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**SUBSTITUTE SENATE BILL 6228**

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**State of Washington**

**68th Legislature**

**2024 Regular Session**

**By** Senate Health & Long Term Care (originally sponsored by Senators Dhingra, Hasegawa, Kuderer, Lovelett, Nobles, Randall, Shewmake, Valdez, and C. Wilson)

READ FIRST TIME 01/29/24.

1 AN ACT Relating to treatment of substance use disorders; amending  
2 RCW 41.05.526, 48.43.761, 71.24.618, 18.225.145, and 43.70.250;  
3 reenacting and amending RCW 41.05.017 and 18.205.095; adding new  
4 sections to chapter 71.24 RCW; adding new sections to chapter 48.43  
5 RCW; and adding a new section to chapter 41.05 RCW.

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

7 NEW SECTION. **Sec. 1.** A new section is added to chapter 71.24  
8 RCW to read as follows:

9 (1) The single standard set of criteria to define medical  
10 necessity for substance use disorder treatment and define substance  
11 use disorder levels of care in Washington is the most recent version  
12 of the ASAM Criteria as published by the American society of  
13 addiction medicine.

14 (2) When updated versions of the ASAM Criteria, inclusive of  
15 adolescent and transition age youth versions, are published by the  
16 American society of addiction medicine, the authority and the office  
17 of the insurance commissioner shall jointly determine the date upon  
18 which the updated version must begin to be used by medicaid managed  
19 care organizations, carriers, and other relevant entities. Both  
20 agencies must post notice of their decision on their websites. For  
21 purposes of the ASAM Criteria, 4th edition, medicaid managed care

1 organizations and carriers must begin to use the updated criteria no  
2 later than January 1, 2026.

3 **Sec. 2.** RCW 41.05.526 and 2020 c 345 s 2 are each amended to  
4 read as follows:

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

12 (2)(a) A health plan offered to employees and their covered  
13 dependents under this chapter (~~((issued or renewed on or after January  
14 1, 2021,))~~) must:

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

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

22 (b) The health plan may not require an enrollee to obtain prior  
23 authorization for the services specified in (a) of this subsection as  
24 a condition for payment of services prior to the times specified in  
25 (a) of this subsection. Once the times specified in (a) of this  
26 subsection have passed, the health plan may initiate utilization  
27 management review procedures if the behavioral health agency  
28 continues to provide services or is in the process of arranging for a  
29 seamless transfer to an appropriate facility or lower level of care  
30 under subsection (6) of this section. When the health plan authorizes  
31 inpatient or residential substance use disorder treatment, the  
32 minimum initial authorization period is for 28 days from the start of  
33 treatment.

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

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

7 (iii) After the time period in (a) of this subsection and receipt  
8 of the material provided under (c)(ii) of this subsection, the plan  
9 may initiate a medical necessity review process. Medical necessity  
10 review must be based on the (~~standard set of criteria established~~  
11 ~~under RCW 41.05.528~~) ASAM Criteria as published by the American  
12 society of addiction medicine. Neither a health plan nor a licensed  
13 or certified behavioral health agency when determining whether the  
14 services are medically necessary may deny services to a person who  
15 meets the ASAM Criteria for the requested substance use disorder  
16 services based on consideration of the person's length of abstinence  
17 independent from applying the ASAM Criteria. If the health plan  
18 determines within one business day from the start of the medical  
19 necessity review period and receipt of the material provided under  
20 (c)(ii) of this subsection that the admission to the facility was not  
21 medically necessary and advises the agency of the decision in  
22 writing, the health plan is not required to pay the facility for  
23 services delivered after the start of the medical necessity review  
24 period, subject to the conclusion of a filed appeal of the adverse  
25 benefit determination. If the health plan's medical necessity review  
26 is completed more than one business day after (~~{the}~~) the start of  
27 the medical necessity review period and receipt of the material  
28 provided under (c)(ii) of this subsection, the health plan must pay  
29 for the services delivered from the time of admission until the time  
30 at which the medical necessity review is completed and the agency is  
31 advised of the decision in writing.

32 (3) The behavioral health agency shall document to the health  
33 plan the patient's need for continuing care and justification for  
34 level of care placement following the current treatment period, based  
35 on the (~~standard set of criteria established under RCW 41.05.528~~)  
36 ASAM Criteria as published by the American society of addiction  
37 medicine, with documentation recorded in the patient's medical  
38 record. The behavioral health agency may not be required to provide  
39 documentation for the need for continuing care for inpatient or

1 residential substance use disorder treatment until the end of the  
2 initial authorization period.

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

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

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

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

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

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

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

32 **Sec. 3.** RCW 48.43.761 and 2020 c 345 s 3 are each amended to  
33 read as follows:

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

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

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

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

10 (b) The health plan may not require an enrollee to obtain prior  
11 authorization for the services specified in (a) of this subsection as  
12 a condition for payment of services prior to the times specified in  
13 (a) of this subsection. Once the times specified in (a) of this  
14 subsection have passed, the health plan may initiate utilization  
15 management review procedures if the behavioral health agency  
16 continues to provide services or is in the process of arranging for a  
17 seamless transfer to an appropriate facility or lower level of care  
18 under subsection (6) of this section. When the health plan authorizes  
19 inpatient or residential substance use disorder treatment, the  
20 minimum initial authorization period is for 28 days from the start of  
21 treatment.

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

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

33 (iii) After the time period in (a) of this subsection and receipt  
34 of the material provided under (c) (ii) of this subsection, the plan  
35 may initiate a medical necessity review process. Medical necessity  
36 review must be based on the (~~standard set of criteria established~~  
37 ~~under RCW 41.05.528~~) ASAM Criteria as published by the American  
38 society of addiction medicine. Neither a health plan nor a licensed  
39 or certified behavioral health agency when determining whether the  
40 services are medically necessary may deny services to a person who

1 meets the ASAM Criteria for the requested substance use disorder  
2 services based on consideration of the person's length of abstinence  
3 independent from applying the ASAM Criteria. If the health plan  
4 determines within one business day from the start of the medical  
5 necessity review period and receipt of the material provided under  
6 (c)(ii) of this subsection that the admission to the facility was not  
7 medically necessary and advises the agency of the decision in  
8 writing, the health plan is not required to pay the facility for  
9 services delivered after the start of the medical necessity review  
10 period, subject to the conclusion of a filed appeal of the adverse  
11 benefit determination. If the health plan's medical necessity review  
12 is completed more than one business day after (~~{the}~~) the start of  
13 the medical necessity review period and receipt of the material  
14 provided under (c)(ii) of this subsection, the health plan must pay  
15 for the services delivered from the time of admission until the time  
16 at which the medical necessity review is completed and the agency is  
17 advised of the decision in writing.

18 (3) The behavioral health agency shall document to the health  
19 plan the patient's need for continuing care and justification for  
20 level of care placement following the current treatment period, based  
21 on the (~~standard set of criteria established under RCW 41.05.528~~)  
22 ASAM Criteria as published by the American society of addiction  
23 medicine, with documentation recorded in the patient's medical  
24 record. The behavioral health agency may not be required to provide  
25 documentation for the need for continuing care for inpatient or  
26 residential substance use disorder treatment until the end of the  
27 initial authorization period.

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

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

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

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

37 (6) When the treatment plan approved by the health plan involves  
38 transfer of the enrollee to a different facility or to a lower level  
39 of care, the care coordination unit of the health plan shall work  
40 with the current agency to make arrangements for a seamless transfer

1 as soon as possible to an appropriate and available facility or level  
2 of care. The health plan shall pay the agency for the cost of care at  
3 the current facility until the seamless transfer to the different  
4 facility or lower level of care is complete. A seamless transfer to a  
5 lower level of care may include same day or next day appointments for  
6 outpatient care, and does not include payment for nontreatment  
7 services, such as housing services. If placement with an agency in  
8 the health plan's network is not available, the health plan shall pay  
9 the current agency until a seamless transfer arrangement is made.

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

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

17 **Sec. 4.** RCW 71.24.618 and 2020 c 345 s 4 are each amended to  
18 read as follows:

19 (1) (~~Beginning January 1, 2021, a~~) A managed care organization  
20 may not require an enrollee to obtain prior authorization for  
21 withdrawal management services or inpatient or residential substance  
22 use disorder treatment services in a behavioral health agency  
23 licensed or certified under RCW 71.24.037.

24 (2) (a) (~~Beginning January 1, 2021, a~~) A managed care  
25 organization must:

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

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

33 (b) The managed care organization may not require an enrollee to  
34 obtain prior authorization for the services specified in (a) of this  
35 subsection as a condition for payment of services prior to the times  
36 specified in (a) of this subsection. Once the times specified in (a)  
37 of this subsection have passed, the managed care organization may  
38 initiate utilization management review procedures if the behavioral  
39 health agency continues to provide services or is in the process of

1 arranging for a seamless transfer to an appropriate facility or lower  
2 level of care under subsection (6) of this section. When the managed  
3 care organization authorizes inpatient or residential substance use  
4 disorder treatment, the minimum initial authorization period is for  
5 28 days from the start of treatment.

6 (c)(i) The behavioral health agency under (a) of this subsection  
7 must notify an enrollee's managed care organization as soon as  
8 practicable after admitting the enrollee, but not later than twenty-  
9 four hours after admitting the enrollee. The time of notification  
10 does not reduce the requirements established in (a) of this  
11 subsection.

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

18 (iii) After the time period in (a) of this subsection and receipt  
19 of the material provided under (c)(ii) of this subsection, the  
20 managed care organization may initiate a medical necessity review  
21 process. Medical necessity review must be based on the (~~standard set~~  
22 ~~of criteria established under RCW 41.05.528~~) ASAM Criteria as  
23 published by the American society of addiction medicine. Neither a  
24 managed care organization nor a licensed or certified behavioral  
25 health agency when determining whether the services are medically  
26 necessary may deny services to a person who meets the ASAM Criteria  
27 for the requested substance use disorder services based on  
28 consideration of the person's length of abstinence independent from  
29 applying the ASAM Criteria. If the health plan determines within one  
30 business day from the start of the medical necessity review period  
31 and receipt of the material provided under (c)(ii) of this subsection  
32 that the admission to the facility was not medically necessary and  
33 advises the agency of the decision in writing, the health plan is not  
34 required to pay the facility for services delivered after the start  
35 of the medical necessity review period, subject to the conclusion of  
36 a filed appeal of the adverse benefit determination. If the managed  
37 care organization's medical necessity review is completed more than  
38 one business day after (~~the~~) the start of the medical necessity  
39 review period and receipt of the material provided under (c)(ii) of  
40 this subsection, the managed care organization must pay for the



1 services delivered from the time of admission until the time at which  
2 the medical necessity review is completed and the agency is advised  
3 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 RCW 41.05.528~~) ASAM Criteria as published by the American  
9 society of addiction medicine, with documentation recorded in the  
10 patient's medical record. The behavioral health agency may not be  
11 required to provide documentation for the need for continuing care  
12 for inpatient or residential substance use disorder treatment until  
13 the end of the initial authorization period.

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

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

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

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

23 (6) When the treatment plan approved by the managed care  
24 organization involves transfer of the enrollee to a different  
25 facility or to a lower level of care, the care coordination unit of  
26 the managed care organization shall work with the current agency to  
27 make arrangements for a seamless transfer as soon as possible to an  
28 appropriate and available facility or level of care. The managed care  
29 organization shall pay the agency for the cost of care at the current  
30 facility until the seamless transfer to the different facility or  
31 lower level of care is complete. A seamless transfer to a lower level  
32 of care may include same day or next day appointments for outpatient  
33 care, and does not include payment for nontreatment services, such as  
34 housing services. If placement with an agency in the managed care  
35 organization's network is not available, the managed care  
36 organization shall pay the current agency at the service level until  
37 a seamless transfer arrangement is made.

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

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

6 NEW SECTION. **Sec. 5.** A new section is added to chapter 48.43  
7 RCW to read as follows:

8 (1) For health plans issued or renewed on or after January 1,  
9 2025, a health carrier shall provide:

10 (a) Coverage for ground ambulance transports to behavioral health  
11 emergency services providers for enrollees who are experiencing an  
12 emergency medical condition as defined in RCW 48.43.005. A health  
13 carrier may not require prior authorization of ground ambulance  
14 services if a prudent layperson acting reasonably would have believed  
15 that an emergency medical condition existed; and

16 (b) Coverage for transportation from the behavioral health  
17 emergency services provider upon discharge to the enrollee's next  
18 level of care when a prudent layperson acting reasonably would  
19 believe that such transportation is necessary to protect the enrollee  
20 from a relapse or other discontinuity in care that would jeopardize  
21 the health and safety of the enrollee, which must be accomplished by  
22 means which a prudent layperson acting reasonably would deem  
23 appropriate to the present circumstances of the enrollee including,  
24 but not limited to, ground ambulance transportation, escorted  
25 transportation in a private vehicle, or use of a taxi service.

26 (2) Coverage of ground ambulance transports to behavioral health  
27 emergency services providers and transportation from the behavioral  
28 health emergency services provider upon discharge may be subject to  
29 applicable in-network copayments, coinsurance, and deductibles, as  
30 provided in chapter 48.49 RCW.

31 **Sec. 6.** RCW 41.05.017 and 2022 c 236 s 3, 2022 c 228 s 2, and  
32 2022 c 10 s 2 are each reenacted and amended to read as follows:

33 Each health plan that provides medical insurance offered under  
34 this chapter, including plans created by insuring entities, plans not  
35 subject to the provisions of Title 48 RCW, and plans created under  
36 RCW 41.05.140, are subject to the provisions of RCW 48.43.500,  
37 70.02.045, 48.43.505 through 48.43.535, 48.43.537, 48.43.545,  
38 48.43.550, 70.02.110, 70.02.900, 48.43.190, 48.43.083, 48.43.0128,

1 48.43.780, 48.43.435, 48.43.815, section 5 of this act, and chapter  
2 48.49 RCW.

3 NEW SECTION. **Sec. 7.** A new section is added to chapter 71.24  
4 RCW to read as follows:

5 (1) A managed care organization must:

6 (a) Provide coverage for ground ambulance transports to  
7 behavioral health emergency services providers for enrollees who are  
8 experiencing an emergency medical condition as defined in RCW  
9 48.43.005. A managed care plan may not require prior authorization of  
10 ground ambulance services if a prudent layperson acting reasonably  
11 would have believed that an emergency medical condition existed; and

12 (b) Provide coverage for transportation from the behavioral  
13 health emergency services provider upon discharge to the enrollee's  
14 next level of care when a prudent layperson acting reasonably would  
15 believe that such transportation is necessary to protect the enrollee  
16 from a relapse or other discontinuity in care that would jeopardize  
17 the health and safety of the enrollee, which must be accomplished by  
18 means which a prudent layperson acting reasonably would deem  
19 appropriate to the present circumstances of the enrollee including,  
20 but not limited to, ground ambulance transportation, escorted  
21 transportation in a private vehicle, or use of a taxi service.

22 (2) Coverage of ground ambulance transports to behavioral health  
23 emergency services providers and transportation from the behavioral  
24 health emergency services provider upon discharge may be subject to  
25 applicable in-network copayments, coinsurance, and deductibles, as  
26 provided in chapter 48.49 RCW.

27 (3) Nothing in this section prevents a managed care plan from  
28 denying coverage based on insurance fraud.

29 (4) If the behavioral health emergency services provider, ground  
30 ambulance transport, or behavioral health emergency services provider  
31 referenced in subsection (1) of this section are not in the  
32 enrollee's network, the managed care organization is not responsible  
33 for reimbursing these entities at a greater rate than they would be  
34 paid if the entity had been in the enrollee's network. The entities  
35 described in this subsection (4) may not balance bill, as defined in  
36 RCW 48.43.005.

37 **Sec. 8.** RCW 18.205.095 and 2021 c 165 s 1 and 2021 c 57 s 1 are  
38 each reenacted and amended to read as follows:

1 (1) The secretary shall issue a trainee certificate to any  
2 applicant who demonstrates to the satisfaction of the secretary that  
3 he or she is working toward the education and experience requirements  
4 in RCW 18.205.090.

5 (2) A trainee certified under this section shall submit to the  
6 secretary for approval a declaration, in accordance with rules  
7 adopted by the department, which shall be updated with the trainee's  
8 annual renewal, that he or she is actively pursuing the experience  
9 requirements under RCW 18.205.090 and is enrolled in:

10 (a) An approved education program; or

11 (b) An apprenticeship program reviewed by the substance use  
12 disorder certification advisory committee, approved by the secretary,  
13 and registered and approved under chapter 49.04 RCW.

14 (3) A trainee certified under this section may practice only  
15 under the supervision of a certified substance use disorder  
16 professional. The first 50 hours of any face-to-face client contact  
17 must be under direct observation. All remaining experience must be  
18 under supervision in accordance with rules adopted by the department.

19 (4) A certified substance use disorder professional trainee  
20 provides substance use disorder assessments, counseling, and case  
21 management (~~((with a state regulated agency))~~) and can provide clinical  
22 services to patients consistent with his or her education, training,  
23 and experience as approved by his or her supervisor.

24 ~~((A trainee certification may only be renewed four times,  
25 unless the secretary finds that a waiver to allow additional renewals  
26 is justified due to barriers to testing or training resulting from a  
27 governor-declared emergency.~~

28 ~~(6))~~) Applicants are subject to denial of a certificate or  
29 issuance of a conditional certificate for the reasons set forth in  
30 chapter 18.130 RCW.

31 ~~((7) A person certified under this chapter holding the title of  
32 chemical dependency professional trainee is considered to hold the  
33 title of substance use disorder professional trainee until such time  
34 as the person's present certification expires or is renewed.))~~

35 **Sec. 9.** RCW 18.225.145 and 2021 c 57 s 2 are each amended to  
36 read as follows:

37 (1) The secretary shall issue an associate license to any  
38 applicant who demonstrates to the satisfaction of the secretary that  
39 the applicant meets the following requirements for the applicant's

1 practice area and submits a declaration that the applicant is working  
2 toward full licensure in that category:

3 (a) Licensed social worker associate—advanced or licensed social  
4 worker associate—independent clinical: Graduation from a master's  
5 degree or doctoral degree educational program in social work  
6 accredited by the council on social work education and approved by  
7 the secretary based upon nationally recognized standards.

8 (b) Licensed mental health counselor associate: Graduation from a  
9 master's degree or doctoral degree educational program in mental  
10 health counseling or a related discipline from a college or  
11 university approved by the secretary based upon nationally recognized  
12 standards.

13 (c) Licensed marriage and family therapist associate: Graduation  
14 from a master's degree or doctoral degree educational program in  
15 marriage and family therapy or graduation from an educational program  
16 in an allied field equivalent to a master's degree or doctoral degree  
17 in marriage and family therapy approved by the secretary based upon  
18 nationally recognized standards.

19 (2) Associates may not provide independent social work, mental  
20 health counseling, or marriage and family therapy for a fee, monetary  
21 or otherwise. Associates must work under the supervision of an  
22 approved supervisor.

23 (3) Associates shall provide each client or patient, during the  
24 first professional contact, with a disclosure form according to RCW  
25 18.225.100, disclosing that he or she is an associate under the  
26 supervision of an approved supervisor.

27 (4) The department shall adopt by rule what constitutes adequate  
28 proof of compliance with the requirements of this section.

29 (5) Applicants are subject to the denial of a license or issuance  
30 of a conditional license for the reasons set forth in chapter 18.130  
31 RCW.

32 (6) ~~((a) Except as provided in (b) of this subsection, an))~~ An  
33 associate license may be renewed ~~((no more than six times, provided~~  
34 ~~that))~~ if the applicant for renewal has successfully completed  
35 eighteen hours of continuing education in the preceding year.  
36 Beginning with the second renewal, at least six of the continuing  
37 education hours in the preceding two years must be in professional  
38 ethics.

39 ~~((b) If the secretary finds that a waiver to allow additional~~  
40 ~~renewals is justified due to barriers to testing or training~~

1 ~~resulting from a governor-declared emergency, additional renewals may~~  
2 ~~be approved.))~~

3 **Sec. 10.** RCW 43.70.250 and 2023 c 469 s 21 are each amended to  
4 read as follows:

5 (1) It shall be the policy of the state of Washington that the  
6 cost of each professional, occupational, or business licensing  
7 program be fully borne by the members of that profession, occupation,  
8 or business.

9 (2) The secretary shall from time to time establish the amount of  
10 all application fees, license fees, registration fees, examination  
11 fees, permit fees, renewal fees, and any other fee associated with  
12 licensing or regulation of professions, occupations, or businesses  
13 administered by the department. Any and all fees or assessments, or  
14 both, levied on the state to cover the costs of the operations and  
15 activities of the interstate health professions licensure compacts  
16 with participating authorities listed under chapter 18.130 RCW shall  
17 be borne by the persons who hold licenses issued pursuant to the  
18 authority and procedures established under the compacts. In fixing  
19 said fees, the secretary shall set the fees for each program at a  
20 sufficient level to defray the costs of administering that program  
21 and the cost of regulating licensed volunteer medical workers in  
22 accordance with RCW 18.130.360, except as provided in RCW 18.79.202.  
23 In no case may the secretary impose any certification, examination,  
24 or renewal fee upon a person seeking certification as a certified  
25 peer specialist trainee under chapter 18.420 RCW or, between July 1,  
26 2025, and July 1, 2030, impose a certification, examination, or  
27 renewal fee of more than \$100 upon any person seeking certification  
28 as a certified peer specialist under chapter 18.420 RCW. Subject to  
29 appropriation for department costs, between July 1, 2024, and July 1,  
30 2029, the secretary may not impose any certification or certification  
31 renewal fee on a person seeking certification as a substance use  
32 disorder professional or substance use disorder professional trainee  
33 under chapter 18.205 RCW of more than \$100.

34 (3) All such fees shall be fixed by rule adopted by the secretary  
35 in accordance with the provisions of the administrative procedure  
36 act, chapter 34.05 RCW.

37 NEW SECTION. **Sec. 11.** A new section is added to chapter 41.05  
38 RCW to read as follows:

1 (1) The single standard set of criteria to define medical  
2 necessity for substance use disorder treatment and define substance  
3 use disorder levels of care in Washington is the most recent version  
4 of the ASAM Criteria as published by the American society of  
5 addiction medicine.

6 (2) When updated versions of the ASAM Criteria, inclusive of  
7 adolescent and transition age youth versions, are published by the  
8 American society of addiction medicine, the authority and the office  
9 of the insurance commissioner shall jointly determine the date upon  
10 which the updated version must begin to be used by medicaid managed  
11 care organizations, carriers, and other relevant entities. Both  
12 agencies must post notice of their decision on their websites. For  
13 purposes of the ASAM Criteria, 4th edition, medicaid managed care  
14 organizations and carriers must begin to use the updated criteria no  
15 later than January 1, 2026.

16 NEW SECTION. **Sec. 12.** A new section is added to chapter 48.43  
17 RCW to read as follows:

18 (1) The single standard set of criteria to define medical  
19 necessity for substance use disorder treatment and define substance  
20 use disorder levels of care in Washington is the most recent version  
21 of the ASAM Criteria as published by the American society of  
22 addiction medicine.

23 (2) When updated versions of the ASAM Criteria, inclusive of  
24 adolescent and transition age youth versions, are published by the  
25 American society of addiction medicine, the health care authority and  
26 the office of the insurance commissioner shall jointly determine the  
27 date upon which the updated version must begin to be used by medicaid  
28 managed care organizations, carriers, and other relevant entities.  
29 Both agencies must post notice of their decision on their websites.  
30 For purposes of the ASAM Criteria, 4th edition, medicaid managed care  
31 organizations and carriers must begin to use the updated criteria no  
32 later than January 1, 2026.

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