medicaid services (~~(by September 13, 2023))~~ after  
37 February 8, 2024, the requirements of (a) of this subsection (~~(may~~  
38 ~~not))~~ shall be enforced (~~(until))~~ beginning January 1, (~~(2026))~~ 2027.

39 (d) (~~((i) If a carrier determines that it will not be able to~~  
40 ~~satisfy the requirements of (a) of this subsection by January 1,~~

1 ~~2025, the carrier shall submit a narrative justification to the~~  
2 ~~commissioner on or before September 1, 2024, describing:~~

3 ~~(A) The reasons that the carrier cannot reasonably satisfy the~~  
4 ~~requirements;~~

5 ~~(B) The impact of noncompliance upon providers and enrollees;~~

6 ~~(C) The current or proposed means of providing health information~~  
7 ~~to the providers; and~~

8 ~~(D) A timeline and implementation plan to achieve compliance with~~  
9 ~~the requirements.~~

10 ~~(ii) The commissioner may grant a one-year delay in enforcement~~  
11 ~~of the requirements of (a) of this subsection (2) if the commissioner~~  
12 ~~determines that the carrier has made a good faith effort to comply~~  
13 ~~with the requirements.~~

14 ~~(iii) This subsection (2)(d) shall not apply if the delay in~~  
15 ~~enforcement in (c) of this subsection takes effect because the~~  
16 ~~federal centers for medicare and medicaid services did not finalize~~  
17 ~~the applicable regulations by September 13, 2023.~~

18 ~~(e))~~ By September 13, 2023, and at least every six months  
19 thereafter until September 13, 2026, the commissioner shall provide  
20 an update to the health care policy committees of the legislature on  
21 the development of rules and implementation guidance from the federal  
22 centers for medicare and medicaid services regarding the standards  
23 for development of application programming interfaces and  
24 interoperable electronic processes related to prior authorization  
25 functions. The updates should include recommendations, as  
26 appropriate, on whether the status of the federal rule development  
27 aligns with the provisions of chapter 382, Laws of 2023. The  
28 commissioner also shall report on any actions by the federal centers  
29 for medicare and medicaid services to exercise enforcement discretion  
30 related to the implementation and maintenance of an application  
31 programming interface for prior authorization functions. The  
32 commissioner shall consult with the health care authority, carriers,  
33 providers, and consumers on the development of these updates and any  
34 recommendations.

35 (3) Nothing in this section applies to prior authorization  
36 determinations made pursuant to RCW 48.43.761.

37 (4) For the purposes of this section:

38 (a) "Expedited prior authorization request" means a request by a  
39 provider or facility for approval of a health care service or  
40 prescription drug where:

1 (i) The passage of time:

2 (A) Could seriously jeopardize the life or health of the  
3 enrollee;

4 (B) Could seriously jeopardize the enrollee's ability to regain  
5 maximum function; or

6 (C) In the opinion of a provider or facility with knowledge of  
7 the enrollee's medical condition, would subject the enrollee to  
8 severe pain that cannot be adequately managed without the health care  
9 service or prescription drug that is the subject of the request; or

10 (ii) The enrollee is undergoing a current course of treatment  
11 using a nonformulary drug.

12 (b) "Standard prior authorization request" means a request by a  
13 provider or facility for approval of a health care service or  
14 prescription drug where the request is made in advance of the  
15 enrollee obtaining a health care service or prescription drug that is  
16 not required to be expedited.

17 **Sec. 2.** RCW 41.05.845 and 2023 c 382 s 2 are each amended to  
18 read as follows:

19 (1) A health plan offered to public employees, retirees, and  
20 their covered dependents under this chapter issued or renewed on or  
21 after January 1, 2024, shall comply with the following standards  
22 related to prior authorization for health care services and  
23 prescription drugs:

24 (a) The health plan shall meet the following time frames for  
25 prior authorization determinations and notifications to a  
26 participating provider or facility that submits the prior  
27 authorization request through an electronic prior authorization  
28 process:

29 (i) For electronic standard prior authorization requests, the  
30 health plan shall make a decision and notify the provider or facility  
31 of the results of the decision within three calendar days, excluding  
32 holidays, of submission of an electronic prior authorization request  
33 by the provider or facility that contains the necessary information  
34 to make a determination. If insufficient information has been  
35 provided to the health plan to make a decision, the health plan shall  
36 request any additional information from the provider or facility  
37 within one calendar day of submission of the electronic prior  
38 authorization request.

1 (ii) For electronic expedited prior authorization requests, the  
2 health plan shall make a decision and notify the provider or facility  
3 of the results of the decision within one calendar day of submission  
4 of an electronic prior authorization request by the provider or  
5 facility that contains the necessary information to make a  
6 determination. If insufficient information has been provided to the  
7 health plan to make a decision, the health plan shall request any  
8 additional information from the provider or facility within one  
9 calendar day of submission of the electronic prior authorization  
10 request.

11 (b) The health plan shall meet the following time frames for  
12 prior authorization determinations and notifications to a  
13 participating provider or facility that submits the prior  
14 authorization request through a process other than an electronic  
15 prior authorization process described in subsection (2) of this  
16 section:

17 (i) For nonelectronic standard prior authorization requests, the  
18 health plan shall make a decision and notify the provider or facility  
19 of the results of the decision within five calendar days of  
20 submission of a nonelectronic prior authorization request by the  
21 provider or facility that contains the necessary information to make  
22 a determination. If insufficient information has been provided to the  
23 health plan to make a decision, the health plan shall request any  
24 additional information from the provider or facility within five  
25 calendar days of submission of the nonelectronic prior authorization  
26 request.

27 (ii) For nonelectronic expedited prior authorization requests,  
28 the health plan shall make a decision and notify the provider or  
29 facility of the results of the decision within two calendar days of  
30 submission of a nonelectronic prior authorization request by the  
31 provider or facility that contains the necessary information to make  
32 a determination. If insufficient information has been provided to the  
33 health plan to make a decision, the health plan shall request any  
34 additional information from the provider or facility within one  
35 calendar day of submission of the nonelectronic prior authorization  
36 request.

37 (c) In any instance in which the health plan has determined that  
38 a provider or facility has not provided sufficient information for  
39 making a determination under (a) and (b) of this subsection, the  
40 health plan may establish a specific reasonable time frame for



1 submission of the additional information. This time frame must be  
2 communicated to the provider and enrollee with the health plan's  
3 request for additional information.

4 (d) The prior authorization requirements of the health plan must  
5 be described in detail and written in easily understandable language.  
6 The health plan shall make its most current prior authorization  
7 requirements and restrictions, including the written clinical review  
8 criteria, available to providers and facilities in an electronic  
9 format upon request. The prior authorization requirements must be  
10 based on peer-reviewed clinical review criteria. The clinical review  
11 criteria must be evidence-based criteria and must accommodate new and  
12 emerging information related to the appropriateness of clinical  
13 criteria with respect to black and indigenous people, other people of  
14 color, gender, and underserved populations. The clinical review  
15 criteria must be evaluated and updated, if necessary, at least  
16 annually.

17 (2)(a) Each health plan offered to public employees, retirees,  
18 and their covered dependents under this chapter shall ~~((build and~~  
19 ~~maintain a prior authorization application programming interface that~~  
20 ~~automates the process for in-network providers to determine whether a~~  
21 ~~prior authorization is required for health care services, identify~~  
22 ~~prior authorization information and documentation requirements, and~~  
23 ~~facilitate the exchange of prior authorization requests and~~  
24 ~~determinations from its electronic health records or practice~~  
25 ~~management system. The application programming interface must support~~  
26 ~~the exchange of prior authorization requests and determinations for~~  
27 ~~health care services beginning January 1, 2025, and must:~~

28 ~~(i) Use health level 7 fast health care interoperability~~  
29 ~~resources in accordance with standards and provisions defined in 45~~  
30 ~~C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);~~

31 ~~(ii) Automate the process to determine whether a prior~~  
32 ~~authorization is required for durable medical equipment or a health~~  
33 ~~care service;~~

34 ~~(iii) Allow providers to query the health plan's prior~~  
35 ~~authorization documentation requirements;~~

36 ~~(iv) Support an automated approach using nonproprietary open~~  
37 ~~workflows to compile and exchange the necessary data elements to~~  
38 ~~populate the prior authorization requirements that are compliant with~~  
39 ~~the federal health insurance portability and accountability act of~~

1 ~~1996 or have an exception from the federal centers for medicare and~~  
2 ~~medicaid services; and~~

3 ~~(v) Indicate that))~~ establish and maintain a prior authorization  
4 application programming interface that is consistent with final rules  
5 issued by the federal centers for medicare and medicaid services and  
6 published in the federal register, and that indicates that a prior  
7 authorization denial or authorization of a service less intensive  
8 than that included in the original request is an adverse benefit  
9 determination and is subject to the health plan's grievance and  
10 appeal process under RCW 48.43.535.

11 (b) Each health plan offered to public employees, retirees, and  
12 their covered dependents under this chapter shall establish and  
13 maintain an interoperable electronic process or application  
14 programming interface that automates the process for in-network  
15 providers to determine whether a prior authorization is required for  
16 a covered prescription drug. The interoperable electronic process or  
17 application programming interface must support the exchange of prior  
18 authorization requests and determinations for prescription drugs,  
19 including information on covered alternative prescription drugs,  
20 beginning January 1, 2027, and must:

21 (i) Allow providers to identify prior authorization information  
22 and documentation requirements;

23 (ii) Facilitate the exchange of prior authorization requests and  
24 determinations from its electronic health records or practice  
25 management system(~~(, and may include the necessary data elements to~~  
26 ~~populate the prior authorization requirements that are compliant with~~  
27 ~~the federal health insurance portability and accountability act of~~  
28 ~~1996 or have an exception from the federal centers for medicare and~~  
29 ~~medicaid services))~~; and

30 (iii) Indicate that a prior authorization denial or authorization  
31 of a drug other than the one included in the original prior  
32 authorization request is an adverse benefit determination and is  
33 subject to the health plan's grievance and appeal process under RCW  
34 48.43.535.

35 (c) ~~((If))~~ Regardless of whether federal rules related to  
36 standards for using an application programming interface to  
37 communicate prior authorization status to providers are revoked,  
38 delayed, suspended, or not finalized by the federal centers for  
39 medicare and medicaid services (~~(by September 13, 2023))~~ after

February 8, 2024, the requirements of (a) of this subsection ((may not)) shall be enforced ((until)) beginning January 1, ((2026)) 2027.

~~((d)(i) If the health plan determines that it will not be able to satisfy the requirements of (a) of this subsection by January 1, 2025, the health plan shall submit a narrative justification to the authority on or before September 1, 2024, describing:~~

~~(A) The reasons that the health plan cannot reasonably satisfy the requirements;~~

~~(B) The impact of noncompliance upon providers and enrollees;~~

~~(C) The current or proposed means of providing health information to the providers; and~~

~~(D) A timeline and implementation plan to achieve compliance with the requirements.~~

~~(ii) The authority may grant a one-year delay in enforcement of the requirements of (a) of this subsection (2) if the authority determines that the health plan has made a good faith effort to comply with the requirements.~~

~~(iii) This subsection (2)(d) shall not apply if the delay in enforcement in (c) of this subsection takes effect because the federal centers for medicare and medicaid services did not finalize the applicable regulations by September 13, 2023.))~~

(3) Nothing in this section applies to prior authorization determinations made pursuant to RCW 41.05.526.

(4) For the purposes of this section:

(a) "Expedited prior authorization request" means a request by a provider or facility for approval of a health care service or prescription drug where:

(i) The passage of time:

(A) Could seriously jeopardize the life or health of the enrollee;

(B) Could seriously jeopardize the enrollee's ability to regain maximum function; or

(C) In the opinion of a provider or facility with knowledge of the enrollee's medical condition, would subject the enrollee to severe pain that cannot be adequately managed without the health care service or prescription drug that is the subject of the request; or

(ii) The enrollee is undergoing a current course of treatment using a nonformulary drug.

(b) "Standard prior authorization request" means a request by a provider or facility for approval of a health care service or

1 prescription drug where the request is made in advance of the  
2 enrollee obtaining a health care service that is not required to be  
3 expedited.

4 (5) This section shall not apply to coverage provided under the  
5 medicare part C or part D programs set forth in Title XVIII of the  
6 social security act of 1965, as amended.

7 **Sec. 3.** RCW 74.09.840 and 2023 c 382 s 3 are each amended to  
8 read as follows:

9 (1) Beginning January 1, 2024, the authority shall require each  
10 managed care organization to comply with the following standards  
11 related to prior authorization for health care services and  
12 prescription drugs:

13 (a) The managed care organization shall meet the following time  
14 frames for prior authorization determinations and notifications to a  
15 participating provider or facility that submits the prior  
16 authorization request through an electronic prior authorization  
17 process, as designated by each managed care organization:

18 (i) For electronic standard prior authorization requests, the  
19 managed care organization shall make a decision and notify the  
20 provider or facility of the results of the decision within three  
21 calendar days, excluding holidays, of submission of an electronic  
22 prior authorization request by the provider or facility that contains  
23 the necessary information to make a determination. If insufficient  
24 information has been provided to the managed care organization to  
25 make a decision, the managed care organization shall request any  
26 additional information from the provider or facility within one  
27 calendar day of submission of the electronic prior authorization  
28 request.

29 (ii) For electronic expedited prior authorization requests, the  
30 managed care organization shall make a decision and notify the  
31 provider or facility of the results of the decision within one  
32 calendar day of submission of an electronic prior authorization  
33 request by the provider or facility that contains the necessary  
34 information to make a determination. If insufficient information has  
35 been provided to the managed care organization to make a decision,  
36 the managed care organization shall request any additional  
37 information from the provider or facility within one calendar day of  
38 submission of the electronic prior authorization request.

1 (b) The managed care organization shall meet the following time  
2 frames for prior authorization determinations and notifications to a  
3 participating provider or facility that submits the prior  
4 authorization request through a process other than an electronic  
5 prior authorization process described in subsection (2) of this  
6 section:

7 (i) For nonelectronic standard prior authorization requests, the  
8 managed care organization shall make a decision and notify the  
9 provider or facility of the results of the decision within five  
10 calendar days of submission of a nonelectronic prior authorization  
11 request by the provider or facility that contains the necessary  
12 information to make a determination. If insufficient information has  
13 been provided to the managed care organization to make a decision,  
14 the managed care organization shall request any additional  
15 information from the provider or facility within five calendar days  
16 of submission of the nonelectronic prior authorization request.

17 (ii) For nonelectronic expedited prior authorization requests,  
18 the managed care organization shall make a decision and notify the  
19 provider or facility of the results of the decision within two  
20 calendar days of submission of a nonelectronic prior authorization  
21 request by the provider or facility that contains the necessary  
22 information to make a determination. If insufficient information has  
23 been provided to the managed care organization to make a decision,  
24 the managed care organization shall request any additional  
25 information from the provider or facility within one calendar day of  
26 submission of the nonelectronic prior authorization request.

27 (c) In any instance in which a managed care organization has  
28 determined that a provider or facility has not provided sufficient  
29 information for making a determination under (a) and (b) of this  
30 subsection, a managed care organization may establish a specific  
31 reasonable time frame for submission of the additional information.  
32 This time frame must be communicated to the provider and enrollee  
33 with a managed care organization's request for additional  
34 information.

35 (d) The prior authorization requirements of the managed care  
36 organization must be described in detail and written in easily  
37 understandable language. The managed care organization shall make its  
38 most current prior authorization requirements and restrictions,  
39 including the written clinical review criteria, available to  
40 providers and facilities in an electronic format upon request. The

1 prior authorization requirements must be based on peer-reviewed  
2 clinical review criteria. The clinical review criteria must be  
3 evidence-based criteria and must accommodate new and emerging  
4 information related to the appropriateness of clinical criteria with  
5 respect to black and indigenous people, other people of color,  
6 gender, and underserved populations. The clinical review criteria  
7 must be evaluated and updated, if necessary, at least annually.

8 (2)(a) Each managed care organization shall ~~((build and maintain~~  
9 ~~a prior authorization application programming interface that~~  
10 ~~automates the process for in-network providers to determine whether a~~  
11 ~~prior authorization is required for health care services, identify~~  
12 ~~prior authorization information and documentation requirements, and~~  
13 ~~facilitate the exchange of prior authorization requests and~~  
14 ~~determinations from its electronic health records or practice~~  
15 ~~management system. The application programming interface must support~~  
16 ~~the exchange of prior authorization requests and determinations for~~  
17 ~~health care services beginning January 1, 2025, and must:~~

18 ~~(i) Use health level 7 fast health care interoperability~~  
19 ~~resources in accordance with standards and provisions defined in 45~~  
20 ~~C.F.R. Sec. 170.215 and 45 C.F.R. Sec. 156.22(3)(b);~~

21 ~~(ii) Automate the process to determine whether a prior~~  
22 ~~authorization is required for durable medical equipment or a health~~  
23 ~~care service;~~

24 ~~(iii) Allow providers to query the managed care organization's~~  
25 ~~prior authorization documentation requirements;~~

26 ~~(iv) Support an automated approach using nonproprietary open~~  
27 ~~workflows to compile and exchange the necessary data elements to~~  
28 ~~populate the prior authorization requirements that are compliant with~~  
29 ~~the federal health insurance portability and accountability act of~~  
30 ~~1996 or have an exception from the federal centers for medicare and~~  
31 ~~medicaid services; and~~

32 ~~(v) Indicate that))~~ establish and maintain a prior authorization  
33 application programming interface that is consistent with final rules  
34 issued by the federal centers for medicare and medicaid services and  
35 published in the federal register, and that indicates that a prior  
36 authorization denial or authorization of a service less intensive  
37 than that included in the original request is an adverse benefit  
38 determination and is subject to the managed care organization's  
39 grievance and appeal process under RCW 48.43.535.

(b) Each managed care organization shall establish and maintain an interoperable electronic process or application programming interface that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The interoperable electronic process or application programming interface must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027, and must:

(i) Allow providers to identify prior authorization information and documentation requirements;

(ii) Facilitate the exchange of prior authorization requests and determinations from its electronic health records or practice management system(~~(, and may include the necessary data elements to populate the prior authorization requirements that are compliant with the federal health insurance portability and accountability act of 1996 or have an exception from the federal centers for medicare and medicaid services))~~); and

(iii) Indicate that a prior authorization denial or authorization of a drug other than the one included in the original prior authorization request is an adverse benefit determination and is subject to the managed care organization's grievance and appeal process under RCW 48.43.535.

(c) (~~(If)~~) Regardless of whether federal rules related to standards for using an application programming interface to communicate prior authorization status to providers are revoked, delayed, suspended, or not finalized (~~by September 13, 2023~~) after February 8, 2024, the requirements of (a) of this subsection (~~may not~~) shall be enforced (~~(until)~~) beginning January 1, (~~(2026)~~) 2027.

~~((d)(i) If a managed care organization determines that it will not be able to satisfy the requirements of (a) of this subsection by January 1, 2025, the managed care organization shall submit a narrative justification to the authority on or before September 1, 2024, describing:~~

~~(A) The reasons that the managed care organization cannot reasonably satisfy the requirements;~~

~~(B) The impact of noncompliance upon providers and enrollees;~~

~~(C) The current or proposed means of providing health information to the providers; and~~

1       ~~(D) A timeline and implementation plan to achieve compliance with~~  
2 ~~the requirements.~~

3       ~~(ii) The authority may grant a one-year delay in enforcement of~~  
4 ~~the requirements of (a) of this subsection (2) if the authority~~  
5 ~~determines that the managed care organization has made a good faith~~  
6 ~~effort to comply with the requirements.~~

7       ~~(iii) This subsection (2)(d) shall not apply if the delay in~~  
8 ~~enforcement in (c) of this subsection takes effect because the~~  
9 ~~federal centers for medicare and medicaid services did not finalize~~  
10 ~~the applicable regulations by September 13, 2023.)~~

11       (3) Nothing in this section applies to prior authorization  
12 determinations made pursuant to RCW 71.24.618 or 74.09.490.

13       (4) For the purposes of this section:

14       (a) "Expedited prior authorization request" means a request by a  
15 provider or facility for approval of a health care service or  
16 prescription drug where:

17       (i) The passage of time:

18       (A) Could seriously jeopardize the life or health of the  
19 enrollee;

20       (B) Could seriously jeopardize the enrollee's ability to regain  
21 maximum function; or

22       (C) In the opinion of a provider or facility with knowledge of  
23 the enrollee's medical condition, would subject the enrollee to  
24 severe pain that cannot be adequately managed without the health care  
25 service or prescription drug that is the subject of the request; or

26       (ii) The enrollee is undergoing a current course of treatment  
27 using a nonformulary drug.

28       (b) "Standard prior authorization request" means a request by a  
29 provider or facility for approval of a health care service or  
30 prescription drug where the request is made in advance of the  
31 enrollee obtaining a health care service or prescription drug that is  
32 not required to be expedited.

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