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ENGROSSED SUBSTITUTE HOUSE BILL 2642

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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, they  
13 recover.

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 substance use  
7 disorder treatment services if:

8        (a) The health care provider is licensed or certified under Title  
9 18 RCW;

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

12       (c) The health care provider is employed by a residential  
13 treatment facility licensed by the department of health under RCW  
14 71.24.037 to provide withdrawal management services or inpatient  
15 substance use disorder treatment services.

16       (2)(a) A health plan offered to employees and their covered  
17 dependents under this chapter issued or renewed on or after January  
18 1, 2021, must:

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

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

26       (b) The health plan may not require an enrollee to obtain prior  
27 authorization for withdrawal management services or residential  
28 substance use disorder treatment as a condition for payment of  
29 services, prior to the times specified in (a) of this subsection.  
30 Once the times specified in (a) of this subsection have passed, the  
31 health plan may initiate utilization management review procedures if  
32 the program providing services requests continuing substance use  
33 disorder treatment services.

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

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

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

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

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

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

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

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

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

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

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

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

23 (7) For the purposes of this section:

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

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

1 (c) "Withdrawal management services" means twenty-four hour  
2 medically managed or medically monitored detoxification and  
3 assessment and treatment referral for adults or adolescents  
4 withdrawing from drugs, which may include induction on medications  
5 for addiction recovery.

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

8 (1) Except as provided in subsection (2) of this section, a  
9 health plan issued or renewed on or January 1, 2021, may not require  
10 an enrollee to obtain prior authorization for substance use disorder  
11 treatment services if:

12 (a) The health care provider is licensed or certified under Title  
13 18 RCW;

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

16 (c) The health care provider is employed by a residential  
17 treatment facility licensed by the department of health under RCW  
18 71.24.037 to provide withdrawal management services or inpatient  
19 substance use disorder treatment services.

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

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

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

29 (b) The health plan may not require an enrollee to obtain prior  
30 authorization for withdrawal management services or residential  
31 substance use disorder treatment as a condition for payment of  
32 services, prior to the times specified in (a) of this subsection.  
33 Once the times specified in (a) of this subsection have passed, the  
34 health plan may initiate utilization management review procedures if  
35 the program providing services requests continuing substance use  
36 disorder treatment services.

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

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

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

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

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

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

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

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

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

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

6 (b) The facility may not balance bill, as defined in RCW  
7 48.43.005.

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

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

25 (7) For the purposes of this section:

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

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

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

3 (c) "Withdrawal management services" means twenty-four hour  
4 medically managed or medically monitored detoxification and  
5 assessment and treatment referral for adults or adolescents  
6 withdrawing from drugs, which may include induction on medications  
7 for addiction recovery.

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

10 (1) Except as provided in subsection (2) of this section,  
11 beginning January 1, 2021, a managed care organization may not  
12 require an enrollee to obtain prior authorization for substance use  
13 disorder treatment services if:

14 (a) The health care provider is licensed or certified under Title  
15 18 RCW;

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

18 (c) The health care provider is employed by a residential  
19 treatment facility licensed by the department of health under RCW  
20 71.24.037 to provide withdrawal management services or inpatient  
21 substance use disorder treatment services.

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

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

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

31 (b) The managed care organization may not require an enrollee to  
32 obtain prior authorization for withdrawal management services or  
33 residential substance use disorder treatment as a condition for  
34 payment of services, prior to the times specified in (a) of this  
35 subsection. Once the times specified in (a) of this subsection have  
36 passed, the managed care organization may initiate utilization  
37 management review procedures if the program providing services  
38 requests continuing substance use disorder treatment services.



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

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

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

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

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

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

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

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

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

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

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

31 (7) For the purposes of this section:

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

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

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

9 (c) "Withdrawal management services" means twenty-four hour  
10 medically managed or medically monitored detoxification and  
11 assessment and treatment referral for adults or adolescents  
12 withdrawing from drugs, which may include induction on medications  
13 for addiction recovery.

14 NEW SECTION. **Sec. 5.** (1) The health care authority shall  
15 develop an action plan to support improved transitions throughout  
16 American society of addiction medicine levels of care for both adults  
17 and adolescents.

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

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

24 (a) Identification of barriers to obtaining timely assessments in  
25 order to facilitate transfers to the appropriate level of care, and  
26 specific actions to remove those barriers; and

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

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

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

37 (b) Developing protocols for the initial notification by a  
38 substance use disorder treatment provider to fully insured health  
39 plans and managed care organizations in regards to an enrollee's

1 admission to a facility and uniformity in the plan's response to the  
2 provider in regards to the receipt of this information;

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

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

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

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

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

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

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