ESHB 2642 - S COMM AMD
By Subcommittee on Behavioral Health

OUT OF ORDER 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 service agency
25 licensed or 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 service

1 agency that provides inpatient or residential substance use disorder
2 treatment prior to conducting a utilization review; and
3 (ii) Provide coverage for no less than three days in a behavioral
4 health service agency that provides withdrawal management services
5 prior to 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 service 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 service agency under (a) of this
16 subsection must notify an enrollee's health plan as soon as
17 practicable after admitting the enrollee, but not later than twenty-
18 four hours after admitting the enrollee. The time of notification
19 does not reduce the requirements established in (a) of this
20 subsection.
21 (ii) The behavioral health service agency under (a) of this
22 subsection must provide the health plan with its initial assessment
23 and initial treatment plan for the enrollee within two business days
24 of admission, excluding weekends and holidays, or within three days
25 in the case of a behavioral health service agency that provides
26 withdrawal management services.
27 (iii) After the time period in (a) of this subsection and receipt
28 of the material provided under (c)(ii) of this subsection, the plan
29 may initiate a medical necessity review process. Medical necessity
30 review must be based on the standard set of criteria established
31 under section 6 of this act. If the health plan determines within one
32 business day from the start of the medical necessity review period
33 and receipt of the material provided under (c)(ii) of this subsection
34 that the admission to the facility was not medically necessary and
35 advises the agency of the decision in writing, the health plan is not
36 required to pay the facility for services delivered after the start
37 of the medical necessity review period, subject to the conclusion of
38 a filed appeal of the adverse benefit determination. If the health
39 plan's medical necessity review is completed more than one business
40 day after start of the medical necessity review period and receipt of

the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan

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

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

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

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

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

30 (b) The behavioral health service agency may not balance bill, as
31 defined in RCW 48.43.005.

32 (6) When the treatment plan approved by the health plan involves
33 transfer of the enrollee to a different facility or to a lower level
34 of care, the care coordination unit of the health plan shall work
35 with the current agency to make arrangements for a seamless transfer
36 as soon as possible to an appropriate and available facility or level
37 of care. The health plan shall pay the agency for the cost of care at
38 the current facility until the seamless transfer to the different
39 facility or lower level of care is complete. A seamless transfer to a
40 lower level of care may include same day or next day appointments for

1 outpatient care, and does not include payment for nontreatment
2 services, such as housing services. If placement with an agency in
3 the health plan's network is not available, the health plan shall pay
4 the current agency until a seamless transfer arrangement is made.
5 (7) The requirements of this section do not apply to treatment
6 provided in out-of-state facilities.
7 (8) For the purposes of this section "withdrawal management
8 services" means twenty-four hour medically managed or medically
9 monitored detoxification and assessment and treatment referral for
10 adults or adolescents withdrawing from alcohol or drugs, which may
11 include induction on medications for addiction recovery.

12 NEW SECTION. **Sec. 4.** A new section is added to chapter 71.24
13 RCW to read as follows:
14 (1) Beginning January 1, 2021, a managed care organization may
15 not require an enrollee to obtain prior authorization for withdrawal
16 management services or inpatient or residential substance use
17 disorder treatment services in a behavioral health service agency
18 licensed or certified under RCW 71.24.037.
19 (2)(a) Beginning January 1, 2021, a managed care organization
20 must:
21 (i) Provide coverage for no less than two business days,
22 excluding weekends and holidays, in a behavioral health service
23 agency that provides inpatient or residential substance use disorder
24 treatment prior to conducting a utilization review; and
25 (ii) Provide coverage for no less than three days in a behavioral
26 health service agency that provides withdrawal management services
27 prior to conducting a utilization review.
28 (b) The managed care organization may not require an enrollee to
29 obtain prior authorization for the services specified in (a) of this
30 subsection as a condition for payment of services prior to the times
31 specified in (a) of this subsection. Once the times specified in (a)
32 of this subsection have passed, the managed care organization may
33 initiate utilization management review procedures if the behavioral
34 health service agency continues to provide services or is in the
35 process of arranging for a seamless transfer to an appropriate
36 facility or lower level of care under subsection (6) of this section.
37 (c)(i) The behavioral health service agency under (a) of this
38 subsection must notify an enrollee's managed care organization as
39 soon as practicable after admitting the enrollee, but not later than

1 twenty-four hours after admitting the enrollee. The time of
2 notification does not reduce the requirements established in (a) of
3 this subsection.

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

10 (iii) After the time period in (a) of this subsection and receipt
11 of the material provided under (c)(ii) of this subsection, the
12 managed care organization may initiate a medical necessity review
13 process. Medical necessity review must be based on the standard set
14 of criteria established under section 6 of this act. If the health
15 plan determines within one business day from the start of the medical
16 necessity review period and receipt of the material provided under
17 (c)(ii) of this subsection that the admission to the facility was not
18 medically necessary and advises the agency of the decision in
19 writing, the health plan is not required to pay the facility for
20 services delivered after the start of the medical necessity review
21 period, subject to the conclusion of a filed appeal of the adverse
22 benefit determination. If the managed care organization's medical
23 necessity review is completed more than one business day after start
24 of the medical necessity review period and receipt of the material
25 provided under (c)(ii) of this subsection, the managed care
26 organization must pay for the services delivered from the time of
27 admission until the time at which the medical necessity review is
28 completed and the agency is advised of the decision in writing.

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

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

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

1 (a) The managed care organization is not responsible for
2 reimbursing the behavioral health service agency at a greater rate
3 than would be paid had the agency been in the enrollee's network; and
4 (b) The behavioral health service agency may not balance bill, as
5 defined in RCW 48.43.005.
6 (6) When the treatment plan approved by the managed care
7 organization involves transfer of the enrollee to a different
8 facility or to a lower level of care, the care coordination unit of
9 the managed care organization shall work with the current agency to
10 make arrangements for a seamless transfer as soon as possible to an
11 appropriate and available facility or level of care. The managed care
12 organization shall pay the agency for the cost of care at the current
13 facility until the seamless transfer to the different facility or
14 lower level of care is complete. A seamless transfer to a lower level
15 of care may include same day or next day appointments for outpatient
16 care, and does not include payment for nontreatment services, such as
17 housing services. If placement with an agency in the managed care
18 organization's network is not available, the managed care
19 organization shall pay the current agency at the service level until
20 a seamless transfer arrangement is made.
21 (7) The requirements of this section do not apply to treatment
22 provided in out-of-state facilities.
23 (8) For the purposes of this section "withdrawal management
24 services" means twenty-four hour medically managed or medically
25 monitored detoxification and assessment and treatment referral for
26 adults or adolescents withdrawing from alcohol or drugs, which may
27 include induction on medications for addiction recovery.

28 NEW SECTION. **Sec. 5.** (1) The health care authority shall
29 develop an action plan to support admission to and improved
30 transitions between levels of care for both adults and adolescents.
31 (2) The health care authority shall develop the action plan in
32 partnership with the office of the insurance commissioner, medicaid
33 managed care organizations, commercial health plans, providers of
34 substance use disorder services, and Indian health care agencies.
35 (3) The health care authority must include the following in the
36 action plan:
37 (a) Identification of barriers in order to facilitate transfers
38 to the appropriate level of care, and specific actions to remove
39 those barriers; and

1 (b) Specific actions that may lead to the increase in the number
2 of persons successfully transitioning from one level of care to the
3 next appropriate level of care.
4 (4) The barriers and action items to be identified and addressed
5 in the action plan under subsection (3) of this section include, but
6 are not limited to:
7 (a) Having the health care authority and department of health
8 explore systems to allow higher acuity withdrawal management
9 facilities to bill for appropriate lower levels of care while
10 maintaining financial stability;
11 (b) Developing protocols for the initial notification by a
12 substance use disorder treatment agency to fully insured health plans
13 and managed care organizations in regards to an enrollee's admission
14 to a facility and uniformity in the plan's response to the agency in
15 regards to the receipt of this information;
16 (c) Facilitating direct transfers to withdrawal management and
17 residential substance use disorder treatment from hospitals and
18 jails;
19 (d) Addressing concerns related to individuals being denied
20 withdrawal management services based on their drug of choice;
21 (e) Exploring options for allowing medicaid managed care
22 organizations to pay an administrative rate and establishing the
23 equivalent reimbursement mechanism for commercial health plans for a
24 plan enrollee who needs to remain in withdrawal management or
25 residential care until a seamless transfer can occur, but no longer
26 requires the higher acuity level that was the reason for the initial
27 admission; and
28 (f) Establishing the minimum amount of medical information
29 necessary to gather from the patient for utilization reviews in a
30 withdrawal management setting.
31 (5) For medicaid services, specific actions must align with
32 federal and state medicaid requirements regarding medical necessity,
33 minimize duplicative or unnecessary burdens for agencies, and be
34 patient-centered for medicaid managed care organizations.
35 (6) The health care authority shall develop options for best
36 communicating the action plan to substance use disorder agencies by
37 December 1, 2020.

38 NEW SECTION. **Sec. 6.** For the purposes of promoting standardized
39 training for behavioral health professionals and facilitating

1 communications between behavioral health service agencies, executive
2 agencies, managed care organizations, private health plans, and plans
3 offered through the public employees' benefits board, it is the
4 policy of the state to adopt a single standard set of criteria to
5 define medical necessity for substance use disorder treatment and to
6 define substance use disorder levels of care in Washington. The
7 criteria selected must be comprehensive, widely understood and
8 accepted in the field, and based on continuously updated research and
9 evidence. The health care authority and the office of the insurance
10 commissioner must independently review their regulations and
11 practices by January 1, 2021. The health care authority may make
12 rules if necessary to promulgate the selected standard set of
13 criteria."

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By Subcommittee on Behavioral Health

OUT OF ORDER 03/06/2020

14 On page 1, line 2 of the title, after "services;" strike the
15 remainder of the title and insert "adding a new section to chapter
16 41.05 RCW; adding a new section to chapter 48.43 RCW; adding a new
17 section to chapter 71.24 RCW; and creating new sections."

EFFECT: (1) Standardizes terminology to refer to behavioral health service 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 service 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.

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