2SHB 2572 - S COMM AMD
By Committee on Human Services & Corrections

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 disorders are on the rise in Washington,
5 affecting victims, families, and communities throughout the state;
6 (b) Access to effective treatment is a necessary component to
7 helping individuals recover from substance use disorders; and
8 (c) When individuals are ready for treatment, they should be able
9 to obtain it with minimal barriers relating to health care coverage.
10 (2) The legislature therefore intends to ensure that there is no
11 wrong door for individuals accessing substance use disorder treatment
12 services by requiring coverage, and prohibiting prior authorization,
13 for certain substance use disorder treatment services.

14 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05
15 RCW to read as follows:
16 (1) To the extent that the following services are covered
17 benefits, a health plan, must cover inpatient hospital
18 detoxification, residential subacute detoxification, inpatient
19 hospital substance use disorder treatment, residential substance use
20 disorder treatment, partial hospitalization substance use disorder
21 treatment, and intensive outpatient substance use disorder treatment
22 for the first twenty-four hours after an enrollee presents for any of
23 these services or is referred for any of these services, without
24 imposing utilization management review limitations on coverage,
25 including prior authorization requirements.
26 (a) If located in Washington, the treatment facility or program
27 must be licensed or certified by the department of health to deliver
28 the level of care being sought by the enrollee. If located in other
29 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 twenty-four 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 twenty-four 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 twenty-four 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 twenty-four 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. 3.** 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,

1 residential substance use disorder treatment, partial hospitalization
2 substance use disorder treatment, and intensive outpatient substance
3 use disorder treatment for the first twenty-four hours after an
4 enrollee presents for any of these services or is referred for any of
5 these services, without imposing utilization management review
6 limitations 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 enrollee. 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 of
12 care being sought by the enrollee.
13 (b) If an enrollee 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 neither it nor any third party
16 induced the enrollee to seek treatment in exchange for payment of
17 goods, nonmedical or mental health services, or moneys, provided
18 either to the enrollee or the third party.
19 (2) The treatment facility or program must provide an enrollee's
20 health plan with notice of admission as soon as practicable after
21 admitting the enrollee, but not later than twenty-four hours after
22 admission. The time of notification does not reduce the requirements
23 established in subsection (1) of this section.
24 (a) The facility's initial assessment, basis for referral, and
25 initial planned services must accompany the notice.
26 (b) Upon receipt of notice of admission and the passage of the
27 first twenty-four hours, as required under subsection (1) of this
28 section, the health plan may initiate its utilization review of the
29 member's need for services, and the remainder of the enrollee's
30 services may be subject to utilization management, including prior
31 authorization, as required by the enrollee's health coverage.
32 (c) If the treatment facility or program is a contracted facility
33 participating in the health plan's provider network, the health plan
34 must conduct any prior authorization or other utilization management
35 review necessary to determine the covered length of stay and course
36 of treatment, as permitted under the enrollee's health plan, on an
37 urgent, expedited basis within twenty-four hours of receipt of all
38 necessary documentation.
39 (3) If the treatment facility or program is not a contracted
40 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 twenty-four 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. 4.** 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 twenty-four 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 twenty-four 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 twenty-four 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

1 remainder of the client's services may be subject to utilization
2 management, including prior authorization, as required by the
3 client's coverage through the behavioral health organization.
4 (c) If the treatment facility or program is a contracted facility
5 participating in the behavioral health organization provider network,
6 the behavioral health organization must conduct any prior
7 authorization or other utilization management review necessary to
8 determine the covered length of stay and course of treatment on an
9 urgent, expedited basis within twenty-four hours of receipt of all
10 necessary documentation.
11 (3) If the treatment facility or program is not a contracted
12 facility participating in the behavioral health organization's
13 provider network, the behavioral health organization must inform the
14 client and the client's attending physician that the facility or
15 program is not in the behavioral health organization's provider
16 network, and whether out-of-network coverage is available. Nothing in
17 this section requires a behavioral health organization to include
18 out-of-network coverage.
19 (a) If the behavioral health organization covers out-of-network
20 services, and the client is admitted to an out-of-network facility or
21 program located in Washington, the behavioral health organization
22 must pay for a covered mode of transfer to an in-network facility or
23 program without requiring payment or cost sharing from the client.
24 Transport must be provided by an in-network provider.
25 (b) A behavioral health organization is not required to cover
26 transportation from an out-of-state treatment program or facility if
27 the client elects to transfer to an in-state, in-network treatment
28 program or facility.
29 (4)(a) If a behavioral health organization determines that the
30 admission to inpatient substance use disorder treatment was not
31 medically necessary or clinically appropriate, the behavioral health
32 organization is not required to pay the facility or program for the
33 services delivered after the initial twenty-four hour admission
34 period, subject to the conclusion of any filed appeals of the adverse
35 benefit determination.
36 (b) If the patient evaluation and plan of care conducted at the
37 facility or program under (a) of this subsection and the behavioral
38 health organization's utilization review process identify a need for
39 services other than those available at the inpatient substance use
40 disorder treatment facility or program, the behavioral health

1 organization in collaboration with the facility or program must fully
2 coordinate the arrangements for assuring that the client obtains the
3 proper medically necessary or clinically appropriate care. To fully
4 coordinate these arrangements, a behavioral health organization may
5 need to identify and contact an available program or facility that
6 offers the medically necessary or clinically appropriate care, assist
7 with arranging the admission or initial appointment between the
8 client and the provider, assist with the transfer of health records
9 including the initial evaluation and plan of care, and conduct other
10 activities to facilitate a seamless transition for the client into
11 the appropriate care.
12 (5) A behavioral health organization must use evidence-based
13 criteria for assessing the medical necessity and clinical
14 appropriateness of a client's need for substance use disorder
15 residential treatment.
16 (6) This section does not restrict the right of clients to seek
17 emergency medical care requiring stabilization or acute
18 detoxification services from any emergency room or urgent care center
19 without prior authorization."

<u>2SHB 2572</u> - S COMM AMD
By Committee on Human Services & Corrections

20 On page 1, line 2 of the title, after "services;" strike the
21 remainder of the title and insert "adding a new section to chapter
22 41.05 RCW; adding a new section to chapter 48.43 RCW; adding a new
23 section to chapter 71.24 RCW; and creating a new section."

<u>EFFECT:</u> (1) 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.
(2) 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.
(3) 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 twenty-four hour admission period, not only inpatient substance use disorder treatment.

--- END ---