

2SSB 6228 - H COMM AMD
By Committee on Appropriations

ADOPTED AND ENGROSSED 02/29/2024

1 Strike everything after the enacting clause and insert the
2 following:

3 "NEW SECTION. **Sec. 1.** (1) The legislature finds that ensuring
4 that individuals with substance use disorders can enter into and
5 complete residential addiction treatment is an important public
6 policy objective. Substance use disorder providers forcing patients
7 to leave treatment prematurely and insurance authorization barriers
8 both present impediments to realizing this goal.

9 (2) The legislature further finds that patients with substance
10 use disorders should be provided information regarding and access to
11 the full panoply of treatment options for their condition, as would
12 be the case with any other life-threatening disease.
13 Pharmacotherapies are incredibly effective and severely underutilized
14 tools in the treatment of opioid use disorder and alcohol use
15 disorder. The federal food and drug administration has approved three
16 medications for the treatment of opioid use disorder and three
17 medications for the treatment of alcohol use disorder. Only 37
18 percent of individuals with opioid use disorder and nine percent of
19 individuals with alcohol use disorder receive medication to treat
20 their condition.

21 (3) Therefore, it is the intent of the legislature to reduce
22 forced patient discharges from residential addiction treatment, to
23 remove arbitrary insurance authorization barriers to residential
24 addiction treatment, and to ensure that patients with opioid use
25 disorder and alcohol use disorder receive access to care that is
26 consistent with clinical best practices.

27 NEW SECTION. **Sec. 2.** A new section is added to chapter 71.24
28 RCW to read as follows:

29 (1)(a) By October 1, 2024, each licensed or certified behavioral
30 health agency providing voluntary inpatient or residential substance
31 use disorder treatment services or withdrawal management services

1 shall submit to the department any policies that the agency maintains
2 regarding the transfer or discharge of a person without the person's
3 consent from a facility providing those services. The policies that
4 agencies must submit include any policies related to situations in
5 which the agency transfers or discharges a person without the
6 person's consent, therapeutic progressive disciplinary processes that
7 the agency maintains, and procedures to assure safe transfers and
8 discharges when a patient is discharged without the patient's
9 consent. Behavioral health agencies that do not maintain such
10 policies must provide an attestation to this effect.

11 (b) By April 1, 2025, the department shall adopt a model policy
12 for licensed or certified behavioral health agencies providing
13 voluntary inpatient or residential substance use disorder treatment
14 services or withdrawal management services to consider when adopting
15 policies related to the transfer or discharge of a person without the
16 person's consent from a facility providing those services. In
17 developing the model policy, the department shall consider the
18 policies submitted by agencies under (a) of this subsection and
19 establish factors to be used in making a decision to transfer or
20 discharge a person without the person's consent. Factors may include,
21 but are not limited to, the person's medical condition, the clinical
22 determination that the person no longer requires treatment or
23 withdrawal management services at the facility, the risk of physical
24 injury presented by the person to the person's self or to other
25 persons at the facility, the extent to which the person's behavior
26 risks the recovery goals of other persons at the facility, and the
27 extent to which the agency has applied a therapeutic progressive
28 disciplinary process. The model policy must include provisions
29 addressing the use of an appropriate therapeutic progressive
30 disciplinary process and procedures to assure safe transfers and
31 discharges of a patient who is discharged without the patient's
32 consent.

33 (2)(a) Beginning July 1, 2025, every licensed or certified
34 behavioral health agency providing voluntary inpatient or residential
35 substance use disorder treatment services or withdrawal management
36 services shall submit a report to the department for each instance in
37 which a person receiving services either: (i) Was transferred or
38 discharged from the facility by the agency without the person's
39 consent; or (ii) released the person's self from the facility prior
40 to a clinical determination that the person had completed treatment.

1 (b) The department shall adopt rules to implement the reporting
2 requirement under (a) of this subsection, using a standard form. The
3 rules must require that the agency provide a description of the
4 circumstances related to the person's departure from the facility,
5 including whether the departure was voluntary or involuntary, the
6 extent to which a therapeutic progressive disciplinary process was
7 applied, the patient's self-reported understanding of the reasons for
8 discharge, efforts that were made to avert the discharge, and efforts
9 that were made to establish a safe discharge plan prior to the
10 patient leaving the facility.

11 (3) Patient health care information contained in reports
12 submitted under subsection (2) of this section is exempt from
13 disclosure under RCW 42.56.360.

14 (4) This section does not apply to hospitals licensed under
15 chapter 70.41 RCW and psychiatric hospitals licensed under chapter
16 71.12 RCW.

17 NEW SECTION. **Sec. 3.** A new section is added to chapter 28B.20
18 RCW to read as follows:

19 The addictions, drug, and alcohol institute at the University of
20 Washington shall create a patient shared decision-making tool to
21 assist behavioral health and medical providers when discussing
22 medication treatment options for patients with alcohol use disorder.
23 The institute shall distribute the tool to behavioral health and
24 medical providers and instruct them on ways to incorporate the use of
25 the tool into their practices. The institute shall conduct regular
26 evaluations of the tool and update the tool as necessary.

27 **Sec. 4.** RCW 71.24.037 and 2023 c 454 s 2 are each amended to
28 read as follows:

29 (1) The secretary shall license or certify any agency or facility
30 that: (a) Submits payment of the fee established under RCW 43.70.110
31 and 43.70.250; (b) submits a complete application that demonstrates
32 the ability to comply with requirements for operating and maintaining
33 an agency or facility in statute or rule; and (c) successfully
34 completes the prelicensure inspection requirement.

35 (2) The secretary shall establish by rule minimum standards for
36 licensed or certified behavioral health agencies that must, at a
37 minimum, establish: (a) Qualifications for staff providing services
38 directly to persons with mental disorders, substance use disorders,

1 or both; (b) the intended result of each service; and (c) the rights
2 and responsibilities of persons receiving behavioral health services
3 pursuant to this chapter and chapter 71.05 RCW. The secretary shall
4 provide for deeming of licensed or certified behavioral health
5 agencies as meeting state minimum standards as a result of
6 accreditation by a recognized behavioral health accrediting body
7 recognized and having a current agreement with the department.

8 (3) The department shall review reports or other information
9 alleging a failure to comply with this chapter or the standards and
10 rules adopted under this chapter and may initiate investigations and
11 enforcement actions based on those reports.

12 (4) The department shall conduct inspections of agencies and
13 facilities, including reviews of records and documents required to be
14 maintained under this chapter or rules adopted under this chapter.

15 (5) The department may suspend, revoke, limit, restrict, or
16 modify an approval, or refuse to grant approval, for failure to meet
17 the provisions of this chapter, or the standards adopted under this
18 chapter. RCW 43.70.115 governs notice of a license or certification
19 denial, revocation, suspension, or modification and provides the
20 right to an adjudicative proceeding.

21 (6) No licensed or certified behavioral health agency may
22 advertise or represent itself as a licensed or certified behavioral
23 health agency if approval has not been granted or has been denied,
24 suspended, revoked, or canceled.

25 (7) Licensure or certification as a behavioral health agency is
26 effective for one calendar year from the date of issuance of the
27 license or certification. The license or certification must specify
28 the types of services provided by the behavioral health agency that
29 meet the standards adopted under this chapter. Renewal of a license
30 or certification must be made in accordance with this section for
31 initial approval and in accordance with the standards set forth in
32 rules adopted by the secretary.

33 (8) Licensure or certification as a licensed or certified
34 behavioral health agency must specify the types of services provided
35 that meet the standards adopted under this chapter. Renewal of a
36 license or certification must be made in accordance with this section
37 for initial approval and in accordance with the standards set forth
38 in rules adopted by the secretary.

1 (9) The department shall develop a process by which a provider
2 may obtain dual licensure as an evaluation and treatment facility and
3 secure withdrawal management and stabilization facility.

4 (10) Licensed or certified behavioral health agencies may not
5 provide types of services for which the licensed or certified
6 behavioral health agency has not been certified. Licensed or
7 certified behavioral health agencies may provide services for which
8 approval has been sought and is pending, if approval for the services
9 has not been previously revoked or denied.

10 (11) The department periodically shall inspect licensed or
11 certified behavioral health agencies at reasonable times and in a
12 reasonable manner.

13 (12) Upon petition of the department and after a hearing held
14 upon reasonable notice to the facility, the superior court may issue
15 a warrant to an officer or employee of the department authorizing him
16 or her to enter and inspect at reasonable times, and examine the
17 books and accounts of, any licensed or certified behavioral health
18 agency refusing to consent to inspection or examination by the
19 department or which the department has reasonable cause to believe is
20 operating in violation of this chapter.

21 (13) The department shall maintain and periodically publish a
22 current list of licensed or certified behavioral health agencies.

23 (14) Each licensed or certified behavioral health agency shall
24 file with the department or the authority upon request, data,
25 statistics, schedules, and information the department or the
26 authority reasonably requires. A licensed or certified behavioral
27 health agency that without good cause fails to furnish any data,
28 statistics, schedules, or information as requested, or files
29 fraudulent returns thereof, may have its license or certification
30 revoked or suspended.

31 (15) The authority shall use the data provided in subsection (14)
32 of this section to evaluate each program that admits children to
33 inpatient substance use disorder treatment upon application of their
34 parents. The evaluation must be done at least once every twelve
35 months. In addition, the authority shall randomly select and review
36 the information on individual children who are admitted on
37 application of the child's parent for the purpose of determining
38 whether the child was appropriately placed into substance use
39 disorder treatment based on an objective evaluation of the child's
40 condition and the outcome of the child's treatment.

1 (16) Any settlement agreement entered into between the department
2 and licensed or certified behavioral health agencies to resolve
3 administrative complaints, license or certification violations,
4 license or certification suspensions, or license or certification
5 revocations may not reduce the number of violations reported by the
6 department unless the department concludes, based on evidence
7 gathered by inspectors, that the licensed or certified behavioral
8 health agency did not commit one or more of the violations.

9 (17) In cases in which a behavioral health agency that is in
10 violation of licensing or certification standards attempts to
11 transfer or sell the behavioral health agency to a family member, the
12 transfer or sale may only be made for the purpose of remedying
13 license or certification violations and achieving full compliance
14 with the terms of the license or certification. Transfers or sales to
15 family members are prohibited in cases in which the purpose of the
16 transfer or sale is to avoid liability or reset the number of license
17 or certification violations found before the transfer or sale. If the
18 department finds that the owner intends to transfer or sell, or has
19 completed the transfer or sale of, ownership of the behavioral health
20 agency to a family member solely for the purpose of resetting the
21 number of violations found before the transfer or sale, the
22 department may not renew the behavioral health agency's license or
23 certification or issue a new license or certification to the
24 behavioral health service provider.

25 (18) Every licensed or certified outpatient behavioral health
26 agency shall display the 988 crisis hotline number in common areas of
27 the premises and include the number as a calling option on any phone
28 message for persons calling the agency after business hours.

29 (19) Every licensed or certified inpatient or residential
30 behavioral health agency must include the 988 crisis hotline number
31 in the discharge summary provided to individuals being discharged
32 from inpatient or residential services.

33 (20) (a) Licensed or certified behavioral health agencies
34 providing voluntary inpatient or residential substance use disorder
35 treatment services or withdrawal management services:

36 (i) Must comply with the policy submission and mandatory
37 reporting requirements established in section 2 of this act; and

38 (ii) May not prohibit a person from receiving services at or
39 being admitted to the agency based solely on prior instances of the

1 person releasing the person's self from the facility prior to a
2 clinical determination that the person had completed treatment.

3 (b) This subsection (20) does not apply to hospitals licensed
4 under chapter 70.41 RCW and psychiatric hospitals licensed under
5 chapter 71.12 RCW.

6 (21)(a) A licensed or certified behavioral health agency shall
7 provide each patient seeking treatment for opioid use disorder or
8 alcohol use disorder, whether receiving inpatient or outpatient
9 treatment, with education related to pharmacological treatment
10 options specific to the patient's diagnosed condition. The education
11 must include an unbiased explanation of all recognized forms of
12 treatment approved by the federal food and drug administration, as
13 required under RCW 7.70.050 and 7.70.060, that are clinically
14 appropriate for the patient. Providers may use the patient shared
15 decision-making tools for opioid use disorder and alcohol use
16 disorder developed by the addictions, drug, and alcohol institute at
17 the University of Washington. If the patient elects a clinically
18 appropriate pharmacological treatment option, the behavioral health
19 agency shall support the patient with the implementation of the
20 pharmacological treatment either by direct provision of the
21 medication or by a warm handoff referral, if the treating provider is
22 unable to directly provide the medication.

23 (b) Unless it meets the requirements of (a) of this subsection, a
24 behavioral health agency may not:

25 (i) Advertise that it treats opioid use disorder or alcohol use
26 disorder; or

27 (ii) Treat patients for opioid use disorder or alcohol use
28 disorder, regardless of the form of treatment that the patient
29 chooses.

30 (c)(i) Failure to meet the education requirements of (a) of this
31 subsection may be an element of proof in demonstrating a breach of
32 the duty to secure an informed consent under RCW 7.70.050.

33 (ii) Failure to meet the education and facilitation requirements
34 of (a) of this subsection may be the basis of a disciplinary action
35 under this section.

36 (d) This subsection does not apply to licensed behavioral health
37 agencies that are units within a hospital licensed under chapter
38 70.41 RCW or a psychiatric hospital licensed under chapter 71.12 RCW.

1 NEW SECTION. **Sec. 5.** A new section is added to chapter 71.24
2 RCW to read as follows:

3 (1) If a behavioral health provider or licensed or certified
4 behavioral health agency that provides withdrawal management services
5 to a patient seeks to discontinue usage or reduce dosage amounts of a
6 medication, including a psychotropic medication, that the patient has
7 been using in accordance with the directions of a prescribing health
8 care provider, the withdrawal management provider shall engage in
9 individualized, patient-centered, shared decision making, using
10 nonjudgmental and compassionate communication and, with the consent
11 of the patient, make a good faith effort to consult the prescribing
12 health care provider. A withdrawal management provider may not, by
13 philosophy or practice, categorically require all patients to
14 discontinue all psychotropic medications, including benzodiazepines
15 and medications for attention deficit hyperactivity disorder.

16 (2) This section does not apply to hospitals licensed under
17 chapter 70.41 RCW and psychiatric hospitals licensed under chapter
18 71.12 RCW.

19 **Sec. 6.** RCW 41.05.526 and 2020 c 345 s 2 are each amended to
20 read as follows:

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

28 (2)(a) A health plan offered to employees and their covered
29 dependents under this chapter issued or renewed on or after January
30 1, 2021, must:

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

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

38 (b) (i) The health plan may not require an enrollee to obtain
39 prior authorization for the services specified in (a) of this

1 subsection as a condition for payment of services prior to the times
2 specified in (a) of this subsection.

3 (ii) Once the times specified in (a) of this subsection have
4 passed, the health plan may initiate utilization management review
5 procedures if the behavioral health agency continues to provide
6 services or is in the process of arranging for a seamless transfer to
7 an appropriate facility or lower level of care under subsection (6)
8 of this section. For a health plan issued or renewed on or after
9 January 1, 2025, if a health plan authorizes inpatient or residential
10 substance use disorder treatment services pursuant to (a)(i) of this
11 subsection following the initial medical necessity review process
12 under (c)(iii) of this subsection, the length of the initial
13 authorization may not be less than 14 days from the date that the
14 patient was admitted to the behavioral health agency. Any subsequent
15 reauthorization that the health plan approves after the first 14 days
16 must continue for no less than seven days prior to requiring further
17 reauthorization. Nothing prohibits a health plan from requesting
18 information to assist with a seamless transfer under this subsection.

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

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

30 (iii) After the time period in (a) of this subsection and receipt
31 of the material provided under (c)(ii) of this subsection, the plan
32 may initiate a medical necessity review process. Medical necessity
33 review must be based on the standard set of criteria established
34 under RCW 41.05.528. In a review for inpatient or residential
35 substance use disorder treatment services, a health plan may not make
36 a determination that a patient does not meet medical necessity
37 criteria based primarily on the patient's length of abstinence. If
38 the patient's abstinence from substance use was due to incarceration,
39 hospitalization, or inpatient treatment, a health plan may not
40 consider the patient's length of abstinence in determining medical

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

15 (3) (a) The behavioral health agency shall document to the health
16 plan the patient's need for continuing care and justification for
17 level of care placement following the current treatment period, based
18 on the standard set of criteria established under RCW 41.05.528, with
19 documentation recorded in the patient's medical record.

20 (b) For a health plan issued or renewed on or after January 1,
21 2025, for inpatient or residential substance use disorder treatment
22 services, the health plan may not consider the patient's length of
23 stay at the behavioral health agency when making decisions regarding
24 the authorization to continue care at the behavioral health agency.

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

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

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

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

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

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

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

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

14 **Sec. 7.** RCW 48.43.761 and 2020 c 345 s 3 are each amended to
15 read as follows:

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

22 (2)(a) A health plan issued or renewed on or after January 1,
23 2021, must:

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

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

31 (b) (i) The health plan may not require an enrollee to obtain
32 prior authorization for the services specified in (a) of this
33 subsection as a condition for payment of services prior to the times
34 specified in (a) of this subsection.

35 (ii) Once the times specified in (a) of this subsection have
36 passed, the health plan may initiate utilization management review
37 procedures if the behavioral health agency continues to provide
38 services or is in the process of arranging for a seamless transfer to
39 an appropriate facility or lower level of care under subsection (6)

1 of this section. For a health plan issued or renewed on or after
2 January 1, 2025, if a health plan authorizes inpatient or residential
3 substance use disorder treatment services pursuant to (a)(i) of this
4 subsection following the initial medical necessity review process
5 under (c)(iii) of this subsection, the length of the initial
6 authorization may not be less than 14 days from the date that the
7 patient was admitted to the behavioral health agency. Any subsequent
8 reauthorization that the health plan approves after the first 14 days
9 must continue for no less than seven days prior to requiring further
10 reauthorization. Nothing prohibits a health plan from requesting
11 information to assist with a seamless transfer under this subsection.

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

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

23 (iii) After the time period in (a) of this subsection and receipt
24 of the material provided under (c)(ii) of this subsection, the plan
25 may initiate a medical necessity review process. Medical necessity
26 review must be based on the standard set of criteria established
27 under RCW 41.05.528. In a review for inpatient or residential
28 substance use disorder treatment services, a health plan may not make
29 a determination that a patient does not meet medical necessity
30 criteria based primarily on the patient's length of abstinence. If
31 the patient's abstinence from substance use was due to incarceration,
32 hospitalization, or inpatient treatment, a health plan may not
33 consider the patient's length of abstinence in determining medical
34 necessity. If the health plan determines within one business day from
35 the start of the medical necessity review period and receipt of the
36 material provided under (c)(ii) of this subsection that the admission
37 to the facility was not medically necessary and advises the agency of
38 the decision in writing, the health plan is not required to pay the
39 facility for services delivered after the start of the medical
40 necessity review period, subject to the conclusion of a filed appeal

1 of the adverse benefit determination. If the health plan's medical
2 necessity review is completed more than one business day after
3 (~~{the}~~) the start of the medical necessity review period and
4 receipt of the material provided under (c)(ii) of this subsection,
5 the health plan must pay for the services delivered from the time of
6 admission until the time at which the medical necessity review is
7 completed and the agency is advised of the decision in writing.

8 (3) (a) The behavioral health agency shall document to the health
9 plan the patient's need for continuing care and justification for
10 level of care placement following the current treatment period, based
11 on the standard set of criteria established under RCW 41.05.528, with
12 documentation recorded in the patient's medical record.

13 (b) For a health plan issued or renewed on or after January 1,
14 2025, for inpatient or residential substance use disorder treatment
15 services, the health plan may not consider the patient's length of
16 stay at the behavioral health agency when making decisions regarding
17 the authorization to continue care at the behavioral health agency.

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

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

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

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

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

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

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

8 **Sec. 8.** RCW 71.24.618 and 2020 c 345 s 4 are each amended to
9 read as follows:

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

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

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

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

24 (b) (i) The managed care organization may not require an enrollee
25 to obtain prior authorization for the services specified in (a) of
26 this subsection as a condition for payment of services prior to the
27 times specified in (a) of this subsection.

28 (ii) Once the times specified in (a) of this subsection have
29 passed, the managed care organization may initiate utilization
30 management review procedures if the behavioral health agency
31 continues to provide services or is in the process of arranging for a
32 seamless transfer to an appropriate facility or lower level of care
33 under subsection (6) of this section. Beginning January 1, 2025, if a
34 managed care organization authorizes inpatient or residential
35 substance use disorder treatment services pursuant to (a)(i) of this
36 subsection following the initial medical necessity review process
37 under (c)(iii) of this subsection, the length of the initial
38 authorization may not be less than 14 days from the date that the
39 patient was admitted to the behavioral health agency. Any subsequent

1 reauthorization that the managed care organization approves after the
2 first 14 days must continue for no less than seven days prior to
3 requiring further reauthorization. Nothing prohibits a managed care
4 organization from requesting information to assist with a seamless
5 transfer under this subsection.

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

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

18 (iii) After the time period in (a) of this subsection and receipt
19 of the material provided under (c) (ii) of this subsection, the
20 managed care organization may initiate a medical necessity review
21 process. Medical necessity review must be based on the standard set
22 of criteria established under RCW 41.05.528. In a review for
23 inpatient or residential substance use disorder treatment services, a
24 managed care organization may not make a determination that a patient
25 does not meet medical necessity criteria based primarily on the
26 patient's length of abstinence. If the patient's abstinence from
27 substance use was due to incarceration, hospitalization, or inpatient
28 treatment, a managed care organization may not consider the patient's
29 length of abstinence in determining medical necessity. 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
39 (~~the~~) the start of the medical necessity review period and
40 receipt of the material provided under (c) (ii) of this subsection,

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

5 (3) (a) The behavioral health agency shall document to the managed
6 care organization the patient's need for continuing care and
7 justification for level of care placement following the current
8 treatment period, based on the standard set of criteria established
9 under RCW 41.05.528, with documentation recorded in the patient's
10 medical record.

11 (b) Beginning January 1, 2025, for inpatient or residential
12 substance use disorder treatment services, the managed care
13 organization may not consider the patient's length of stay at the
14 behavioral health agency when making decisions regarding the
15 authorization to continue care at the behavioral health agency.

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

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

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

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

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

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

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

8 NEW SECTION. **Sec. 9.** (1) The health care authority, in
9 collaboration with the insurance commissioner, shall convene a work
10 group consisting of commercial health carriers, medicaid managed care
11 organizations, and behavioral health agencies that provide inpatient
12 or residential substance use disorder treatment services. The work
13 group shall develop recommendations for streamlining commercial
14 health carrier and medicaid managed care organization requirements
15 and processes related to the authorization and reauthorization of
16 inpatient or residential substance use disorder treatment. The
17 recommendations must include a universal format accepted by all
18 health carriers and medicaid managed care organizations for
19 behavioral health agencies to use for service authorization and
20 reauthorization requests with common data requirements and a
21 standardized form and simplified electronic process. The health care
22 authority shall submit the recommendations of the work group to the
23 appropriate policy committees of the legislature by December 1, 2024.

24 (2) This section expires June 1, 2025.

25 NEW SECTION. **Sec. 10.** A new section is added to chapter 41.05
26 RCW to read as follows:

27 When updated versions of the ASAM Criteria, treatment criteria
28 for addictive, substance related, and co-occurring conditions,
29 inclusive of adolescent and transition age youth versions, are
30 published by the American society of addiction medicine, the health
31 care authority and the office of the insurance commissioner shall
32 jointly determine whether to use the updated version, and, if so, the
33 date upon which the updated version must begin to be used by medicaid
34 managed care organizations, carriers, and other relevant entities.
35 Both agencies shall post notice of their decision on their websites.
36 For purposes of the ASAM Criteria, 4th edition, medicaid managed care
37 organizations and carriers shall begin to use the updated criteria no
38 later than January 1, 2026, unless the health care authority and the

1 office of the insurance commissioner jointly determine that it should
2 not be used.

3 NEW SECTION. **Sec. 11.** A new section is added to chapter 48.43
4 RCW to read as follows:

5 When updated versions of the ASAM Criteria, treatment criteria
6 for addictive, substance related, and co-occurring conditions,
7 inclusive of adolescent and transition age youth versions, are
8 published by the American society of addiction medicine, the health
9 care authority and the office of the insurance commissioner shall
10 jointly determine whether to use the updated version, and, if so, the
11 date upon which the updated version must begin to be used by medicaid
12 managed care organizations, carriers, and other relevant entities.
13 Both agencies shall post notice of their decision on their websites.
14 For purposes of the ASAM Criteria, 4th edition, medicaid managed care
15 organizations and carriers shall begin to use the updated criteria no
16 later than January 1, 2026, unless the health care authority and the
17 office of the insurance commissioner jointly determine that it should
18 not be used.

19 NEW SECTION. **Sec. 12.** A new section is added to chapter 71.24
20 RCW to read as follows:

21 When updated versions of the ASAM Criteria, treatment criteria
22 for addictive, substance related, and co-occurring conditions,
23 inclusive of adolescent and transition age youth versions, are
24 published by the American society of addiction medicine, the health
25 care authority and the office of the insurance commissioner shall
26 jointly determine whether to use the updated version, and, if so, the
27 date upon which the updated version must begin to be used by medicaid
28 managed care organizations, carriers, and other relevant entities.
29 Both agencies shall post notice of their decision on their websites.
30 For purposes of the ASAM Criteria, 4th edition, medicaid managed care
31 organizations and carriers shall begin to use the updated criteria no
32 later than January 1, 2026, unless the health care authority and the
33 office of the insurance commissioner jointly determine that it should
34 not be used.

35 NEW SECTION. **Sec. 13.** The health care authority shall provide a
36 gap analysis of nonemergency transportation benefits provided to
37 medicaid enrollees in Washington, Oregon, and other comparison states

1 selected by the health care authority and provide an analysis of the
2 costs and benefits of available alternatives to the governor and
3 appropriate committees of the legislature by December 1, 2024,
4 including the option of an enhanced nonemergency transportation
5 benefit for persons being discharged from a behavioral health
6 emergency services provider to the next level of care in
7 circumstances when a prudent layperson acting reasonably would
8 believe such transportation is necessary to protect the enrollee from
9 relapse or other discontinuity in care that would jeopardize the
10 health or safety of the enrollee. In recognizing that some behavioral
11 health patients are not well-served by the current nonemergency
12 transportation system for medical assistance patients due to
13 inflexible rules, the authority shall also evaluate the possibility
14 of creating a network of peer-led, trauma-informed transportation
15 providers that could provide nonemergency transportation to youth and
16 adult medical assistance patients traveling to receive behavioral
17 health services.

18 **Sec. 14.** RCW 43.70.250 and 2023 c 469 s 21 are each amended to
19 read as follows:

20 (1) It shall be the policy of the state of Washington that the
21 cost of each professional, occupational, or business licensing
22 program be fully borne by the members of that profession, occupation,
23 or business.

24 (2) The secretary shall from time to time establish the amount of
25 all application fees, license fees, registration fees, examination
26 fees, permit fees, renewal fees, and any other fee associated with
27 licensing or regulation of professions, occupations, or businesses
28 administered by the department. Any and all fees or assessments, or
29 both, levied on the state to cover the costs of the operations and
30 activities of the interstate health professions licensure compacts
31 with participating authorities listed under chapter 18.130 RCW shall
32 be borne by the persons who hold licenses issued pursuant to the
33 authority and procedures established under the compacts. In fixing
34 said fees, the secretary shall set the fees for each program at a
35 sufficient level to defray the costs of administering that program
36 and the cost of regulating licensed volunteer medical workers in
37 accordance with RCW 18.130.360, except as provided in RCW 18.79.202.
38 In no case may the secretary impose any certification, examination,
39 or renewal fee upon a person seeking certification as a certified

1 peer specialist trainee under chapter 18.420 RCW or, between July 1,
2 2025, and July 1, 2030, impose a certification, examination, or
3 renewal fee of more than \$100 upon any person seeking certification
4 as a certified peer specialist under chapter 18.420 RCW. Subject to
5 amounts appropriated for this specific purpose, between July 1, 2024,
6 and July 1, 2029, the secretary may not impose any certification or
7 certification renewal fee on a person seeking certification as a
8 substance use disorder professional or substance use disorder
9 professional trainee under chapter 18.205 RCW of more than \$100.

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

13 NEW SECTION. **Sec. 15.** A new section is added to chapter 71.05
14 RCW to read as follows:

15 The authority must contract with an association that represents
16 designated crisis responders in Washington to develop and begin
17 delivering by July 1, 2025, a training program for social workers
18 licensed under chapter 18.225 RCW who practice in an emergency
19 department with responsibilities related to civil commitments under
20 this chapter. The training must include instruction emphasizing
21 standards and procedures relating to the civil commitment of persons
22 with substance use disorders and mental illness, including which
23 clinical presentations warrant summoning a designated crisis
24 responder. The training must emphasize the manner in which a patient
25 with a primary substance use disorder may present as a risk of harm
26 to self or others, or gravely disabled. Each hospital shall ensure
27 that, by July 1, 2026, or within three months of hire, all social
28 workers employed in the emergency department with responsibilities
29 relating to civil commitments under this chapter complete the
30 training every three years.

31 **Sec. 16.** RCW 41.05.527 and 2021 c 273 s 10 are each amended to
32 read as follows:

33 (1) A health plan offered to public employees and their covered
34 dependents under this chapter that is issued or renewed on or after
35 January 1, 2023, must participate in the bulk purchasing and
36 distribution program for opioid overdose reversal medication
37 established in RCW 70.14.170 once the program is operational.

1 (2) For health plans issued or renewed on or after January 1,
2 2025, a health carrier must reimburse a hospital or psychiatric
3 hospital that bills for the following outpatient services:

4 (a) For opioid overdose reversal medication dispensed or
5 distributed to a patient under RCW 70.41.485 as a separate
6 reimbursable expense; and

7 (b) For the administration of long-acting injectable
8 buprenorphine as a separate reimbursable expense.

9 (3) Reimbursements provided under subsection (2) of this section
10 must be separate from any bundled payment for outpatient hospital or
11 emergency department services.

12 **Sec. 17.** RCW 48.43.762 and 2021 c 273 s 11 are each amended to
13 read as follows:

14 (1) For health plans issued or renewed on or after January 1,
15 2023, health carriers must participate in the opioid overdose
16 reversal medication bulk purchasing and distribution program
17 established in RCW 70.14.170 once the program is operational. A
18 health plan may not impose enrollee cost sharing related to opioid
19 overdose reversal medication provided through the bulk purchasing and
20 distribution program established in RCW 70.14.170.

21 (2) For health plans issued or renewed on or after January 1,
22 2025, a health carrier must reimburse a hospital or psychiatric
23 hospital that bills for the following outpatient services:

24 (a) For opioid overdose reversal medication dispensed or
25 distributed to a patient under RCW 70.41.485 as a separate
26 reimbursable expense; and

27 (b) For the administration of long-acting injectable
28 buprenorphine as a separate reimbursable expense.

29 (3) Reimbursements provided under subsection (2) of this section
30 must be separate from any bundled payment for outpatient hospital or
31 emergency department services.

32 NEW SECTION. **Sec. 18.** A new section is added to chapter 74.09
33 RCW to read as follows:

34 (1) The authority shall establish appropriate billing codes for
35 hospitals and psychiatric hospitals that administer long-acting
36 injectable buprenorphine on an outpatient basis to use for billing
37 patients enrolled in a medical assistance program.

1 (2) Upon initiation or renewal of a contract with the authority
2 to administer a medicaid managed care plan, a managed care
3 organization must reimburse a hospital or psychiatric hospital that
4 bills for the administration of long-acting injectable buprenorphine
5 on an outpatient basis as a separate reimbursable expense.

6 (3) Beginning January 1, 2025, for individuals enrolled in a
7 medical assistance program that is not a medicaid managed care plan,
8 the authority must reimburse a hospital or psychiatric hospital that
9 bills for the administration of long-acting injectable buprenorphine
10 on an outpatient basis administered as a separate reimbursable
11 expense.

12 (4) Reimbursements provided under this section must be separate
13 from any bundled payment for outpatient hospital or emergency
14 department services.

15 **Sec. 19.** RCW 42.56.360 and 2023 sp.s. c 1 s 23 are each amended
16 to read as follows:

17 (1) The following health care information is exempt from
18 disclosure under this chapter:

19 (a) Information obtained by the pharmacy quality assurance
20 commission as provided in RCW 69.45.090;

21 (b) Information obtained by the pharmacy quality assurance
22 commission or the department of health and its representatives as
23 provided in RCW 69.41.044, 69.41.280, and 18.64.420;

24 (c) Information and documents created specifically for, and
25 collected and maintained by a quality improvement committee under RCW
26 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee
27 under RCW 4.24.250, or by a quality assurance committee pursuant to
28 RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW
29 43.70.056, for reporting of health care-associated infections under
30 RCW 43.70.056, a notification of an incident under RCW 70.56.040(5),
31 and reports regarding adverse events under RCW 70.56.020(2)(b),
32 regardless of which agency is in possession of the information and
33 documents;

34 (d)(i) Proprietary financial and commercial information that the
35 submitting entity, with review by the department of health,
36 specifically identifies at the time it is submitted and that is
37 provided to or obtained by the department of health in connection
38 with an application for, or the supervision of, an antitrust
39 exemption sought by the submitting entity under RCW 43.72.310;

1 (ii) If a request for such information is received, the
2 submitting entity must be notified of the request. Within ten
3 business days of receipt of the notice, the submitting entity shall
4 provide a written statement of the continuing need for
5 confidentiality, which shall be provided to the requester. Upon
6 receipt of such notice, the department of health shall continue to
7 treat information designated under this subsection (1)(d) as exempt
8 from disclosure;

9 (iii) If the requester initiates an action to compel disclosure
10 under this chapter, the submitting entity must be joined as a party
11 to demonstrate the continuing need for confidentiality;

12 (e) Records of the entity obtained in an action under RCW
13 18.71.300 through 18.71.340;

14 (f) Complaints filed under chapter 18.130 RCW after July 27,
15 1997, to the extent provided in RCW 18.130.095(1);

16 (g) Information obtained by the department of health under
17 chapter 70.225 RCW;

18 (h) Information collected by the department of health under
19 chapter 70.245 RCW except as provided in RCW 70.245.150;

20 (i) Cardiac and stroke system performance data submitted to
21 national, state, or local data collection systems under RCW
22 70.168.150(2)(b);

23 (j) All documents, including completed forms, received pursuant
24 to a wellness program under RCW 41.04.362, but not statistical
25 reports that do not identify an individual;

26 (k) Data and information exempt from disclosure under RCW
27 43.371.040;

28 (l) Medical information contained in files and records of members
29 of retirement plans administered by the department of retirement
30 systems or the law enforcement officers' and firefighters' plan 2
31 retirement board, as provided to the department of retirement systems
32 under RCW 41.04.830; and

33 (m) Data submitted to the data integration platform under RCW
34 71.24.908.

35 (2) Chapter 70.02 RCW applies to public inspection and copying of
36 health care information of patients.

37 (3)(a) Documents related to infant mortality reviews conducted
38 pursuant to RCW 70.05.170 are exempt from disclosure as provided for
39 in RCW 70.05.170(3).

1 (b) (i) If an agency provides copies of public records to another
2 agency that are exempt from public disclosure under this subsection
3 (3), those records remain exempt to the same extent the records were
4 exempt in the possession of the originating entity.

5 (ii) For notice purposes only, agencies providing exempt records
6 under this subsection (3) to other agencies may mark any exempt
7 records as "exempt" so that the receiving agency is aware of the
8 exemption, however whether or not a record is marked exempt does not
9 affect whether the record is actually exempt from disclosure.

10 (4) Information and documents related to maternal mortality
11 reviews conducted pursuant to RCW 70.54.450 are confidential and
12 exempt from public inspection and copying.

13 (5) Patient health care information contained in reports
14 submitted under section 2(2) of this act are confidential and exempt
15 from public inspection.

16 NEW SECTION. **Sec. 20.** If specific funding for the purposes of
17 this act, referencing this act by bill or chapter number, is not
18 provided by June 30, 2024, in the omnibus appropriations act, this
19 act is null and void."

20 Correct the title.

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