H-3881.1

HOUSE BILL 2642

State of Washington 66th Legislature 2020 Regular Session

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 01/16/20. Referred to Committee on Health Care & Wellness.

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 a new section.

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 the effective date of this section 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 the effective date of this section 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 five days of withdrawal management services, including an extension to allow for any intervening weekend days or holidays, in a state-licensed withdrawal management program.

(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 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.

(ii) Upon receipt of the materials in (c)(i) of this subsection, the plan may initiate the medical necessity review process. If a health plan determines, within twenty-four hours 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 twenty-four hours 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)(i) of this subsection until the time at which the review has been completed.

(iii) The enrollee's use of stimulants may not be the sole grounds for determining that an admission to a withdrawal management facility is not medically necessary or clinically appropriate. The enrollee's decision to begin medication assisted treatment for opioid use disorder may not be the sole grounds for determining that an admission to a withdrawal management facility is not medically necessary or clinically appropriate.

(3) The treating provider shall determine 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.

(4) When a patient is at an addiction stabilization facility and the recommended plan of treatment 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 is complete. 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.

(5) 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 after the effective date of this section 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 the effective date of this section 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 five days of withdrawal management services, including an extension to allow for any intervening weekend days or holidays, in a state-licensed withdrawal management program.

(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 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.

(ii) Upon receipt of the materials in (c)(i) of this subsection, the plan may initiate the medical necessity review process. If a health plan determines, within twenty-four hours 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 twenty-four hours 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)(i) of this subsection until the time at which the review has been completed.

(iii) The enrollee's use of stimulants may not be the sole grounds for determining that an admission to a withdrawal management facility is not medically necessary or clinically appropriate. The enrollee's decision to begin medication assisted treatment for opioid use disorder may not be the sole grounds for determining that an

admission to a withdrawal management facility is not medically necessary or clinically appropriate.

(3) The treating provider shall determine 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.

(4) When a patient is at an addiction stabilization facility and the recommended plan of treatment 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 is complete. 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.

(5) 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 five days of withdrawal management services, including an extension to allow for any intervening weekend days or holidays, in a state-licensed withdrawal management program.

(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 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.

(ii) Upon receipt of the materials in (c)(i) of this subsection, the managed care organization may initiate the medical necessity review process. If a managed care organization determines, within twenty-four hours 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 twenty-four hours 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)(i) of this subsection until the time at which the review has been completed.

(iii) The enrollee's use of stimulants may not be the sole grounds for determining that an admission to a withdrawal management facility is not medically necessary or clinically appropriate. The enrollee's decision to begin medication assisted treatment for opioid use disorder may not be the sole grounds for determining that an admission to a withdrawal management facility is not medically necessary or clinically appropriate.

(3) The treating provider shall determine 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.

(4) When a patient is at an addiction stabilization facility and the recommended plan of treatment 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 is complete. 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.

(5) 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.

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