

**ESHB 2642** - S COMM AMD  
By Committee on Ways & Means

**ADOPTED 03/06/2020**

1 Strike everything after the enacting clause and insert the  
2 following:

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

4 (a) Substance use disorder is a treatable brain disease from  
5 which people recover;

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

8 (c) When people with substance use disorder are provided rapid  
9 access to quality treatment within their window of willingness,  
10 recovery happens.

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

17 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05  
18 RCW to read as follows:

19 (1) Except as provided in subsection (2) of this section, a  
20 health plan offered to employees and their covered dependents under  
21 this chapter issued or renewed on or after January 1, 2021, may not  
22 require an enrollee to obtain prior authorization for withdrawal  
23 management services or inpatient or residential substance use  
24 disorder treatment services in a behavioral health agency licensed or  
25 certified under RCW 71.24.037.

26 (2)(a) A health plan offered to employees and their covered  
27 dependents under this chapter issued or renewed on or after January  
28 1, 2021, must:

29 (i) Provide coverage for no less than two business days,  
30 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 section 6 of this act. 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 start of the medical necessity review period and receipt of  
40 the material provided under (c)(ii) of this subsection, the health

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

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

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

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

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

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

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

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

33 (8) For the purposes of this section "withdrawal management  
34 services" means twenty-four hour medically managed or medically  
35 monitored detoxification and assessment and treatment referral for  
36 adults or adolescents withdrawing from alcohol or drugs, which may  
37 include induction on medications for addiction recovery.

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

1 (1) Except as provided in subsection (2) of this section, a  
2 health plan issued or renewed on or after January 1, 2021, may not  
3 require an enrollee to obtain prior authorization for withdrawal  
4 management services or inpatient or residential substance use  
5 disorder treatment services in a behavioral health agency licensed or  
6 certified under RCW 71.24.037.

7 (2)(a) A health plan issued or renewed on or after January 1,  
8 2021, must:

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

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

16 (b) The health plan may not require an enrollee to obtain prior  
17 authorization for the services specified in (a) of this subsection as  
18 a condition for payment of services prior to the times specified in  
19 (a) of this subsection. Once the times specified in (a) of this  
20 subsection have passed, the health plan may initiate utilization  
21 management review procedures if the behavioral health agency  
22 continues to provide services or is in the process of arranging for a  
23 seamless transfer to an appropriate facility or lower level of care  
24 under subsection (6) of this section.

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

30 (ii) The behavioral health agency under (a) of this subsection  
31 must provide the health plan with its initial assessment and initial  
32 treatment plan for the enrollee within two business days of  
33 admission, excluding weekends and holidays, or within three days in  
34 the case of a behavioral health agency that provides withdrawal  
35 management services.

36 (iii) After the time period in (a) of this subsection and receipt  
37 of the material provided under (c)(ii) of this subsection, the plan  
38 may initiate a medical necessity review process. Medical necessity  
39 review must be based on the standard set of criteria established  
40 under section 6 of this act. If the health plan determines within one

1 business day from the start of the medical necessity review period  
2 and receipt of the material provided under (c)(ii) of this subsection  
3 that the admission to the facility was not medically necessary and  
4 advises the agency of the decision in writing, the health plan is not  
5 required to pay the facility for services delivered after the start  
6 of the medical necessity review period, subject to the conclusion of  
7 a filed appeal of the adverse benefit determination. If the health  
8 plan's medical necessity review is completed more than one business  
9 day after start of the medical necessity review period and receipt of  
10 the material provided under (c)(ii) of this subsection, the health  
11 plan must pay for the services delivered from the time of admission  
12 until the time at which the medical necessity review is completed and  
13 the agency is advised of the decision in writing.

14 (3) The behavioral health agency shall document to the health  
15 plan the patient's need for continuing care and justification for  
16 level of care placement following the current treatment period, based  
17 on the standard set of criteria established under section 6 of this  
18 act, with documentation recorded in the patient's medical record.

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

21 (5) If the behavioral health agency under subsection (2)(a) of  
22 this section is not in the enrollee's network:

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

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

28 (6) When the treatment plan approved by the health plan involves  
29 transfer of the enrollee to a different facility or to a lower level  
30 of care, the care coordination unit of the health plan shall work  
31 with the current agency to make arrangements for a seamless transfer  
32 as soon as possible to an appropriate and available facility or level  
33 of care. The health plan shall pay the agency for the cost of care at  
34 the current facility until the seamless transfer to the different  
35 facility or lower level of care is complete. A seamless transfer to a  
36 lower level of care may include same day or next day appointments for  
37 outpatient care, and does not include payment for nontreatment  
38 services, such as housing services. If placement with an agency in  
39 the health plan's network is not available, the health plan shall pay  
40 the current agency until 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 the purposes of this section "withdrawal management  
4 services" means twenty-four hour medically managed or medically  
5 monitored detoxification and assessment and treatment referral for  
6 adults or adolescents withdrawing from alcohol or drugs, which may  
7 include induction on medications for addiction recovery.

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

10 (1) Beginning January 1, 2021, a managed care organization may  
11 not require an enrollee to obtain prior authorization for withdrawal  
12 management services or inpatient or residential substance use  
13 disorder treatment services in a behavioral health agency licensed or  
14 certified under RCW 71.24.037.

15 (2)(a) Beginning January 1, 2021, a managed care organization  
16 must:

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

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

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

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

1 (ii) The behavioral health agency under (a) of this subsection  
2 must provide the managed care organization with its initial  
3 assessment and initial treatment plan for the enrollee within two  
4 business days of admission, excluding weekends and holidays, or  
5 within three days in the case of a behavioral health agency that  
6 provides withdrawal 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  
9 managed care organization may initiate a medical necessity review  
10 process. Medical necessity review must be based on the standard set  
11 of criteria established under section 6 of this act. If the health  
12 plan determines within one business day from the start of the medical  
13 necessity review period and receipt of the material provided under  
14 (c)(ii) of this subsection that the admission to the facility was not  
15 medically necessary and advises the agency of the decision in  
16 writing, the health plan is not required to pay the facility for  
17 services delivered after the start of the medical necessity review  
18 period, subject to the conclusion of a filed appeal of the adverse  
19 benefit determination. If the managed care organization's medical  
20 necessity review is completed more than one business day after start  
21 of the medical necessity review period and receipt of the material  
22 provided under (c)(ii) of this subsection, the managed care  
23 organization must pay for the services delivered from the time of  
24 admission until the time at which the medical necessity review is  
25 completed and the agency is advised of the decision in writing.

26 (3) The behavioral health agency shall document to the managed  
27 care organization the patient's need for continuing care and  
28 justification for level of care placement following the current  
29 treatment period, based on the standard set of criteria established  
30 under section 6 of this act, with documentation recorded in the  
31 patient's medical record.

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

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

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

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

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

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

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

23 NEW SECTION. **Sec. 5.** (1) The health care authority shall  
24 develop an action plan to support admission to and improved  
25 transitions between levels of care for both adults and adolescents.

26 (2) The health care authority shall develop the action plan in  
27 partnership with the office of the insurance commissioner, medicaid  
28 managed care organizations, commercial health plans, providers of  
29 substance use disorder services, and Indian health care agencies.

30 (3) The health care authority must include the following in the  
31 action plan:

32 (a) Identification of barriers in order to facilitate transfers  
33 to the appropriate level of care, and specific actions to remove  
34 those barriers; and

35 (b) Specific actions that may lead to the increase in the number  
36 of persons successfully transitioning from one level of care to the  
37 next appropriate level of care.



1 (4) The barriers and action items to be identified and addressed  
2 in the action plan under subsection (3) of this section include, but  
3 are not limited to:

4 (a) Having the health care authority and department of health  
5 explore systems to allow higher acuity withdrawal management  
6 facilities to bill for appropriate lower levels of care while  
7 maintaining financial stability;

8 (b) Developing protocols for the initial notification by a  
9 substance use disorder treatment agency to fully insured health plans  
10 and managed care organizations in regards to an enrollee's admission  
11 to a facility and uniformity in the plan's response to the agency in  
12 regards to the receipt of this information;

13 (c) Facilitating direct transfers to withdrawal management and  
14 residential substance use disorder treatment from hospitals and  
15 jails;

16 (d) Addressing concerns related to individuals being denied  
17 withdrawal management services based on their drug of choice;

18 (e) Exploring options for allowing medicaid managed care  
19 organizations to pay an administrative rate and establishing the  
20 equivalent reimbursement mechanism for commercial health plans for a  
21 plan enrollee who needs to remain in withdrawal management or  
22 residential care until a seamless transfer can occur, but no longer  
23 requires the higher acuity level that was the reason for the initial  
24 admission; and

25 (f) Establishing the minimum amount of medical information  
26 necessary to gather from the patient for utilization reviews in a  
27 withdrawal management setting.

28 (5) For medicaid services, specific actions must align with  
29 federal and state medicaid requirements regarding medical necessity,  
30 minimize duplicative or unnecessary burdens for agencies, and be  
31 patient-centered for medicaid managed care organizations.

32 (6) The health care authority shall develop options for best  
33 communicating the action plan to substance use disorder agencies by  
34 December 1, 2020.

35 NEW SECTION. **Sec. 6.** For the purposes of promoting standardized  
36 training for behavioral health professionals and facilitating  
37 communications between behavioral health agencies, executive  
38 agencies, managed care organizations, private health plans, and plans  
39 offered through the public employees' benefits board, it is the

1 policy of the state to adopt a single standard set of criteria to  
2 define medical necessity for substance use disorder treatment and to  
3 define substance use disorder levels of care in Washington. The  
4 criteria selected must be comprehensive, widely understood and  
5 accepted in the field, and based on continuously updated research and  
6 evidence. The health care authority and the office of the insurance  
7 commissioner must independently review their regulations and  
8 practices by January 1, 2021. The health care authority may make  
9 rules if necessary to promulgate the selected standard set of  
10 criteria."

**ESHB 2642** - S COMM AMD

By Committee on Ways & Means

**ADOPTED 03/06/2020**

11 On page 1, line 2 of the title, after "services;" strike the  
12 remainder of the title and insert "adding a new section to chapter  
13 41.05 RCW; adding a new section to chapter 48.43 RCW; adding a new  
14 section to chapter 71.24 RCW; and creating new sections."

EFFECT: (1) Standardizes terminology to refer to behavioral health agencies that are licensed or certified to provide withdrawal management services and/or inpatient or residential substance use disorder treatment services;

(2) Removes references to the American Society of Addiction Medicine and replaces them with references to an established standard set of criteria;

(3) Requires health plans and managed care organizations to advise the behavioral health agency of an adverse benefit determination in writing within the time limit to avoid incurring further payment obligations;

(4) Removes requirements for health plans or managed care organizations to provide coverage for transportation between substance use disorder treatment facilities;

(5) Specifies that the obligation to pay for services provided pending seamless transfer to a different facility or lower level of care by a managed care organization must be a payment at service level for the patient;

(6) Removes definitions of "addiction stabilization services" and "substance use disorder treatment services";

(7) Requires the Health Care Authority and Office of the Insurance Commissioner to select a single standard set of criteria to define medical necessity and levels of care for substance use disorder treatment in Washington by January 1, 2021, and authorizes the Health Care Authority to make rules to promulgate the criteria; and

(8) Makes additional technical corrections.

--- **END** ---