

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.

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

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

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

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

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

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

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

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

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

10 (2)(a) A health plan offered to employees and their covered
11 dependents under this chapter issued or renewed on or after January
12 1, 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) The health plan may not require an enrollee to obtain prior
21 authorization for the services specified in (a) of this subsection as
22 a condition for payment of services prior to the times specified in
23 (a) of this subsection. Once the times specified in (a) of this
24 subsection have passed, the health plan may initiate utilization
25 management review procedures if the behavioral health agency
26 continues to provide services or is in the process of arranging for a
27 seamless transfer to an appropriate facility or lower level of care
28 under subsection (6) of this section.

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

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

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

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

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

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

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

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

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

1 lower level of care may include same day or next day appointments for
2 outpatient care, and does not include payment for nontreatment
3 services, such as housing services. If placement with an agency in
4 the health plan's network is not available, the health plan shall pay
5 the current agency until a seamless transfer arrangement is made.

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

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

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

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

21 (2)(a) A health plan issued or renewed on or after January 1,
22 2021, must:

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

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

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

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

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

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

30 (3) The behavioral health agency shall document to the health
31 plan the patient's need for continuing care and justification for
32 level of care placement following the current treatment period, based
33 on the standard set of criteria established under section 6 of this
34 act, with documentation recorded in the 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 agency under subsection (2)(a) of
38 this section is not in the enrollee's network:

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

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

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

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

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

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

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

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

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

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

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

13 (c)(i) The behavioral health agency under (a) of this subsection
14 must notify an enrollee's managed care organization as soon as
15 practicable after admitting the enrollee, but not later than twenty-
16 four hours after admitting the enrollee. The time of notification
17 does not reduce the requirements established in (a) of this
18 subsection.

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

25 (iii) After the time period in (a) of this subsection and receipt
26 of the material provided under (c)(ii) of this subsection, the
27 managed care organization may initiate a medical necessity review
28 process. Medical necessity review must be based on the standard set
29 of criteria established under section 6 of this act. If the health
30 plan determines within one business day from the start of the medical
31 necessity review period and receipt of the material provided under
32 (c)(ii) of this subsection that the admission to the facility was not
33 medically necessary and advises the agency of the decision in
34 writing, the health plan is not required to pay the facility for
35 services delivered after the start of the medical necessity review
36 period, subject to the conclusion of a filed appeal of the adverse
37 benefit determination. If the managed care organization's medical
38 necessity review is completed more than one business day after start
39 of the medical necessity review period and receipt of the material
40 provided under (c)(ii) of this subsection, the managed care

1 organization must pay for the services delivered from the time of
2 admission until the time at which the medical necessity review is
3 completed and the agency is advised of the decision in writing.

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

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 NEW SECTION.

2 **Sec. 5.**

3 (1) The health care authority shall
4 develop an action plan to support admission to and improved
5 transitions between levels of care for both adults and adolescents.

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

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

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

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

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

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

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

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

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

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

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

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

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

11 NEW SECTION. **Sec. 6.** For the purposes of promoting standardized
12 training for behavioral health professionals and facilitating
13 communications between behavioral health agencies, executive
14 agencies, managed care organizations, private health plans, and plans
15 offered through the public employees' benefits board, it is the
16 policy of the state to adopt a single standard set of criteria to
17 define medical necessity for substance use disorder treatment and to
18 define substance use disorder levels of care in Washington. The
19 criteria selected must be comprehensive, widely understood and
20 accepted in the field, and based on continuously updated research and
21 evidence. The health care authority and the office of the insurance
22 commissioner must independently review their regulations and
23 practices by January 1, 2021. The health care authority may make
24 rules if necessary to promulgate the selected standard set of
25 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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