

ESHB 2489 - S AMD TO S-5789.1 **959**

By Senator Darneille

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

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

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

7
8 NEW SECTION. **Sec. 35.** A new section is added to chapter 41.05
9 RCW to read as follows:

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

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

26 (b) If an enrollee presents without a referral from a hospital
27 or provider, the treatment facility or program must make a good

1 faith effort to confirm and document that a third party did not
2 induce the enrollee to seek treatment in exchange for payment of
3 goods, nonmedical or mental health services, or moneys, provided
4 either to the enrollee or the third party.

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

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

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

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

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

32 (a) If the health plan covers out-of-network services, and the
33 enrollee is admitted to an out-of-network facility or program
34 located in Washington, the health plan must pay for a covered mode

1 of transfer to an in-network facility or program without requiring
2 payment or cost sharing from the enrollee. Transport must be
3 provided by an in-network provider.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (4)(a) If a health plan determines that any substance use
34 disorder admission or treatment set forth in subsection (1) of this

1 section was not medically necessary or clinically appropriate, the
2 health plan is not required to pay the facility or program for the
3 services delivered after the initial forty-eight hour admission
4 period, subject to the conclusion of any filed appeals of the
5 adverse benefit determination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

33 (b) If the patient evaluation and plan of care conducted at the
34 facility or program under (a) of this subsection and the behavioral

1 health organization's utilization review process identify a need for
2 services other than those available at the inpatient substance use
3 disorder treatment facility or program, the behavioral health
4 organization in collaboration with the facility or program must
5 fully coordinate the arrangements for assuring that the client
6 obtains the proper medically necessary or clinically appropriate
7 care. To fully coordinate these arrangements, a behavioral health
8 organization may need to identify and contact an available program
9 or facility that offers the medically necessary or clinically
10 appropriate care, assist with arranging the admission or initial
11 appointment between the client and the provider, assist with the
12 transfer of health records including the initial evaluation and plan
13 of care, and conduct other activities to facilitate a seamless
14 transition for the client into the appropriate care.

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

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

23 Renumber the remaining sections consecutively and correct any
24 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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