
HOUSE BILL 2642

State of Washington

66th Legislature

2020 Regular Session

By Representatives Davis, Cody, Chopp, Harris, Leavitt, Caldier, Smith, Goodman, Orwall, Thai, Macri, Stonier, Schmick, Tharinger, Riccelli, Robinson, Griffey, Graham, Appleton, Callan, Irwin, Bergquist, Lekanoff, Barkis, Senn, Doglio, Walen, Peterson, Ormsby, and Pollet

Read first time 01/16/20. Referred to Committee on Health Care & Wellness.

1 AN ACT Relating to removing health coverage barriers to accessing
2 substance use disorder treatment services; adding a new section to
3 chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; adding
4 a new section to chapter 71.24 RCW; and creating a new section.

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

6 NEW SECTION. **Sec. 1.** (1) The legislature finds that:

7 (a) Substance use disorder is a treatable brain disease from
8 which people recover;

9 (b) Electing to go to addiction treatment is an act of great
10 courage; and

11 (c) When people with substance use disorder are provided rapid
12 access to quality treatment within their window of willingness, they
13 recover.

14 (2) The legislature therefore intends to ensure that there is no
15 wrong door for individuals accessing substance use disorder treatment
16 services by requiring coverage, and prohibiting barriers created by
17 prior authorization and premature utilization management review when
18 persons with substance use disorders are ready or urgently in need of
19 treatment services.

1 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05

2 RCW to read as follows:

3 (1) Except as provided in subsection (2) of this section, a
4 health plan offered to employees and their covered dependents under
5 this chapter issued or renewed on or after the effective date of this
6 section may not require an enrollee to obtain prior authorization for
7 substance use disorder treatment services if:

8 (a) The health care provider is licensed or certified under Title
9 18 RCW;

10 (b) The treatment is within the health care provider's scope of
11 practice; and

12 (c) The health care provider is employed by a residential
13 treatment facility licensed by the department of health under RCW
14 71.24.037 to provide withdrawal management services or inpatient
15 substance use disorder treatment services.

16 (2)(a) A health plan offered to employees and their covered
17 dependents under this chapter issued or renewed on or after the
18 effective date of this section must:

19 (i) Provide coverage for no less than two business days,
20 including an extension to allow for any intervening weekend days or
21 holidays, in a state-licensed substance use disorder residential
22 treatment facility prior to conducting a utilization review; and

23 (ii) Provide coverage for no less than five days of withdrawal
24 management services, including an extension to allow for any
25 intervening weekend days or holidays, in a state-licensed withdrawal
26 management program.

27 (b) The health plan may not require an enrollee to obtain prior
28 authorization for withdrawal management services or residential
29 substance use disorder treatment as a condition for payment of
30 services, prior to the times specified in (a) of this subsection.
31 Once the times specified in (a) of this subsection have passed, the
32 health plan may initiate utilization management review procedures if
33 the program providing services requests continuing substance use
34 disorder treatment services.

35 (c)(i) The facility providing the services shall provide the
36 health plan with notification of admission, initial assessment, and
37 the initial treatment plan within two business days of admission,
38 including an extension to allow for any intervening weekend days or
39 holidays.

1 (ii) Upon receipt of the materials in (c)(i) of this subsection,
2 the plan may initiate the medical necessity review process. If a
3 health plan determines, within twenty-four hours of receiving the
4 materials, that the admission to the facility was not medically
5 necessary or clinically appropriate, the health plan is not required
6 to pay the facility for the services delivered after the initial
7 admission periods specified in (a) of this subsection, subject to the
8 conclusion of any filed appeals of the adverse benefit determination.
9 If the health plan's medical necessity review is completed more than
10 twenty-four hours after the receipt of the materials and the review
11 determines that the admission to the facility was not medically
12 necessary or clinically appropriate, the health plan must pay for the
13 services delivered following the health plan's receipt of the
14 materials in (c)(i) of this subsection until the time at which the
15 review has been completed.

16 (iii) The enrollee's use of stimulants may not be the sole
17 grounds for determining that an admission to a withdrawal management
18 facility is not medically necessary or clinically appropriate. The
19 enrollee's decision to begin medication assisted treatment for opioid
20 use disorder may not be the sole grounds for determining that an
21 admission to a withdrawal management facility is not medically
22 necessary or clinically appropriate.

23 (3) The treating provider shall determine the patient's need for
24 continuing care and justification of treatment placement after
25 stabilization, based on the American society of addiction medicine
26 criteria for determining medical necessity with documentation
27 recorded in the patient's medical record.

28 (4) When a patient is at an addiction stabilization facility and
29 the recommended plan of treatment involves placement in a different
30 facility or at a lower level of care, the care coordination unit of
31 the health plan shall work with the current provider to make
32 arrangements for a seamless transfer as soon as possible to an
33 appropriate and available facility. The health plan shall continue to
34 cover the cost of care at the current facility until the seamless
35 transfer is complete. If placement with a provider that offers proper
36 medically necessary or clinically appropriate care in the health
37 plan's network is not available, the health plan shall continue to
38 pay the addiction stabilization facility until such an alternate
39 arrangement is made.

40 (5) For the purposes of this section:

1 (a) "Addiction stabilization services" means intensive services
2 provided by a residential treatment facility licensed to provide
3 withdrawal management or inpatient addiction treatment and include
4 twenty-four hour observation and supervision; physical and mental
5 health screening; substance use disorder assessment; counseling and
6 education on treatment and recovery resources and supports; treatment
7 placement or discharge planning; family education and assistance;
8 recovery medications as an adjunct to treatment; and aftercare
9 planning and referral to collaborating providers, including programs
10 that specialize in medication-assisted treatment.

11 (b) "Substance use disorder treatment services" means early
12 intervention services for substance use disorder treatment; substance
13 use disorder evaluation; outpatient services, including individual
14 and group counseling, case management, and medication-assisted
15 therapies; intensive outpatient and partial hospitalization services;
16 intensive inpatient and long-term residential treatment.

17 (c) "Withdrawal management services" means twenty-four hour
18 medically managed or medically monitored detoxification and
19 assessment and treatment referral for adults or adolescents
20 withdrawing from drugs, which may include induction on medications
21 for addiction recovery.

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

24 (1) Except as provided in subsection (2) of this section, a
25 health plan issued or renewed on or after the effective date of this
26 section may not require an enrollee to obtain prior authorization for
27 substance use disorder treatment services if:

28 (a) The health care provider is licensed or certified under Title
29 18 RCW;

30 (b) The treatment is within the health care provider's scope of
31 practice; and

32 (c) The health care provider is employed by a residential
33 treatment facility licensed by the department of health under RCW
34 71.24.037 to provide withdrawal management services or inpatient
35 substance use disorder treatment services.

36 (2) (a) A health plan issued or renewed on or after the effective
37 date of this section must:

38 (i) Provide coverage for no less than two business days,
39 including an extension to allow for any intervening weekend days or

1 holidays, in a state-licensed substance use disorder residential
2 treatment facility prior to conducting a utilization review; and

3 (ii) Provide coverage for no less than five days of withdrawal
4 management services, including an extension to allow for any
5 intervening weekend days or holidays, in a state-licensed withdrawal
6 management program.

7 (b) The health plan may not require an enrollee to obtain prior
8 authorization for withdrawal management services or residential
9 substance use disorder treatment as a condition for payment of
10 services, prior to the times specified in (a) of this subsection.
11 Once the times specified in (a) of this subsection have passed, the
12 health plan may initiate utilization management review procedures if
13 the program providing services requests continuing substance use
14 disorder treatment services.

15 (c)(i) The facility providing the services shall provide the
16 health plan with notification of admission, initial assessment, and
17 the initial treatment plan within two business days of admission,
18 including an extension to allow for any intervening weekend days or
19 holidays.

20 (ii) Upon receipt of the materials in (c)(i) of this subsection,
21 the plan may initiate the medical necessity review process. If a
22 health plan determines, within twenty-four hours of receiving the
23 materials, that the admission to the facility was not medically
24 necessary or clinically appropriate, the health plan is not required
25 to pay the facility for the services delivered after the initial
26 admission periods specified in (a) of this subsection, subject to the
27 conclusion of any filed appeals of the adverse benefit determination.
28 If the health plan's medical necessity review is completed more than
29 twenty-four hours after the receipt of the materials and the review
30 determines that the admission to the facility was not medically
31 necessary or clinically appropriate, the health plan must pay for the
32 services delivered following the health plan's receipt of the
33 materials in (c)(i) of this subsection until the time at which the
34 review has been completed.

35 (iii) The enrollee's use of stimulants may not be the sole
36 grounds for determining that an admission to a withdrawal management
37 facility is not medically necessary or clinically appropriate. The
38 enrollee's decision to begin medication assisted treatment for opioid
39 use disorder may not be the sole grounds for determining that an

1 admission to a withdrawal management facility is not medically
2 necessary or clinically appropriate.

3 (3) The treating provider shall determine the patient's need for
4 continuing care and justification of treatment placement after
5 stabilization, based on American society of addiction medicine
6 criteria for determining medical necessity with documentation
7 recorded in the patient's medical record.

8 (4) When a patient is at an addiction stabilization facility and
9 the recommended plan of treatment involves placement in a different
10 facility or at a lower level of care, the care coordination unit of
11 the health plan shall work with the current provider to make
12 arrangements for a seamless transfer as soon as possible to an
13 appropriate and available facility. The health plan shall continue to
14 cover the cost of care at the current facility until the seamless
15 transfer is complete. If placement with a provider that offers proper
16 medically necessary or clinically appropriate care in the health
17 plan's network is not available, the health plan shall continue to
18 pay the addiction stabilization facility until such an alternate
19 arrangement is made.

20 (5) For the purposes of this section:

21 (a) "Addiction stabilization services" means intensive services
22 provided by a residential treatment facility licensed to provide
23 withdrawal management or inpatient addiction treatment and include
24 twenty-four hour observation and supervision; physical and mental
25 health screening; substance use disorder assessment; counseling and
26 education on treatment and recovery resources and supports; treatment
27 placement or discharge planning; family education and assistance;
28 recovery medications as an adjunct to treatment; and aftercare
29 planning and referral to collaborating providers, including programs
30 that specialize in medication-assisted treatment.

31 (b) "Substance use disorder treatment services" means early
32 intervention services for substance use disorder treatment; substance
33 use disorder evaluation; outpatient services, including individual
34 and group counseling, case management, and medication-assisted
35 therapies; intensive outpatient and partial hospitalization services;
36 intensive inpatient and long-term residential treatment.

37 (c) "Withdrawal management services" means twenty-four hour
38 medically managed or medically monitored detoxification and
39 assessment and treatment referral for adults or adolescents

1 withdrawing from drugs, which may include induction on medications
2 for addiction recovery.

3 NEW SECTION. **Sec. 4.** A new section is added to chapter 71.24
4 RCW to read as follows:

5 (1) Except as provided in subsection (2) of this section,
6 beginning January 1, 2021, a managed care organization may not
7 require an enrollee to obtain prior authorization for substance use
8 disorder treatment services if:

9 (a) The health care provider is licensed or certified under Title
10 18 RCW;

11 (b) The treatment is within the health care provider's scope of
12 practice; and

13 (c) The health care provider is employed by a residential
14 treatment facility licensed by the department of health under RCW
15 71.24.037 to provide withdrawal management services or inpatient
16 substance use disorder treatment services.

17 (2)(a) Beginning January 1, 2021, a managed care organization
18 must:

19 (i) Provide coverage for no less than two business days,
20 including an extension to allow for any intervening weekend days or
21 holidays, in a state-licensed substance use disorder residential
22 treatment facility prior to conducting a utilization review; and

23 (ii) Provide coverage for no less than five days of withdrawal
24 management services, including an extension to allow for any
25 intervening weekend days or holidays, in a state-licensed withdrawal
26 management program.

27 (b) The managed care organization may not require an enrollee to
28 obtain prior authorization for withdrawal management services or
29 residential substance use disorder treatment as a condition for
30 payment of services, prior to the times specified in (a) of this
31 subsection. Once the times specified in (a) of this subsection have
32 passed, the managed care organization may initiate utilization
33 management review procedures if the program providing services
34 requests continuing substance use disorder treatment services.

35 (c)(i) The facility providing the services shall provide the
36 managed care organization with notification of admission, initial
37 assessment, and the initial treatment plan within two business days
38 of admission, including an extension to allow for any intervening
39 weekend days or holidays.

1 (ii) Upon receipt of the materials in (c)(i) of this subsection,
2 the managed care organization may initiate the medical necessity
3 review process. If a managed care organization determines, within
4 twenty-four hours of receiving the materials, that the admission to
5 the facility was not medically necessary or clinically appropriate,
6 the managed care organization is not required to pay the facility for
7 the services delivered after the initial admission periods specified
8 in (a) of this subsection, subject to the conclusion of any filed
9 appeals of the adverse benefit determination. If the managed care
10 organization's medical necessity review is completed more than
11 twenty-four hours after the receipt of the materials and the review
12 determines that the admission to the facility was not medically
13 necessary or clinically appropriate, the managed care organization
14 must pay for the services delivered following the managed care
15 organization's receipt of the materials in (c)(i) of this subsection
16 until the time at which the review has been completed.

17 (iii) The enrollee's use of stimulants may not be the sole
18 grounds for determining that an admission to a withdrawal management
19 facility is not medically necessary or clinically appropriate. The
20 enrollee's decision to begin medication assisted treatment for opioid
21 use disorder may not be the sole grounds for determining that an
22 admission to a withdrawal management facility is not medically
23 necessary or clinically appropriate.

24 (3) The treating provider shall determine the patient's need for
25 continuing care and justification of treatment placement after
26 stabilization, based on American society of addiction medicine
27 criteria for determining medical necessity with documentation
28 recorded in the patient's medical record.

29 (4) When a patient is at an addiction stabilization facility and
30 the recommended plan of treatment involves placement in a different
31 facility or at a lower level of care, the care coordination unit of
32 the managed care organization must work with the current provider to
33 make arrangements for a seamless transfer as soon as possible to an
34 appropriate and available facility. The managed care organization
35 must continue to cover the cost of care at the current facility until
36 the seamless transfer is complete. If placement with a provider that
37 offers proper medically necessary or clinically appropriate care in
38 the managed care organization's network is not available, the managed
39 care organization must continue to pay the addiction stabilization
40 facility until such an alternate arrangement is made.

1 (5) For the purposes of this section:

2 (a) "Addiction stabilization services" means intensive services
3 provided by a residential treatment facility licensed to provide
4 withdrawal management or inpatient addiction treatment and include
5 twenty-four hour observation and supervision; physical and mental
6 health screening; substance use disorder assessment; counseling and
7 education on treatment and recovery resources and supports; treatment
8 placement or discharge planning; family education and assistance;
9 recovery medications as an adjunct to treatment; and aftercare
10 planning and referral to collaborating providers, including programs
11 that specialize in medication-assisted treatment.

12 (b) "Substance use disorder treatment services" means early
13 intervention services for substance use disorder treatment; substance
14 use disorder evaluation; outpatient services, including individual
15 and group counseling, case management, and medication-assisted
16 therapies; intensive outpatient and partial hospitalization services;
17 intensive inpatient and long-term residential treatment.

18 (c) "Withdrawal management services" means twenty-four hour
19 medically managed or medically monitored detoxification and
20 assessment and treatment referral for adults or adolescents
21 withdrawing from drugs, which may include induction on medications
22 for addiction recovery.

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