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**SECOND SUBSTITUTE SENATE BILL 6228**

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**State of Washington**

**68th Legislature**

**2024 Regular Session**

**By** Senate Ways & Means (originally sponsored by Senators Dhingra, Hasegawa, Kuderer, Lovelett, Nobles, Randall, Shewmake, Valdez, and C. Wilson)

READ FIRST TIME 02/05/24.

1 AN ACT Relating to treatment of substance use disorders; amending  
2 RCW 41.05.526, 48.43.761, 71.24.618, 18.225.145, and 43.70.250;  
3 reenacting and amending RCW 18.205.095; adding new sections to  
4 chapter 71.24 RCW; adding a new section to chapter 41.05 RCW; adding  
5 a new section to chapter 48.43 RCW; and creating a new section.

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

7 NEW SECTION. **Sec. 1.** A new section is added to chapter 71.24  
8 RCW to read as follows:

9 (1) The single standard set of criteria to define medical  
10 necessity for substance use disorder treatment and define substance  
11 use disorder levels of care in Washington is the most recent version  
12 of the ASAM Criteria as published by the American society of  
13 addiction medicine.

14 (2) When updated versions of the ASAM Criteria, inclusive of  
15 adolescent and transition age youth versions, are published by the  
16 American society of addiction medicine, the authority and the office  
17 of the insurance commissioner shall jointly determine the date upon  
18 which the updated version must begin to be used by medicaid managed  
19 care organizations, carriers, and other relevant entities. Both  
20 agencies must post notice of their decision on their websites. For  
21 purposes of the ASAM Criteria, 4th edition, medicaid managed care

1 organizations and carriers must begin to use the updated criteria no  
2 later than January 1, 2026.

3 **Sec. 2.** RCW 41.05.526 and 2020 c 345 s 2 are each amended to  
4 read as follows:

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

12 (2)(a) A health plan offered to employees and their covered  
13 dependents under this chapter issued or renewed on or after January  
14 1, 2021, must:

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

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

22 (b) (i) The health plan may not require an enrollee to obtain  
23 prior authorization for the services specified in (a) of this  
24 subsection as a condition for payment of services prior to the times  
25 specified in (a) of this subsection. (~~Onee~~)

26 (ii)(A) Except as provided in (b)(ii)(B) of this subsection, once  
27 the times specified in (a) of this subsection have passed, the health  
28 plan may initiate utilization management review procedures if the  
29 behavioral health agency continues to provide services or is in the  
30 process of arranging for a seamless transfer to an appropriate  
31 facility or lower level of care under subsection (6) of this section.

32 (B)(I) For a health plan issued or renewed on or after January 1,  
33 2025, for inpatient or residential substance use disorder treatment  
34 services, after the times specified in (a) of this subsection have  
35 passed, if a health plan authorizes services pursuant to the initial  
36 medical necessity review process permitted under (c)(iii) of this  
37 subsection, the length of the initial authorization may not be less  
38 than 14 days from the date that the patient was admitted to the  
39 behavioral health agency. Any subsequent reauthorization that the

1 health plan approves after the first 14 days must continue for no  
2 less than seven days prior to requiring further reauthorization.

3 (II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a  
4 health plan from requesting information to assist with a transfer as  
5 permitted under this subsection (2)(b)(ii).

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

11 (ii) The behavioral health agency under (a) of this subsection  
12 must provide the health plan with its initial assessment and initial  
13 treatment plan for the enrollee within two business days of  
14 admission, excluding weekends and holidays, or within three days in  
15 the case of a behavioral health agency that provides withdrawal  
16 management services.

17 (iii) After the time period in (a) of this subsection and receipt  
18 of the material provided under (c)(ii) of this subsection, the plan  
19 may initiate a medical necessity review process. Medical necessity  
20 review must be based on the standard set of criteria established  
21 under RCW 41.05.528. In a review for inpatient or residential  
22 substance use disorder treatment services, a health plan may not make  
23 a determination that a patient does not meet medical necessity  
24 criteria based primarily on the patient's length of abstinence. If  
25 the patient's abstinence from substance use was due to incarceration  
26 or hospitalization, a health plan may not consider the patient's  
27 length of abstinence in determining medical necessity. If the health  
28 plan determines within one business day from the start of the medical  
29 necessity review period and receipt of the material provided under  
30 (c)(ii) of this subsection that the admission to the facility was not  
31 medically necessary and advises the agency of the decision in  
32 writing, the health plan is not required to pay the facility for  
33 services delivered after the start of the medical necessity review  
34 period, subject to the conclusion of a filed appeal of the adverse  
35 benefit determination. If the health plan's medical necessity review  
36 is completed more than one business day after (~~the~~) the start of  
37 the medical necessity review period and receipt of the material  
38 provided under (c)(ii) of this subsection, the health plan must pay  
39 for the services delivered from the time of admission until the time

1 at which the medical necessity review is completed and the agency is  
2 advised of the decision in writing.

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

8 (b) For a health plan issued or renewed on or after January 1,  
9 2025, for inpatient or residential substance use disorder treatment  
10 services, the health plan may not consider the patient's length of  
11 stay at the behavioral health agency when making decisions regarding  
12 the authorization to continue care at the behavioral health agency.

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

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

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

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

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

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

37 (8) For the purposes of this section "withdrawal management  
38 services" means twenty-four hour medically managed or medically  
39 monitored detoxification and assessment and treatment referral for

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

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

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

11 (2)(a) A health plan issued or renewed on or after January 1,  
12 2021, must:

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

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

20 (b) (i) The health plan may not require an enrollee to obtain  
21 prior authorization for the services specified in (a) of this  
22 subsection as a condition for payment of services prior to the times  
23 specified in (a) of this subsection. (~~Onee~~)

24 (ii) (A) Except as provided in (b) (ii) (B) of this subsection, once  
25 the times specified in (a) of this subsection have passed, the health  
26 plan may initiate utilization management review procedures if the  
27 behavioral health agency continues to provide services or is in the  
28 process of arranging for a seamless transfer to an appropriate  
29 facility or lower level of care under subsection (6) of this section.

30 (B) (I) For a health plan issued or renewed on or after January 1,  
31 2025, for inpatient or residential substance use disorder treatment  
32 services, after the times specified in (a) of this subsection have  
33 passed, if a health plan authorizes services pursuant to the initial  
34 medical necessity review process permitted under (c) (iii) of this  
35 subsection, the length of the initial authorization may not be less  
36 than 14 days from the date that the patient was admitted to the  
37 behavioral health agency. Any subsequent reauthorization that the  
38 health plan approves after the first 14 days must continue for no  
39 less than seven days prior to requiring further reauthorization.

1       (II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a  
2 health plan from requesting information to assist with a transfer as  
3 permitted under this subsection (2)(b)(ii).

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

9       (ii) The behavioral health agency under (a) of this subsection  
10 must provide the health plan with its initial assessment and initial  
11 treatment plan for the enrollee within two business days of  
12 admission, excluding weekends and holidays, or within three days in  
13 the case of a behavioral health agency that provides withdrawal  
14 management services.

15       (iii) After the time period in (a) of this subsection and receipt  
16 of the material provided under (c)(ii) of this subsection, the plan  
17 may initiate a medical necessity review process. Medical necessity  
18 review must be based on the standard set of criteria established  
19 under RCW 41.05.528. In a review for inpatient or residential  
20 substance use disorder treatment services, a health plan may not make  
21 a determination that a patient does not meet medical necessity  
22 criteria based primarily on the patient's length of abstinence. If  
23 the patient's abstinence from substance use was due to incarceration  
24 or hospitalization, a health plan may not consider the patient's  
25 length of abstinence in determining medical necessity. If the health  
26 plan determines within one business day from the start of the medical  
27 necessity review period and receipt of the material provided under  
28 (c)(ii) of this subsection that the admission to the facility was not  
29 medically necessary and advises the agency of the decision in  
30 writing, the health plan is not required to pay the facility for  
31 services delivered after the start of the medical necessity review  
32 period, subject to the conclusion of a filed appeal of the adverse  
33 benefit determination. If the health plan's medical necessity review  
34 is completed more than one business day after (~~the~~) the start of  
35 the medical necessity review period and receipt of the material  
36 provided under (c)(ii) of this subsection, the health plan must pay  
37 for the services delivered from the time of admission until the time  
38 at which the medical necessity review is completed and the agency is  
39 advised of the decision in writing.

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

6 (b) For a health plan issued or renewed on or after January 1,  
7 2025, for inpatient or residential substance use disorder treatment  
8 services, the health plan may not consider the patient's length of  
9 stay at the behavioral health agency when making decisions regarding  
10 the authorization to continue care at the behavioral health agency.

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

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

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

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

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

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

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

1       **Sec. 4.** RCW 71.24.618 and 2020 c 345 s 4 are each amended to  
2 read as follows:

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

8       (2)(a) Beginning January 1, 2021, a managed care organization  
9 must:

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

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

17       (b) (i) The managed care organization may not require an enrollee  
18 to obtain prior authorization for the services specified in (a) of  
19 this subsection as a condition for payment of services prior to the  
20 times specified in (a) of this subsection. (~~Onee~~)

21       (ii) (A) Except as provided in (b) (ii) (B) of this subsection, once  
22 the times specified in (a) of this subsection have passed, the  
23 managed care organization may initiate utilization management review  
24 procedures if the behavioral health agency continues to provide  
25 services or is in the process of arranging for a seamless transfer to  
26 an appropriate facility or lower level of care under subsection (6)  
27 of this section.

28       (B) (I) Beginning January 1, 2025, for inpatient or residential  
29 substance use disorder treatment services, after the times specified  
30 in (a) of this subsection have passed, if a managed care organization  
31 authorizes services pursuant to the initial medical necessity review  
32 process permitted under (c) (iii) of this subsection, the length of  
33 the initial authorization may not be less than 14 days from the date  
34 that the patient was admitted to the behavioral health agency. Any  
35 subsequent reauthorization that the managed care organization  
36 approves after the first 14 days must continue for no less than seven  
37 days prior to requiring further reauthorization.

38       (II) Nothing in (b) (ii) (B) (I) of this subsection (2) prohibits a  
39 managed care organization from requesting information to assist with  
40 a transfer as permitted under this subsection (2) (b) (ii).



1 (c)(i) The behavioral health agency under (a) of this subsection  
2 must notify an enrollee's managed care organization as soon as  
3 practicable after admitting the enrollee, but not later than twenty-  
4 four hours after admitting the enrollee. The time of notification  
5 does not reduce the requirements established in (a) of this  
6 subsection.

7 (ii) The behavioral health agency under (a) of this subsection  
8 must provide the managed care organization with its initial  
9 assessment and initial treatment plan for the enrollee within two  
10 business days of admission, excluding weekends and holidays, or  
11 within three days in the case of a behavioral health agency that  
12 provides withdrawal management services.

13 (iii) After the time period in (a) of this subsection and receipt  
14 of the material provided under (c)(ii) of this subsection, the  
15 managed care organization may initiate a medical necessity review  
16 process. Medical necessity review must be based on the standard set  
17 of criteria established under RCW 41.05.528. In a review for  
18 inpatient or residential substance use disorder treatment services, a  
19 managed care organization may not make a determination that a patient  
20 does not meet medical necessity criteria based primarily on the  
21 patient's length of abstinence. If the patient's abstinence from  
22 substance use was due to incarceration or hospitalization, a managed  
23 care organization may not consider the patient's length of abstinence  
24 in determining medical necessity. If the health plan determines  
25 within one business day from the start of the medical necessity  
26 review period and receipt of the material provided under (c)(ii) of  
27 this subsection that the admission to the facility was not medically  
28 necessary and advises the agency of the decision in writing, the  
29 health plan is not required to pay the facility for services  
30 delivered after the start of the medical necessity review period,  
31 subject to the conclusion of a filed appeal of the adverse benefit  
32 determination. If the managed care organization's medical necessity  
33 review is completed more than one business day after (~~the~~) the  
34 start of the medical necessity review period and receipt of the  
35 material provided under (c)(ii) of this subsection, the managed care  
36 organization must pay for the services delivered from the time of  
37 admission until the time at which the medical necessity review is  
38 completed and the agency is advised of the decision in writing.

39 (3)(a) The behavioral health agency shall document to the managed  
40 care organization the patient's need for continuing care and

1 justification for level of care placement following the current  
2 treatment period, based on the standard set of criteria established  
3 under RCW 41.05.528, with documentation recorded in the patient's  
4 medical record.

5 (b) Beginning January 1, 2025, for inpatient or residential  
6 substance use disorder treatment services, the managed care  
7 organization may not consider the patient's length of stay at the  
8 behavioral health agency when making decisions regarding the  
9 authorization to continue care at the behavioral health agency.

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 network:

14 (a) The managed care organization is not responsible for  
15 reimbursing the behavioral health agency at a greater rate than would  
16 be paid had the 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 managed care  
20 organization involves transfer of the enrollee to a different  
21 facility or to a lower level of care, the care coordination unit of  
22 the managed care organization shall work with the current agency to  
23 make arrangements for a seamless transfer as soon as possible to an  
24 appropriate and available facility or level of care. The managed care  
25 organization shall pay the agency for the cost of care at the current  
26 facility until the seamless transfer to the different facility or  
27 lower level of care is complete. A seamless transfer to a lower level  
28 of care may include same day or next day appointments for outpatient  
29 care, and does not include payment for nontreatment services, such as  
30 housing services. If placement with an agency in the managed care  
31 organization's network is not available, the managed care  
32 organization shall pay the current agency at the service level until  
33 a seamless transfer arrangement is made.

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

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

1       **Sec. 5.** RCW 18.205.095 and 2021 c 165 s 1 and 2021 c 57 s 1 are  
2 each reenacted and amended to read as follows:

3       (1) The secretary shall issue a trainee certificate to any  
4 applicant who demonstrates to the satisfaction of the secretary that  
5 he or she is working toward the education and experience requirements  
6 in RCW 18.205.090.

7       (2) A trainee certified under this section shall submit to the  
8 secretary for approval a declaration, in accordance with rules  
9 adopted by the department, which shall be updated with the trainee's  
10 annual renewal, that he or she is actively pursuing the experience  
11 requirements under RCW 18.205.090 and is enrolled in:

12       (a) An approved education program; or

13       (b) An apprenticeship program reviewed by the substance use  
14 disorder certification advisory committee, approved by the secretary,  
15 and registered and approved under chapter 49.04 RCW.

16       (3) A trainee certified under this section may practice only  
17 under the supervision of a certified substance use disorder  
18 professional. The first 50 hours of any face-to-face client contact  
19 must be under direct observation. All remaining experience must be  
20 under supervision in accordance with rules adopted by the department.  
21 A certified substance use disorder professional trainee may not  
22 provide independent substance use disorder counseling or clinical  
23 services for a fee.

24       (4) A certified substance use disorder professional trainee  
25 provides substance use disorder assessments, counseling, and case  
26 management (~~(with a state regulated agency)~~) and can provide clinical  
27 services to patients consistent with his or her education, training,  
28 and experience as approved by his or her supervisor.

29       ~~(5) ((A trainee certification may only be renewed four times,~~  
30 ~~unless the secretary finds that a waiver to allow additional renewals~~  
31 ~~is justified due to barriers to testing or training resulting from a~~  
32 ~~governor-declared emergency.~~

33       ~~(6))~~ Applicants are subject to denial of a certificate or  
34 issuance of a conditional certificate for the reasons set forth in  
35 chapter 18.130 RCW.

36       ~~((7) A person certified under this chapter holding the title of~~  
37 ~~chemical dependency professional trainee is considered to hold the~~  
38 ~~title of substance use disorder professional trainee until such time~~  
39 ~~as the person's present certification expires or is renewed.))~~

1       **Sec. 6.** RCW 18.225.145 and 2021 c 57 s 2 are each amended to  
2 read as follows:

3       (1) The secretary shall issue an associate license to any  
4 applicant who demonstrates to the satisfaction of the secretary that  
5 the applicant meets the following requirements for the applicant's  
6 practice area and submits a declaration that the applicant is working  
7 toward full licensure in that category:

8       (a) Licensed social worker associate—advanced or licensed social  
9 worker associate—~~independent clinical~~: Graduation from a master's  
10 degree or doctoral degree educational program in social work  
11 accredited by the council on social work education and approved by  
12 the secretary based upon nationally recognized standards.

13       (b) Licensed mental health counselor associate: Graduation from a  
14 master's degree or doctoral degree educational program in mental  
15 health counseling or a related discipline from a college or  
16 university approved by the secretary based upon nationally recognized  
17 standards.

18       (c) Licensed marriage and family therapist associate: Graduation  
19 from a master's degree or doctoral degree educational program in  
20 marriage and family therapy or graduation from an educational program  
21 in an allied field equivalent to a master's degree or doctoral degree  
22 in marriage and family therapy approved by the secretary based upon  
23 nationally recognized standards.

24       (2) Associates may not provide independent social work, mental  
25 health counseling, or marriage and family therapy for a fee, monetary  
26 or otherwise. Associates must work under the supervision of an  
27 approved supervisor.

28       (3) Associates shall provide each client or patient, during the  
29 first professional contact, with a disclosure form according to RCW  
30 18.225.100, disclosing that he or she is an associate under the  
31 supervision of an approved supervisor.

32       (4) The department shall adopt by rule what constitutes adequate  
33 proof of compliance with the requirements of this section.

34       (5) Applicants are subject to the denial of a license or issuance  
35 of a conditional license for the reasons set forth in chapter 18.130  
36 RCW.

37       (6) ~~((a) Except as provided in (b) of this subsection, an)~~ An  
38 associate license may be renewed ~~((no more than six times, provided~~  
39 ~~that))~~ if the applicant for renewal has successfully completed  
40 eighteen hours of continuing education in the preceding year.

1 Beginning with the second renewal, at least six of the continuing  
2 education hours in the preceding two years must be in professional  
3 ethics.

4 ~~((b) If the secretary finds that a waiver to allow additional  
5 renewals is justified due to barriers to testing or training  
6 resulting from a governor-declared emergency, additional renewals may  
7 be approved.))~~

8 **Sec. 7.** RCW 43.70.250 and 2023 c 469 s 21 are each amended to  
9 read as follows:

10 (1) It shall be the policy of the state of Washington that the  
11 cost of each professional, occupational, or business licensing  
12 program be fully borne by the members of that profession, occupation,  
13 or business.

14 (2) The secretary shall from time to time establish the amount of  
15 all application fees, license fees, registration fees, examination  
16 fees, permit fees, renewal fees, and any other fee associated with  
17 licensing or regulation of professions, occupations, or businesses  
18 administered by the department. Any and all fees or assessments, or  
19 both, levied on the state to cover the costs of the operations and  
20 activities of the interstate health professions licensure compacts  
21 with participating authorities listed under chapter 18.130 RCW shall  
22 be borne by the persons who hold licenses issued pursuant to the  
23 authority and procedures established under the compacts. In fixing  
24 said fees, the secretary shall set the fees for each program at a  
25 sufficient level to defray the costs of administering that program  
26 and the cost of regulating licensed volunteer medical workers in  
27 accordance with RCW 18.130.360, except as provided in RCW 18.79.202.  
28 In no case may the secretary impose any certification, examination,  
29 or renewal fee upon a person seeking certification as a certified  
30 peer specialist trainee under chapter 18.420 RCW or, between July 1,  
31 2025, and July 1, 2030, impose a certification, examination, or  
32 renewal fee of more than \$100 upon any person seeking certification  
33 as a certified peer specialist under chapter 18.420 RCW. Subject to  
34 amounts appropriated for this specific purpose, between July 1, 2024,  
35 and July 1, 2029, the secretary may not impose any certification or  
36 certification renewal fee on a person seeking certification as a  
37 substance use disorder professional or substance use disorder  
38 professional trainee under chapter 18.205 RCW of more than \$100.

1 (3) All such fees shall be fixed by rule adopted by the secretary  
2 in accordance with the provisions of the administrative procedure  
3 act, chapter 34.05 RCW.

4 NEW SECTION. **Sec. 8.** A new section is added to chapter 41.05  
5 RCW to read as follows:

6 (1) The single standard set of criteria to define medical  
7 necessity for substance use disorder treatment and define substance  
8 use disorder levels of care in Washington is the most recent version  
9 of the ASAM Criteria as published by the American society of  
10 addiction medicine.

11 (2) When updated versions of the ASAM Criteria, inclusive of  
12 adolescent and transition age youth versions, are published by the  
13 American society of addiction medicine, the authority and the office  
14 of the insurance commissioner shall jointly determine the date upon  
15 which the updated version must begin to be used by medicaid managed  
16 care organizations, carriers, and other relevant entities. Both  
17 agencies must post notice of their decision on their websites. For  
18 purposes of the ASAM Criteria, 4th edition, medicaid managed care  
19 organizations and carriers must begin to use the updated criteria no  
20 later than January 1, 2026.

21 NEW SECTION. **Sec. 9.** A new section is added to chapter 48.43  
22 RCW to read as follows:

23 (1) The single standard set of criteria to define medical  
24 necessity for substance use disorder treatment and define substance  
25 use disorder levels of care in Washington is the most recent version  
26 of the ASAM Criteria as published by the American society of  
27 addiction medicine.

28 (2) When updated versions of the ASAM Criteria, inclusive of  
29 adolescent and transition age youth versions, are published by the  
30 American society of addiction medicine, the health care authority and  
31 the office of the insurance commissioner shall jointly determine the  
32 date upon which the updated version must begin to be used by medicaid  
33 managed care organizations, carriers, and other relevant entities.  
34 Both agencies must post notice of their decision on their websites.  
35 For purposes of the ASAM Criteria, 4th edition, medicaid managed care  
36 organizations and carriers must begin to use the updated criteria no  
37 later than January 1, 2026.

1        NEW SECTION.    **Sec. 10.**    A new section is added to chapter 71.24  
2 RCW to read as follows:

3        (1) The authority, in collaboration with the office of the  
4 insurance commissioner and in consultation with medicaid managed care  
5 organizations, health carriers, and substance use disorder inpatient  
6 and residential treatment providers, shall undertake development of  
7 standardized clinical documentation requirements for initial  
8 authorization and concurrent utilization review for residential  
9 treatment of substance use disorders. Medicaid managed care  
10 organizations and health carriers shall begin to use the standardized  
11 requirements by July 1, 2025.

12        (2) Any standardized documentation and associated process  
13 requirements must align with the centers for medicare and medicaid  
14 services interoperability and prior authorization final rule issued  
15 on January 17, 2024.

16        NEW SECTION.    **Sec. 11.**    The health care authority shall provide a  
17 gap analysis of nonemergency transportation benefits provided to  
18 medicaid enrollees in Washington, Oregon, and other comparison states  
19 selected by the health care authority and provide an analysis of the  
20 costs and benefits of available alternatives to the governor and  
21 appropriate committees of the legislature by December 1, 2024,  
22 including the option of an enhanced nonemergency transportation  
23 benefit for persons being discharged from a behavioral health  
24 emergency services provider to the next level of care in  
25 circumstances when a prudent layperson acting reasonably would  
26 believe such transportation is necessary to protect the enrollee from  
27 relapse or other discontinuity in care that would jeopardize the  
28 health or safety of the enrollee.

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