CERTIFICATION OF ENROLLMENT

ENGROSSED SUBSTITUTE HOUSE BILL 2642

Chapter 345, Laws of 2020

66th Legislature
2020 Regular Session

SUBSTANCE USE DISORDER TREATMENT--HEALTH COVERAGE

EFFECTIVE DATE: June 11, 2020

Passed by the House March 10, 2020
Yeas 97 Nays 0

LAURIE JINKINS

Speaker of the House of Representatives

Passed by the Senate March 6, 2020
Yeas 48 Nays 0

CYRUS HABIB

President of the Senate

Approved April 3, 2020 1:54 PM

JAY INSLEE

Governor of the State of Washington

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE HOUSE BILL 2642** as passed by the House of Representatives and the Senate on the dates hereon set forth.

BERNARD DEAN

Chief Clerk

FILED

April 3, 2020

Secretary of State
State of Washington

ENGROSSED SUBSTITUTE HOUSE BILL 2642

AS AMENDED BY THE SENATE

Passed Legislature - 2020 Regular Session

State of Washington 66th Legislature 2020 Regular Session

By House Health Care & Wellness (originally sponsored by Representatives Davis, Cody, Chopp, Harris, Leavitt, Caldier, Smith, Goodman, Orwall, Thai, Macri, Stonier, Schmick, Tharinger, Riccelli, Robinson, Griffey, Graham, Appleton, Callan, Irwin, Bergquist, Lekanoff, Barkis, Senn, Doglio, Walen, Peterson, Ormsby, and Pollet)

READ FIRST TIME 02/07/20.

AN ACT Relating to removing health coverage barriers to accessing substance use disorder treatment services; adding a new section to chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; adding a new section to chapter 71.24 RCW; and creating new sections.

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

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

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

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

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

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

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

(1) Except as provided in subsection (2) of this section, a health plan offered to employees and their covered dependents under this chapter 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 agency licensed or certified under RCW 71.24.037.

(2)(a) A health plan offered to employees and their covered dependents under this chapter 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 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 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 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 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 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 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 may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under section 6 of this act. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business 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 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 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 agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health 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 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 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 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 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 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 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 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 may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under section 6 of this act. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business 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 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 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 agency at a greater rate than would be paid had the agency been in the enrollee's network; and

(b) The behavioral health 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. 4.** A new section is added to chapter 71.24 RCW to read as follows:

(1) Beginning January 1, 2021, a managed care organization 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 agency licensed or certified under RCW 71.24.037.

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

(i) Provide coverage for no less than two business days, excluding weekends and holidays, in a behavioral health 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 agency that provides withdrawal management services prior to conducting a utilization review.

(b) The managed care organization 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 managed care organization may initiate utilization management review procedures if the behavioral health 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 agency under (a) of this subsection must notify an enrollee's managed care organization 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 agency under (a) of this subsection must provide the managed care organization 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 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 managed care organization may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under section 6 of this act. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the managed care organization's medical necessity review is completed more than one business day after start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the managed care

organization 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 agency shall document to the managed care organization 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 agency under subsection (2)(a) of this section is not in the enrollee's network:

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

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

(6) When the treatment plan approved by the managed care organization involves transfer of the enrollee to a different facility or to a lower level of care, the care coordination unit of the managed care organization 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 managed care organization 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 managed care organization's network is not available, the managed care organization shall pay the current agency at the service level 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. 5.** (1) The health care authority shall develop an action plan to support admission to and improved transitions between levels of care for both adults and adolescents.

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

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

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

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

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

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

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

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

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

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

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

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

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

NEW SECTION. **Sec. 6.** For the purposes of promoting standardized training for behavioral health professionals and facilitating communications between behavioral health agencies, executive agencies, managed care organizations, private health plans, and plans offered through the public employees' benefits board, it is the policy of the state to adopt a single standard set of criteria to define medical necessity for substance use disorder treatment and to define substance use disorder levels of care in Washington. The criteria selected must be comprehensive, widely understood and accepted in the field, and based on continuously updated research and evidence. The health care authority and the office of the insurance commissioner must independently review their regulations and practices by January 1, 2021. The health care authority may make rules if necessary to promulgate the selected standard set of criteria.

Passed by the House March 10, 2020.
Passed by the Senate March 6, 2020.
Approved by the Governor April 3, 2020.
Filed in Office of Secretary of State April 3, 2020.

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