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**HOUSE BILL 1464**

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**State of Washington**

**67th Legislature**

**2021 Regular Session**

**By** Representatives Davis, Cody, Simmons, J. Johnson, Ryu, Valdez, Lekanoff, Santos, Slatter, Ortiz-Self, Sutherland, Ormsby, Chopp, Hackney, and Harris-Talley

Read first time 02/02/21. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to removing health care coverage barriers to  
2 accessing substance use disorder treatment services; and amending RCW  
3 41.05.526, 48.43.761, and 71.24.618.

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

5 **Sec. 1.** RCW 41.05.526 and 2020 c 345 s 2 are each amended to  
6 read as follows:

7 (1) Except as provided in subsection (2) of this section, a  
8 health plan offered to employees and their covered dependents under  
9 this chapter issued or renewed on or after January 1, 2021, may not  
10 require an enrollee to obtain prior authorization for withdrawal  
11 management services or inpatient or residential substance use  
12 disorder treatment services in a behavioral health agency licensed or  
13 certified under RCW 71.24.037 unless it is a planned or scheduled  
14 admission as provided in subsection (8) of this section.

15 (2) (a) ((A)) When an enrollee is admitted under subsection (1) of  
16 this section, a health plan offered to employees and their covered  
17 dependents under this chapter issued or renewed on or after January  
18 1, 2021, must:

19 (i) Provide coverage for no less than two business days,  
20 excluding weekends and holidays, in a behavioral health agency that

1 provides inpatient or residential substance use disorder treatment  
2 prior to conducting a utilization review; and

3 (ii) Provide coverage for no less than three days in a behavioral  
4 health agency that provides withdrawal management services prior to  
5 conducting a utilization review.

6 (b) The health plan may not require an enrollee to obtain prior  
7 authorization for the services specified in (a) of this subsection as  
8 a condition for payment of services prior to the times specified in  
9 (a) of this subsection. Once the times specified in (a) of this  
10 subsection have passed, the health plan may initiate utilization  
11 management review procedures if the behavioral health agency  
12 continues to provide services or is in the process of arranging for a  
13 seamless transfer to an appropriate facility or lower level of care  
14 under subsection (6) of this section.

15 (c)(i) The behavioral health agency under (a) of this subsection  
16 must notify an enrollee's health plan as soon as practicable after  
17 admitting the enrollee, but not later than twenty-four hours after  
18 admitting the enrollee. The time of notification does not reduce the  
19 requirements established in (a) of this subsection.

20 (ii) The behavioral health agency under (a) of this subsection  
21 must provide the health plan with its initial assessment and initial  
22 treatment plan for the enrollee within two business days of  
23 admission, excluding weekends and holidays, or within three days in  
24 the case of a behavioral health agency that provides withdrawal  
25 management services.

26 (iii) After the time period in (a) of this subsection and receipt  
27 of the material provided under (c)(ii) of this subsection, the plan  
28 may initiate a medical necessity review process. Medical necessity  
29 review must be based on the standard set of criteria established  
30 under RCW 41.05.528. If the health plan determines within one  
31 business day from the start of the medical necessity review period  
32 and receipt of the material provided under (c)(ii) of this subsection  
33 that the admission to the facility was not medically necessary and  
34 advises the agency of the decision in writing, the health plan is not  
35 required to pay the facility for services delivered after the start  
36 of the medical necessity review period, subject to the conclusion of  
37 a filed appeal of the adverse benefit determination. If the health  
38 plan's medical necessity review is completed more than one business  
39 day after (~~the~~) the start of the medical necessity review period  
40 and receipt of the material provided under (c)(ii) of this

1 subsection, the health plan must pay for the services delivered from  
2 the time of admission until the time at which the medical necessity  
3 review is completed and the agency is advised of the decision in  
4 writing.

5 (3) The behavioral health agency shall document to the health  
6 plan the patient's need for continuing care and justification for  
7 level of care placement following the current treatment period, based  
8 on the standard set of criteria established under RCW 41.05.528, with  
9 documentation recorded in the patient's medical record.

10 (4) Nothing in this section prevents a health carrier from  
11 denying coverage based on insurance fraud.

12 (5) If the behavioral health agency under subsection (2)(a) of  
13 this section is not in the (~~enrollee's~~) health plan's network:

14 (a) The health plan is not responsible for reimbursing the  
15 behavioral health agency at a greater rate than would be paid had the  
16 agency been in the enrollee's network; and

17 (b) The behavioral health agency may not balance bill, as defined  
18 in RCW 48.43.005.

19 (6) When the treatment plan approved by the health plan involves  
20 transfer of the enrollee to a different facility or to a lower level  
21 of care, the care coordination unit of the health plan shall work  
22 with the current agency to make arrangements for a seamless transfer  
23 as soon as possible to an appropriate and available facility or level  
24 of care. The health plan shall pay the agency for the cost of care at  
25 the current facility until the seamless transfer to the different  
26 facility or lower level of care is complete. A seamless transfer to a  
27 lower level of care may include same day or next day appointments for  
28 outpatient care, and does not include payment for nontreatment  
29 services, such as housing services. If placement with an agency in  
30 the health plan's network is not available, the health plan shall pay  
31 the current agency until a seamless transfer arrangement is made.

32 (7) The requirements of this section do not apply to treatment  
33 provided in out-of-state facilities.

34 (8) For instances in which an enrollee elects a planned or  
35 scheduled admission to inpatient or residential substance use  
36 disorder treatment services in a behavioral health agency licensed or  
37 certified under RCW 71.24.037, a health plan may apply utilization  
38 management procedures, including prior authorization, prior to  
39 admission to treatment.

1       (9) For the purposes of this section "withdrawal management  
2 services" means twenty-four hour medically managed or medically  
3 monitored detoxification and assessment and treatment referral for  
4 adults or adolescents withdrawing from alcohol or drugs, which may  
5 include induction on medications for addiction recovery.

6       **Sec. 2.** RCW 48.43.761 and 2020 c 345 s 3 are each amended to  
7 read as follows:

8       (1) Except as provided in subsection (2) of this section, a  
9 health plan issued or renewed on or after January 1, 2021, may not  
10 require an enrollee to obtain prior authorization for withdrawal  
11 management services or inpatient or residential substance use  
12 disorder treatment services in a behavioral health agency licensed or  
13 certified under RCW 71.24.037 unless it is a planned or scheduled  
14 admission as provided in subsection (8) of this section.

15       (2) (a) ((A)) When an enrollee is admitted under subsection (1) of  
16 this section, a health plan issued or renewed on or after January 1,  
17 2021, must:

18       (i) Provide coverage for no less than two business days,  
19 excluding weekends and holidays, in a behavioral health agency that  
20 provides inpatient or residential substance use disorder treatment  
21 prior to conducting a utilization review; and

22       (ii) Provide coverage for no less than three days in a behavioral  
23 health agency that provides withdrawal management services prior to  
24 conducting a utilization review.

25       (b) The health plan may not require an enrollee to obtain prior  
26 authorization for the services specified in (a) of this subsection as  
27 a condition for payment of services prior to the times specified in  
28 (a) of this subsection. Once the times specified in (a) of this  
29 subsection have passed, the health plan may initiate utilization  
30 management review procedures if the behavioral health agency  
31 continues to provide services or is in the process of arranging for a  
32 seamless transfer to an appropriate facility or lower level of care  
33 under subsection (6) of this section.

34       (c) (i) The behavioral health agency under (a) of this subsection  
35 must notify an enrollee's health plan as soon as practicable after  
36 admitting the enrollee, but not later than twenty-four hours after  
37 admitting the enrollee. The time of notification does not reduce the  
38 requirements established in (a) of this subsection.

1 (ii) The behavioral health agency under (a) of this subsection  
2 must provide the health plan with its initial assessment and initial  
3 treatment plan for the enrollee within two business days of  
4 admission, excluding weekends and holidays, or within three days in  
5 the case of a behavioral health agency that provides withdrawal  
6 management services.

7 (iii) After the time period in (a) of this subsection and receipt  
8 of the material provided under (c)(ii) of this subsection, the plan  
9 may initiate a medical necessity review process. Medical necessity  
10 review must be based on the standard set of criteria established  
11 under RCW 41.05.528. If the health plan determines within one  
12 business day from the start of the medical necessity review period  
13 and receipt of the material provided under (c)(ii) of this subsection  
14 that the admission to the facility was not medically necessary and  
15 advises the agency of the decision in writing, the health plan is not  
16 required to pay the facility for services delivered after the start  
17 of the medical necessity review period, subject to the conclusion of  
18 a filed appeal of the adverse benefit determination. If the health  
19 plan's medical necessity review is completed more than one business  
20 day after ~~((the))~~ the start of the medical necessity review period  
21 and receipt of the material provided under (c)(ii) of this  
22 subsection, the health plan must pay for the services delivered from  
23 the time of admission until the time at which the medical necessity  
24 review is completed and the agency is advised of the decision in  
25 writing.

26 (3) The behavioral health agency shall document to the health  
27 plan the patient's need for continuing care and justification for  
28 level of care placement following the current treatment period, based  
29 on the standard set of criteria established under RCW 41.05.528, with  
30 documentation recorded in the patient's medical record.

31 (4) Nothing in this section prevents a health carrier from  
32 denying coverage based on insurance fraud.

33 (5) If the behavioral health agency under subsection (2)(a) of  
34 this section is not in the ~~((enrollee's))~~ health plan's network:

35 (a) The health plan is not responsible for reimbursing the  
36 behavioral health agency at a greater rate than would be paid had the  
37 agency been in the enrollee's network; and

38 (b) The behavioral health agency may not balance bill, as defined  
39 in RCW 48.43.005.

1 (6) When the treatment plan approved by the health plan involves  
2 transfer of the enrollee to a different facility or to a lower level  
3 of care, the care coordination unit of the health plan shall work  
4 with the current agency to make arrangements for a seamless transfer  
5 as soon as possible to an appropriate and available facility or level  
6 of care. The health plan shall pay the agency for the cost of care at  
7 the current facility until the seamless transfer to the different  
8 facility or lower level of care is complete. A seamless transfer to a  
9 lower level of care may include same day or next day appointments for  
10 outpatient care, and does not include payment for nontreatment  
11 services, such as housing services. If placement with an agency in  
12 the health plan's network is not available, the health plan shall pay  
13 the current agency until a seamless transfer arrangement is made.

14 (7) The requirements of this section do not apply to treatment  
15 provided in out-of-state facilities.

16 (8) For instances in which an enrollee elects a planned or  
17 scheduled admission to inpatient or residential substance use  
18 disorder treatment services in a behavioral health agency licensed or  
19 certified under RCW 71.24.037, a health plan may apply utilization  
20 management procedures, including prior authorization, prior to  
21 admission to treatment.

22 (9) For the purposes of this section "withdrawal management  
23 services" means twenty-four hour medically managed or medically  
24 monitored detoxification and assessment and treatment referral for  
25 adults or adolescents withdrawing from alcohol or drugs, which may  
26 include induction on medications for addiction recovery.

27 **Sec. 3.** RCW 71.24.618 and 2020 c 345 s 4 are each amended to  
28 read as follows:

29 (1) Beginning January 1, 2021, except as provided in subsection  
30 (2) of this section, a managed care organization may not require an  
31 enrollee to obtain prior authorization for withdrawal management  
32 services or inpatient or residential substance use disorder treatment  
33 services in a behavioral health agency licensed or certified under  
34 RCW 71.24.037 unless it is a planned or scheduled admission as  
35 provided in subsection (8) of this section.

36 (2)(a) Beginning January 1, 2021, when an enrollee is admitted  
37 under subsection (1) of this section, a managed care organization  
38 must:

1 (i) Provide coverage for no less than two business days,  
2 excluding weekends and holidays, in a behavioral health agency that  
3 provides inpatient or residential substance use disorder treatment  
4 prior to conducting a utilization review; and

5 (ii) Provide coverage for no less than three days in a behavioral  
6 health agency that provides withdrawal management services prior to  
7 conducting a utilization review.

8 (b) The managed care organization may not require an enrollee to  
9 obtain prior authorization for the services specified in (a) of this  
10 subsection as a condition for payment of services prior to the times  
11 specified in (a) of this subsection. Once the times specified in (a)  
12 of this subsection have passed, the managed care organization may  
13 initiate utilization management review procedures if the behavioral  
14 health agency continues to provide services or is in the process of  
15 arranging for a seamless transfer to an appropriate facility or lower  
16 level of care under subsection (6) of this section.

17 (c) (i) The behavioral health agency under (a) of this subsection  
18 must notify an enrollee's managed care organization as soon as  
19 practicable after admitting the enrollee, but not later than twenty-  
20 four hours after admitting the enrollee. The time of notification  
21 does not reduce the requirements established in (a) of this  
22 subsection.

23 (ii) The behavioral health agency under (a) of this subsection  
24 must provide the managed care organization with its initial  
25 assessment and initial treatment plan for the enrollee within two  
26 business days of admission, excluding weekends and holidays, or  
27 within three days in the case of a behavioral health agency that  
28 provides withdrawal management services.

29 (iii) After the time period in (a) of this subsection and receipt  
30 of the material provided under (c)(ii) of this subsection, the  
31 managed care organization may initiate a medical necessity review  
32 process. Medical necessity review must be based on the standard set  
33 of criteria established under RCW 41.05.528. If the health plan  
34 determines within one business day from the start of the medical  
35 necessity review period and receipt of the material provided under  
36 (c)(ii) of this subsection that the admission to the facility was not  
37 medically necessary and advises the agency of the decision in  
38 writing, the health plan is not required to pay the facility for  
39 services delivered after the start of the medical necessity review  
40 period, subject to the conclusion of a filed appeal of the adverse

1 benefit determination. If the managed care organization's medical  
2 necessity review is completed more than one business day after  
3 (~~the~~) the start of the medical necessity review period and  
4 receipt of the material provided under (c)(ii) of this subsection,  
5 the managed care organization must pay for the services delivered  
6 from the time of admission until the time at which the medical  
7 necessity review is completed and the agency is advised of the  
8 decision in writing.

9 (3) The behavioral health agency shall document to the managed  
10 care organization the patient's need for continuing care and  
11 justification for level of care placement following the current  
12 treatment period, based on the standard set of criteria established  
13 under RCW 41.05.528, with documentation recorded in the patient's  
14 medical record.

15 (4) Nothing in this section prevents a health carrier from  
16 denying coverage based on insurance fraud.

17 (5) If the behavioral health agency under subsection (2)(a) of  
18 this section is not in the (~~enrollee's~~) managed care organization's  
19 network:

20 (a) The managed care organization is not responsible for  
21 reimbursing the behavioral health agency at a greater rate than would  
22 be paid had the agency been in the enrollee's network; and

23 (b) The behavioral health agency may not balance bill, as defined  
24 in RCW 48.43.005.

25 (6) When the treatment plan approved by the managed care  
26 organization involves transfer of the enrollee to a different  
27 facility or to a lower level of care, the care coordination unit of  
28 the managed care organization shall work with the current agency to  
29 make arrangements for a seamless transfer as soon as possible to an  
30 appropriate and available facility or level of care. The managed care  
31 organization shall pay the agency for the cost of care at the current  
32 facility until the seamless transfer to the different facility or  
33 lower level of care is complete. A seamless transfer to a lower level  
34 of care may include same day or next day appointments for outpatient  
35 care, and does not include payment for nontreatment services, such as  
36 housing services. If placement with an agency in the managed care  
37 organization's network is not available, the managed care  
38 organization shall pay the current agency at the service level until  
39 a seamless transfer arrangement is made.



1 (7) The requirements of this section do not apply to treatment  
2 provided in out-of-state facilities.

3 (8) For instances in which an enrollee elects a planned or  
4 scheduled admission to inpatient or residential substance use  
5 disorder treatment services in a behavioral health agency licensed or  
6 certified under RCW 71.24.037, a managed care organization may apply  
7 utilization management procedures, including prior authorization,  
8 prior to admission to treatment.

9 (9) For the purposes of this section "withdrawal management  
10 services" means twenty-four hour medically managed or medically  
11 monitored detoxification and assessment and treatment referral for  
12 adults or adolescents withdrawing from alcohol or drugs, which may  
13 include induction on medications for addiction recovery.

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