

2SHB 2572 - S COMM AMD

By Committee on Ways & Means

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 forty-eight 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
30 state agency with the authority to issue credentials for the level of
31 care being sought by the enrollee.

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (1) To the extent that the following services are covered
35 benefits, a health plan, as defined in RCW 48.43.005, must cover
36 inpatient hospital detoxification, residential subacute
37 detoxification, inpatient hospital substance use disorder treatment,
38 residential substance use disorder treatment, partial hospitalization
39 substance use disorder treatment, and intensive outpatient substance

1 use disorder treatment for the first forty-eight hours after an
2 enrollee presents for any of these services or is referred for any of
3 these services, without imposing utilization management review
4 limitations on coverage, including prior authorization requirements.

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

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

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

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

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

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

37 (3) If the treatment facility or program is not a contracted
38 facility participating in the health plan's provider network, the
39 health plan must inform the enrollee and the enrollee's attending
40 physician that the facility is not in the health plan's provider

1 network, and whether out-of-network coverage is available. Nothing in
2 this section requires a carrier to include out-of-network coverage in
3 a health plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

34 (b) Upon receipt of notice of admission and the passage of the
35 first forty-eight hours, as required under subsection (1) of this
36 section, the behavioral health organization may initiate its
37 utilization review of the client's need for services, and the
38 remainder of the client's services may be subject to utilization

1 management, including prior authorization, as required by the
2 client's coverage through the behavioral health organization.

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

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

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

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

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

35 (b) If the patient evaluation and plan of care conducted at the
36 facility or program under (a) of this subsection and the behavioral
37 health organization's utilization review process identify a need for
38 services other than those available at the inpatient substance use
39 disorder treatment facility or program, the behavioral health
40 organization in collaboration with the facility or program must fully

1 coordinate the arrangements for assuring that the client obtains the
2 proper medically necessary or clinically appropriate care. To fully
3 coordinate these arrangements, a behavioral health organization may
4 need to identify and contact an available program or facility that
5 offers the medically necessary or clinically appropriate care, assist
6 with arranging the admission or initial appointment between the
7 client and the provider, assist with the transfer of health records
8 including the initial evaluation and plan of care, and conduct other
9 activities to facilitate a seamless transition for the client into
10 the appropriate care.

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

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

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

EFFECT: (1) 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.

(2) 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.

(3) 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.

(4) 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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