ENGROSSED SUBSTITUTE HOUSE BILL 2642

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, they recover.

(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 substance use disorder treatment services if:

(a) The health care provider is licensed or certified under Title 18 RCW;

(b) The treatment is within the health care provider's scope of practice; and

(c) The health care provider is employed by a residential treatment facility licensed by the department of health under RCW 71.24.037 to provide withdrawal management services or inpatient substance use disorder treatment services.

(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, including an extension to allow for any intervening weekend days or holidays, in a state-licensed substance use disorder residential treatment facility prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in state-licensed withdrawal management programs prior to conducting a utilization review.

(b) The health plan may not require an enrollee to obtain prior authorization for withdrawal management services or residential substance use disorder treatment 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 program providing services requests continuing substance use disorder treatment services.

(c)(i) The substance use disorder residential treatment facility or the withdrawal management program must provide an enrollee's health plan with notice of admission as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time notification does not reduce the requirements established in (a) of this subsection.

(ii) The facility providing the services shall provide the health plan with notification of admission, initial assessment, and the initial treatment plan within two business days of admission, including an extension to allow for any intervening weekend days or holidays.

(iii) Upon receipt of the materials in (c)(ii) of this subsection, the plan may initiate the medical necessity review process based on the American society of addiction medicine criteria. If a health plan determines, within one business day of receiving the materials, that the admission to the facility was not medically necessary or clinically appropriate, the health plan is not required to pay the facility for the services delivered after the initial admission periods specified in (a) of this subsection, subject to the conclusion of any filed appeals of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after the receipt of the materials and the review determines that the admission to the facility was not medically necessary or clinically appropriate, the health plan must pay for the services delivered following the health plan's receipt of the materials in (c)(ii) of this subsection until the time at which the review has been completed.

(3)(a) The treating provider shall document to the health plan the patient's need for continuing care and justification of treatment placement after stabilization, based on the American society of addiction medicine criteria for determining medical necessity with documentation recorded in the patient's medical record.

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

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

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

(4) If the facility providing the services is not in the enrollee's network:

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

(b) The facility may not balance bill, as defined in RCW 48.43.005.

(5) When a patient is at an addiction stabilization facility and the treatment plan approved by the health plan involves placement in a different facility or at a lower level of care, the care coordination unit of the health plan shall work with the current provider to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility. The health plan shall continue to cover the cost of care at the current facility until the seamless transfer to the appropriate facility or level of treatment is complete. A seamless transfer to an appropriate level of care may include same day or next day appointments for outpatient care, but does not include nontreatment services, such as housing services. If placement with a provider that offers proper medically necessary or clinically appropriate care in the health plan's network is not available, the health plan shall continue to pay the addiction stabilization facility until such an alternate arrangement is made.

(6) Nothing in this section applies to a facility providing services outside of Washington state.

(7) For the purposes of this section:

(a) "Addiction stabilization services" means intensive services provided by a residential treatment facility licensed to provide withdrawal management or inpatient addiction treatment and include twenty-four hour observation and supervision; physical and mental health screening; substance use disorder assessment; counseling and education on treatment and recovery resources and supports; treatment placement or discharge planning; family education and assistance; recovery medications as an adjunct to treatment; and aftercare planning and referral to collaborating providers, including programs that specialize in medication-assisted treatment.

(b) "Substance use disorder treatment services" means early intervention services for substance use disorder treatment; substance use disorder evaluation; outpatient services, including individual and group counseling, case management, and medication-assisted therapies; intensive outpatient and partial hospitalization services; intensive inpatient and long-term residential treatment.

(c) "Withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from 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 January 1, 2021, may not require an enrollee to obtain prior authorization for substance use disorder treatment services if:

(a) The health care provider is licensed or certified under Title 18 RCW;

(b) The treatment is within the health care provider's scope of practice; and

(c) The health care provider is employed by a residential treatment facility licensed by the department of health under RCW 71.24.037 to provide withdrawal management services or inpatient substance use disorder treatment services.

(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, including an extension to allow for any intervening weekend days or holidays, in a state-licensed substance use disorder residential treatment facility prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in state-licensed withdrawal management programs prior to conducting a utilization review.

(b) The health plan may not require an enrollee to obtain prior authorization for withdrawal management services or residential substance use disorder treatment 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 program providing services requests continuing substance use disorder treatment services.

(c)(i) The substance use disorder residential treatment facility or the withdrawal management program must provide an enrollee's health plan with notice of admission as soon as practicable after

admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time notification does not reduce the requirements established in (a) of this subsection.

(ii) The facility providing the services shall provide the health plan with notification of admission, initial assessment, and the initial treatment plan within two business days of admission, including an extension to allow for any intervening weekend days or holidays.

(iii) Upon receipt of the materials in (c)(ii) of this subsection, the plan may initiate the medical necessity review process based on the American society of addiction medicine criteria. If a health plan determines, within one business day of receiving the materials, that the admission to the facility was not medically necessary or clinically appropriate, the health plan is not required to pay the facility for the services delivered after the initial admission periods specified in (a) of this subsection, subject to the conclusion of any filed appeals of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after the receipt of the materials and the review determines that the admission to the facility was not medically necessary or clinically appropriate, the health plan must pay for the services delivered following the health plan's receipt of the materials in (c)(ii) of this subsection until the time at which the review has been completed.

(3)(a) The treating provider shall document to the health plan the patient's need for continuing care and justification of treatment placement after stabilization, based on American society of addiction medicine criteria for determining medical necessity with documentation recorded in the patient's medical record.

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

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

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

(4) If the facility providing the services is not in the enrollee's network:

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

(b) The facility may not balance bill, as defined in RCW 48.43.005.

(5) When a patient is at an addiction stabilization facility and the treatment plan approved by the health plan involves placement in a different facility or at a lower level of care, the care coordination unit of the health plan shall work with the current provider to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility. The health plan shall continue to cover the cost of care at the current facility until the seamless transfer to the appropriate facility or level of treatment is complete. A seamless transfer to an appropriate level of care may include same day or next day appointments for outpatient care, but does not include nontreatment services, such as housing services. If placement with a provider that offers proper medically necessary or clinically appropriate care in the health plan's network is not available, the health plan shall continue to pay the addiction stabilization facility until such an alternate arrangement is made.

(6) Nothing in this section applies to a facility providing services outside of Washington state.

(7) For the purposes of this section:

(a) "Addiction stabilization services" means intensive services provided by a residential treatment facility licensed to provide withdrawal management or inpatient addiction treatment and include twenty-four hour observation and supervision; physical and mental health screening; substance use disorder assessment; counseling and education on treatment and recovery resources and supports; treatment placement or discharge planning; family education and assistance; recovery medications as an adjunct to treatment; and aftercare planning and referral to collaborating providers, including programs that specialize in medication-assisted treatment.

(b) "Substance use disorder treatment services" means early intervention services for substance use disorder treatment; substance use disorder evaluation; outpatient services, including individual and group counseling, case management, and medication-assisted

therapies; intensive outpatient and partial hospitalization services; intensive inpatient and long-term residential treatment.

(c) "Withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from 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) Except as provided in subsection (2) of this section, beginning January 1, 2021, a managed care organization may not require an enrollee to obtain prior authorization for substance use disorder treatment services if:

(a) The health care provider is licensed or certified under Title 18 RCW;

(b) The treatment is within the health care provider's scope of practice; and

(c) The health care provider is employed by a residential treatment facility licensed by the department of health under RCW 71.24.037 to provide withdrawal management services or inpatient substance use disorder treatment services.

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

(i) Provide coverage for no less than two business days, including an extension to allow for any intervening weekend days or holidays, in a state-licensed substance use disorder residential treatment facility prior to conducting a utilization review; and

(ii) Provide coverage for no less than three days in state-licensed withdrawal management programs prior to conducting a utilization review.

(b) The managed care organization may not require an enrollee to obtain prior authorization for withdrawal management services or residential substance use disorder treatment 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 program providing services requests continuing substance use disorder treatment services.

(c)(i) The substance use disorder residential treatment facility or the withdrawal management program must provide an enrollee's managed care organization with notice of admission as soon as practicable after admitting the enrollee, but not later than twenty-four hours after admitting the enrollee. The time notification does not reduce the requirements established in (a) of this subsection.

(ii) The facility providing the services shall provide the managed care organization with notification of admission, initial assessment, and the initial treatment plan within two business days of admission, including an extension to allow for any intervening weekend days or holidays.

(iii) Upon receipt of the materials in (c)(ii) of this subsection, the managed care organization may initiate the medical necessity review process based on the American society of addiction medicine criteria. If a managed care organization determines, within one business day of receiving the materials, that the admission to the facility was not medically necessary or clinically appropriate, the managed care organization is not required to pay the facility for the services delivered after the initial admission periods specified in (a) of this subsection, subject to the conclusion of any filed appeals of the adverse benefit determination. If the managed care organization's medical necessity review is completed more than one business day after the receipt of the materials and the review determines that the admission to the facility was not medically necessary or clinically appropriate, the managed care organization must pay for the services delivered following the managed care organization's receipt of the materials in (c)(ii) of this subsection until the time at which the review has been completed.

(3)(a) The treating provider shall document to the managed care organization the patient's need for continuing care and justification of treatment placement after stabilization, based on American society of addiction medicine criteria for determining medical necessity with documentation recorded in the patient's medical record.

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

(c) A managed care organization is not required to cover transportation from an out-of-state treatment program or facility if the enrollee elects to transfer to an in-state, in-network treatment program or facility.

(4) If the facility providing the services is not in the enrollee's network:

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

(b) The facility may not balance bill, as defined in RCW 48.43.005.

(5) When a patient is at an addiction stabilization facility and the treatment plan approved by the managed care organization involves placement in a different facility or at a lower level of care, the care coordination unit of the managed care organization must work with the current provider to make arrangements for a seamless transfer as soon as possible to an appropriate and available facility. The managed care organization must continue to cover the cost of care at the current facility until the seamless transfer to the appropriate facility or level of treatment is complete. A seamless transfer to an appropriate level of care may include same day or next day appointments for outpatient care, but does not include nontreatment services, such as housing services. If placement with a provider that offers proper medically necessary or clinically appropriate care in the managed care organization's network is not available, the managed care organization must continue to pay the addiction stabilization facility until such an alternate arrangement is made.

(6) Nothing in this section applies to a facility providing services outside of Washington state.

(7) For the purposes of this section:

(a) "Addiction stabilization services" means intensive services provided by a residential treatment facility licensed to provide withdrawal management or inpatient addiction treatment and include twenty-four hour observation and supervision; physical and mental health screening; substance use disorder assessment; counseling and education on treatment and recovery resources and supports; treatment placement or discharge planning; family education and assistance; recovery medications as an adjunct to treatment; and aftercare

planning and referral to collaborating providers, including programs that specialize in medication-assisted treatment.

(b) "Substance use disorder treatment services" means early intervention services for substance use disorder treatment; substance use disorder evaluation; outpatient services, including individual and group counseling, case management, and medication-assisted therapies; intensive outpatient and partial hospitalization services; intensive inpatient and long-term residential treatment.

(c) "Withdrawal management services" means twenty-four hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from 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 improved transitions throughout American society of addiction medicine 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 providers.

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

(a) Identification of barriers to obtaining timely assessments 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 develop 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 provider 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 provider in regards to the receipt of this information;

(c) Developing standardized definitions for the different American society of addiction medicine criteria and levels of care to apply across regions, including lengths of stay in various levels of care based on American society of addiction medicine criteria;

(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) Specific actions must align with federal and state medicaid requirements regarding medical necessity, minimize duplicative or unnecessary burdens for providers, and be patient-centered.

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

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