

CERTIFICATION OF ENROLLMENT  
**ENGROSSED SUBSTITUTE HOUSE BILL 2642**

66th Legislature  
2020 Regular Session

Passed by the House March 10, 2020  
Yeas 97 Nays 0

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**Speaker of the House of  
Representatives**

Passed by the Senate March 6, 2020  
Yeas 48 Nays 0

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**President of the Senate**

Approved

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**Governor of the State of Washington**

CERTIFICATE

I, Bernard Dean, Chief Clerk of the House of Representatives of the State of Washington, do hereby certify that the attached is **ENGROSSED SUBSTITUTE HOUSE BILL 2642** as passed by the House of Representatives and the Senate on the dates hereon set forth.

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**Chief Clerk**

FILED

**Secretary of State  
State of Washington**

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**ENGROSSED SUBSTITUTE HOUSE BILL 2642**

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AS AMENDED BY THE SENATE

Passed Legislature - 2020 Regular Session

**State of Washington                      66th Legislature                      2020 Regular Session**

**By** House Health Care & Wellness (originally sponsored by Representatives Davis, Cody, Chopp, Harris, Leavitt, Caldier, Smith, Goodman, Orwall, Thai, Macri, Stonier, Schmick, Tharinger, Riccelli, Robinson, Griffey, Graham, Appleton, Callan, Irwin, Bergquist, Lekanoff, Barkis, Senn, Doglio, Walen, Peterson, Ormsby, and Pollet)

READ FIRST TIME 02/07/20.

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

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

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

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

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

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

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

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

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

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

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

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

20       (b) The health plan may not require an enrollee to obtain prior  
21    authorization for the services specified in (a) of this subsection as  
22    a condition for payment of services prior to the times specified in  
23    (a) of this subsection. Once the times specified in (a) of this  
24    subsection have passed, the health plan may initiate utilization  
25    management review procedures if the behavioral health agency  
26    continues to provide services or is in the process of arranging for a  
27    seamless transfer to an appropriate facility or lower level of care  
28    under subsection (6) of this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

1        NEW SECTION.

2        **Sec. 5.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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