**ESHB 2489** - S AMD TO S-5789.1 **959**
By Senator Darneille

On page 3, after line 7 after "life.", insert the following:

"These goals shall not interfere with the ultimate goal of working toward abstinence."

On page 37, after line 4, insert the following:

NEW SECTION. **Sec. 35.** A new section is added to chapter 41.05 RCW to read as follows:

(1) To the extent that the following services are covered benefits, a health plan, must cover inpatient hospital detoxification, residential subacute detoxification, inpatient hospital substance use disorder treatment, residential substance use disorder treatment, partial hospitalization substance use disorder treatment, and intensive outpatient substance use disorder treatment for the first forty-eight hours after an enrollee presents for any of these services or is referred for any of these services, without imposing utilization management review limitations on coverage, including prior authorization requirements.

(a) If located in Washington, the treatment facility or program must be licensed or certified by the department of health to deliver the level of care being sought by the enrollee. If located in other states, the facility or program must be licensed or certified by the state agency with the authority to issue credentials for the level of care being sought by the enrollee.

(b) If an enrollee presents without a referral from a hospital or provider, the treatment facility or program must make a good faith effort to confirm and document that a third party did not induce the enrollee to seek treatment in exchange for payment of goods, nonmedical or mental health services, or moneys, provided either to the enrollee or the third party.

(2) The treatment facility or program must provide an enrollee's health plan with notice of admission as soon as practicable after admitting the enrollee, but not later than forty-eight hours after admission. The time of notification does not reduce the requirements established in subsection (1) of this section.

(a) The facility's initial assessment, basis for referral, and initial planned services must accompany the notice.

(b) Upon receipt of notice of admission and the passage of the first forty-eight hours, as required under subsection (1) of this section, the health plan may initiate its utilization review of the member's need for services, and the remainder of the enrollee's services may be subject to utilization management, including prior authorization, as required by the enrollee's health coverage.

(c) If the treatment facility or program is a contracted facility participating in the health plan's provider network, the health plan must conduct any prior authorization or other utilization management review necessary to determine the covered length of stay and course of treatment, as permitted under the enrollee's health plan, on an urgent, expedited basis within forty-eight hours of receipt of all necessary documentation.

(3) If the treatment facility or program is not a contracted facility participating in the health plan's provider network, the health plan must inform the enrollee and the enrollee's attending physician that the facility is not in the health plan's provider network, and whether out-of-network coverage is available. Nothing in this section requires a carrier to include out-of-network coverage in a health plan.

(a) If the health plan covers out-of-network services, and the enrollee is admitted to an out-of-network facility or program located in Washington, the health plan must pay for a covered mode of transfer to an in-network facility or program without requiring payment or cost sharing from the enrollee. Transport must be provided by an in-network provider.

(b) A health plan is not required to cover transportation from an out-of-state treatment program or facility if the enrollee elects to transfer to an in-state, in-network treatment program or facility.

(4)(a) If a health plan determines that the admission to inpatient substance use disorder treatment was not medically necessary or clinically appropriate, the health plan is not required to pay the facility or program for the services delivered after the initial forty-eight hour admission period, subject to the conclusion of any filed appeals of the adverse benefit determination.

(b) If the patient evaluation and plan of care conducted at the facility under (a) of this subsection and the health plan's utilization review process identify a need for services other than those available at the inpatient substance use disorder treatment facility or program, the health plan in collaboration with the facility must fully coordinate the arrangements for assuring that the enrollee obtains the proper medically necessary or clinically appropriate care. To fully coordinate these arrangements, a health plan may need to identify and contact an available program or facility that offers the medically necessary or clinically appropriate care, assist with arranging the admission or initial appointment between the enrollee and the provider, assist with the transfer of health records including the initial evaluation and plan of care, and conduct other activities to facilitate a seamless transition for the enrollee into the appropriate care.

(5) A health plan must use evidence-based criteria for assessing the medical necessity and clinical appropriateness of an enrollee's need for substance use disorder residential treatment.

(6) This section does not restrict the right of enrollees to seek emergency medical care requiring stabilization or acute

detoxification services from any emergency room or urgent care center without prior authorization.

NEW SECTION. **Sec. 36.** A new section is added to chapter 48.43 RCW to read as follows:

(1) To the extent that the following services are covered benefits, a health plan, as defined in RCW 48.43.005, must cover inpatient hospital detoxification, residential subacute detoxification, inpatient hospital substance use disorder treatment, residential substance use disorder treatment, partial hospitalization substance use disorder treatment, and intensive outpatient substance use disorder treatment for the first forty-eight hours after an enrollee presents for any of these services or is referred for any of these services, without imposing utilization management review limitations on coverage, including prior authorization requirements.

(a) If located in Washington, the treatment facility or program must be licensed or certified by the department of health to deliver the level of care being sought by the enrollee. If located in other states, the facility or program must be licensed or certified by the state agency with the authority to issue credentials for the level of care being sought by the enrollee.

(b) If an enrollee presents without a referral from a hospital or provider, the treatment facility or program must make a good faith effort to confirm and document that neither it nor any third party induced the enrollee to seek treatment in exchange for payment of goods, nonmedical or mental health services, or moneys, provided either to the enrollee or the third party.

(2) The treatment facility or program must provide an enrollee's health plan with notice of admission as soon as practicable after admitting the enrollee, but not later than forty-eight hours after admission. The time of notification does not reduce the requirements established in subsection (1) of this section.

(a) The facility's initial assessment, basis for referral, and initial planned services must accompany the notice.

(b) Upon receipt of notice of admission and the passage of the first forty-eight hours, as required under subsection (1) of this section, the health plan may initiate its utilization review of the member's need for services, and the remainder of the enrollee's services may be subject to utilization management, including prior authorization, as required by the enrollee's health coverage.

(c) If the treatment facility or program is a contracted facility participating in the health plan's provider network, the health plan must conduct any prior authorization or other utilization management review necessary to determine the covered length of stay and course of treatment, as permitted under the enrollee's health plan, on an urgent, expedited basis within forty-eight hours of receipt of all necessary documentation.

(3) If the treatment facility or program is not a contracted facility participating in the health plan's provider network, the health plan must inform the enrollee and the enrollee's attending physician that the facility is not in the health plan's provider network, and whether out-of-network coverage is available. Nothing in this section requires a carrier to include out-of-network coverage in a health plan.

(a) If the health plan does not cover out-of-network services, and the enrollee is admitted to an out-of-network facility or program located in Washington, the health plan must pay for a covered mode of transfer to an in-network facility or program without requiring payment or cost sharing from the enrollee. Transport must be provided by an in-network provider.

(b) A health plan is not required to cover transportation from an out-of-state treatment program or facility if the enrollee elects to transfer to an in-state, in-network treatment program or facility.

(4)(a) If a health plan determines that any substance use disorder admission or treatment set forth in subsection (1) of this section was not medically necessary or clinically appropriate, the health plan is not required to pay the facility or program for the services delivered after the initial forty-eight hour admission period, subject to the conclusion of any filed appeals of the adverse benefit determination.

(b) If the patient evaluation and plan of care conducted at the facility under (a) of this subsection and the health plan's utilization review process identify a need for services other than those available at the inpatient substance use disorder treatment facility or program, the health plan in collaboration with the facility must fully coordinate the arrangements for assuring that the enrollee obtains the proper medically necessary or clinically appropriate care. To fully coordinate these arrangements, a health plan may need to identify and contact an available program or facility that offers the medically necessary or clinically appropriate care, assist with arranging the admission or initial appointment between the enrollee and the provider, assist with the transfer of health records including the initial evaluation and plan of care, and conduct other activities to facilitate a seamless transition for the enrollee into the appropriate care.

(5) A health plan must use evidence-based criteria for assessing the medical necessity and clinical appropriateness of an enrollee's need for substance use disorder residential treatment.

(6) This section does not restrict the right of enrollees to seek emergency medical care requiring stabilization or acute detoxification services from any emergency room or urgent care center without prior authorization.

NEW SECTION. **Sec. 38.** A new section is added to chapter 71.24 RCW to read as follows:

(1) To the extent that the following services are covered benefits, a behavioral health organization must cover inpatient hospital detoxification, residential subacute detoxification, inpatient hospital substance use disorder treatment, residential

substance use disorder treatment, partial hospitalization substance use disorder treatment, and intensive outpatient substance use disorder treatment for the first forty-eight hours after a client presents for any of these services or is referred for any of these services, without imposing utilization management review limitations on coverage, including prior authorization requirements.

(a) If located in Washington, the treatment facility or program must be licensed or certified by the department of health to deliver the level of care being sought by the client. If located in other states, the facility or program must be licensed or certified by the state agency with the authority to issue credentials for the level of care being sought by the client.

(b) If a client presents without a referral from a hospital or provider, the treatment facility or program must make a good faith effort to confirm and document that a third party did not induce the client to seek treatment in exchange for payment of goods, nonmedical or mental health services, or moneys, provided either to the client or the third party.

(2) The treatment facility or program must provide a client's behavioral health organization with notice of admission as soon as practicable after admitting the client, but not later than forty-eight hours after admission. The time of notification does not reduce the requirements established in subsection (1) of this section.

(a) The facility's initial assessment, basis for referral, and initial planned services must accompany the notice.

(b) Upon receipt of notice of admission and the passage of the first forty-eight hours, as required under subsection (1) of this section, the behavioral health organization may initiate its utilization review of the client's need for services, and the remainder of the client's services may be subject to utilization management, including prior authorization, as required by the client's coverage through the behavioral health organization.

(c) If the treatment facility or program is a contracted facility participating in the behavioral health organization provider network, the behavioral health organization must conduct any prior authorization or other utilization management review necessary to determine the covered length of stay and course of treatment on an urgent, expedited basis within forty-eight hours of receipt of all necessary documentation.

(3) If the treatment facility or program is not a contracted facility participating in the behavioral health organization's provider network, the behavioral health organization must inform the client and the client's attending physician that the facility or program is not in the behavioral health organization's provider network, and whether out-of-network coverage is available. Nothing in this section requires a behavioral health organization to include out-of-network coverage.

(a) If the behavioral health organization covers out-of-network services, and the client is admitted to an out-of-network facility or program located in Washington, the behavioral health organization must pay for a covered mode of transfer to an in-network facility or program without requiring payment or cost sharing from the client. Transport must be provided by an in-network provider.

(b) A behavioral health organization is not required to cover transportation from an out-of-state treatment program or facility if the client elects to transfer to an in-state, in-network treatment program or facility.

(4)(a) If a behavioral health organization determines that the admission to inpatient substance use disorder treatment was not medically necessary or clinically appropriate, the behavioral health organization is not required to pay the facility or program for the services delivered after the initial forty-eight hour admission period, subject to the conclusion of any filed appeals of the adverse benefit determination.

(b) If the patient evaluation and plan of care conducted at the facility or program under (a) of this subsection and the behavioral health organization's utilization review process identify a need for services other than those available at the inpatient substance use disorder treatment facility or program, the behavioral health organization in collaboration with the facility or program must fully coordinate the arrangements for assuring that the client obtains the proper medically necessary or clinically appropriate care. To fully coordinate these arrangements, a behavioral health organization may need to identify and contact an available program or facility that offers the medically necessary or clinically appropriate care, assist with arranging the admission or initial appointment between the client and the provider, assist with the transfer of health records including the initial evaluation and plan of care, and conduct other activities to facilitate a seamless transition for the client into the appropriate care.

(5) A behavioral health organization must use evidence-based criteria for assessing the medical necessity and clinical appropriateness of a client's need for substance use disorder residential treatment.

(6) This section does not restrict the right of clients to seek emergency medical care requiring stabilization or acute detoxification services from any emergency room or urgent care center without prior authorization."

Renumber the remaining sections consecutively and correct any internal references accordingly.

EFFECT: (1) Adds that goal of opioid treatment shall not interfere with the ultimate goal of working toward abstinence.

(2) Requires health plans and/or behavioral health organizations (BHOs) to cover the first 48 hours of certain substance use disorder (SUD) treatments, without prior authorization or utilization management review, to the extent that the treatment services are covered benefits.

(3) Adds the treatment facility or program as entities that must also confirm and document that they did not induce the enrollee to seek treatment in exchange for payment of goods, nonmedical or mental health services, or moneys, provided either to the enrollee or the third party, in chapter 48.43 RCW.

(4) Changes that if the health plan as defined in RCW 48.43.005 does not cover out-of-network services, and the enrollee is

admitted to an out-of-network facility or program located in Washington, the health plan must pay for a covered mode of transfer to an in-network facility or program without requiring payment or cost sharing from the enrollee.

(5) Clarifies that if a health plan as defined in RCW 48.43.005 determines that the admission to inpatient hospital detoxification, residential subacute detoxification, inpatient hospital substance use disorder treatment, residential substance use disorder treatment, partial hospitalization substance use disorder treatment, or intensive outpatient substance use disorder treatment was not medically necessary or clinically appropriate, the health plan is not required to pay the facility or program for the services delivered after the initial forty-eight hour admission period, not only inpatient substance use disorder treatment.

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