
SECOND SUBSTITUTE HOUSE BILL 2319

State of Washington

68th Legislature

2024 Regular Session

By House Appropriations (originally sponsored by Representatives Davis, Macri, Mosbrucker, Griffey, Stearns, Fosse, Ramel, Simmons, Nance, Kloba, Farivar, Bateman, Reed, Ryu, Chopp, Ortiz-Self, Eslick, Jacobsen, Goodman, Alvarado, Peterson, Pollet, and Shavers)

READ FIRST TIME 02/05/24.

1 AN ACT Relating to substance use disorder treatment; amending RCW
2 71.24.037, 41.05.526, 48.43.761, 71.24.618, and 42.56.360; adding new
3 sections to chapter 71.24 RCW; adding a new section to chapter 28B.20
4 RCW; adding a new section to chapter 41.05 RCW; adding a new section
5 to chapter 48.43 RCW; creating new sections; and providing an
6 expiration date.

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

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

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

1 medications for the treatment of alcohol use disorder. Only 37
2 percent of individuals with opioid use disorder and nine percent of
3 individuals with alcohol use disorder receive medication to treat
4 their condition.

5 (3) Therefore, it is the intent of the legislature to reduce
6 forced patient discharges from residential addiction treatment, to
7 remove arbitrary insurance authorization barriers to residential
8 addiction treatment, and to ensure that patients with opioid use
9 disorder and alcohol use disorder receive access to care that is
10 consistent with clinical best practices.

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

13 (1)(a) By October 1, 2024, each licensed or certified behavioral
14 health agency providing voluntary inpatient or residential substance
15 use disorder treatment services or withdrawal management services
16 shall submit to the department any policies that the agency maintains
17 regarding the transfer or discharge of a person without the person's
18 consent from a facility providing those services. The policies that
19 agencies must submit include any policies related to situations in
20 which the agency transfers or discharges a person without the
21 person's consent, therapeutic progressive disciplinary processes that
22 the agency maintains, and procedures to assure safe transfers and
23 discharges when a patient is discharged without the patient's
24 consent.

25 (b) By April 1, 2025, the department shall adopt a model policy
26 for licensed or certified behavioral health agencies providing
27 voluntary inpatient or residential substance use disorder treatment
28 services or withdrawal management services to consider when adopting
29 policies related to the transfer or discharge of a person without the
30 person's consent from a facility providing those services. In
31 developing the model policy, the department shall consider the
32 policies submitted by agencies under (a) of this subsection and
33 establish factors to be used in making a decision to transfer or
34 discharge a person without the person's consent. Factors may include,
35 but are not limited to, the person's medical condition, the clinical
36 determination that the person no longer requires treatment or
37 withdrawal management services at the facility, the risk of physical
38 injury presented by the person to the person's self or to other
39 persons at the facility, the extent to which the person's behavior

1 risks the recovery goals of other persons at the facility, and the
2 extent to which the agency has applied a therapeutic progressive
3 disciplinary process. The model policy must include provisions
4 addressing the use of an appropriate therapeutic progressive
5 disciplinary process and procedures to assure safe transfers and
6 discharges of a patient who is discharged without the patient's
7 consent.

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

16 (b) The department shall adopt rules to implement the reporting
17 requirement under (a) of this subsection, using a standard form. The
18 rules must require that the agency provide a description of the
19 circumstances related to the person's departure from the facility,
20 including whether the departure was voluntary or involuntary, the
21 extent to which a therapeutic progressive disciplinary process was
22 applied, the patient's self-reported understanding of the reasons for
23 discharge, efforts that were made to avert the discharge, and efforts
24 that were made to establish a safe discharge plan prior to the
25 patient leaving the facility.

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

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

31 The addictions, drug, and alcohol institute at the University of
32 Washington shall create a patient shared decision-making tool to
33 assist behavioral health providers when discussing medication
34 treatment options for patients with alcohol use disorder. The
35 institute shall distribute the tool to behavioral health providers
36 and instruct them on ways to incorporate the use of the tool into
37 their practices. The institute shall conduct regular evaluations of
38 the tool and update the tool as necessary.

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

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

9 (2) The secretary shall establish by rule minimum standards for
10 licensed or certified behavioral health agencies that must, at a
11 minimum, establish: (a) Qualifications for staff providing services
12 directly to persons with mental disorders, substance use disorders,
13 or both; (b) the intended result of each service; and (c) the rights
14 and responsibilities of persons receiving behavioral health services
15 pursuant to this chapter and chapter 71.05 RCW. The secretary shall
16 provide for deeming of licensed or certified behavioral health
17 agencies as meeting state minimum standards as a result of
18 accreditation by a recognized behavioral health accrediting body
19 recognized and having a current agreement with the department.

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

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

27 (5) The department may suspend, revoke, limit, restrict, or
28 modify an approval, or refuse to grant approval, for failure to meet
29 the provisions of this chapter, or the standards adopted under this
30 chapter. RCW 43.70.115 governs notice of a license or certification
31 denial, revocation, suspension, or modification and provides the
32 right to an adjudicative proceeding.

33 (6) No licensed or certified behavioral health agency may
34 advertise or represent itself as a licensed or certified behavioral
35 health agency if approval has not been granted or has been denied,
36 suspended, revoked, or canceled.

37 (7) Licensure or certification as a behavioral health agency is
38 effective for one calendar year from the date of issuance of the
39 license or certification. The license or certification must specify
40 the types of services provided by the behavioral health agency that

1 meet the standards adopted under this chapter. Renewal of a license
2 or certification must be made in accordance with this section for
3 initial approval and in accordance with the standards set forth in
4 rules adopted by the secretary.

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

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

14 (10) Licensed or certified behavioral health agencies may not
15 provide types of services for which the licensed or certified
16 behavioral health agency has not been certified. Licensed or
17 certified behavioral health agencies may provide services for which
18 approval has been sought and is pending, if approval for the services
19 has not been previously revoked or denied.

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

23 (12) Upon petition of the department and after a hearing held
24 upon reasonable notice to the facility, the superior court may issue
25 a warrant to an officer or employee of the department authorizing him
26 or her to enter and inspect at reasonable times, and examine the
27 books and accounts of, any licensed or certified behavioral health
28 agency refusing to consent to inspection or examination by the
29 department or which the department has reasonable cause to believe is
30 operating in violation of this chapter.

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

33 (14) Each licensed or certified behavioral health agency shall
34 file with the department or the authority upon request, data,
35 statistics, schedules, and information the department or the
36 authority reasonably requires. A licensed or certified behavioral
37 health agency that without good cause fails to furnish any data,
38 statistics, schedules, or information as requested, or files
39 fraudulent returns thereof, may have its license or certification
40 revoked or suspended.

1 (15) The authority shall use the data provided in subsection (14)
2 of this section to evaluate each program that admits children to
3 inpatient substance use disorder treatment upon application of their
4 parents. The evaluation must be done at least once every twelve
5 months. In addition, the authority shall randomly select and review
6 the information on individual children who are admitted on
7 application of the child's parent for the purpose of determining
8 whether the child was appropriately placed into substance use
9 disorder treatment based on an objective evaluation of the child's
10 condition and the outcome of the child's treatment.

11 (16) Any settlement agreement entered into between the department
12 and licensed or certified behavioral health agencies to resolve
13 administrative complaints, license or certification violations,
14 license or certification suspensions, or license or certification
15 revocations may not reduce the number of violations reported by the
16 department unless the department concludes, based on evidence
17 gathered by inspectors, that the licensed or certified behavioral
18 health agency did not commit one or more of the violations.

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

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

39 (19) Every licensed or certified inpatient or residential
40 behavioral health agency must include the 988 crisis hotline number

1 in the discharge summary provided to individuals being discharged
2 from inpatient or residential services.

3 (20)(a) Licensed or certified behavioral health agencies
4 providing voluntary inpatient or residential substance use disorder
5 treatment services or withdrawal management services:

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

8 (ii) May not prohibit a person from receiving services at or
9 being admitted to the agency based solely on prior instances of the
10 person releasing the person's self from the facility prior to a
11 clinical determination that the person had completed treatment.

12 (b) This subsection (20) does not apply to hospitals licensed
13 under chapter 70.41 RCW and psychiatric hospitals licensed under
14 chapter 71.12 RCW.

15 (21)(a) A licensed or certified behavioral health agency shall
16 provide each patient seeking treatment for opioid use disorder or
17 alcohol use disorder, whether receiving inpatient or outpatient
18 treatment, with education related to treatment options specific to
19 the patient's diagnosed condition of either opioid use disorder or
20 alcohol use disorder. The education must include an unbiased
21 explanation of all recognized forms of treatment approved by the
22 federal food and drug administration, as required under RCW 7.70.050
23 and 7.70.060, including any available pharmacological treatments for
24 the patient's diagnosed opioid use disorder or alcohol use disorder.
25 In addition, the behavioral health agency shall support the patient
26 with the implementation of the patient's chosen course of treatment
27 in a manner that meets clinically accepted standards, including
28 facilitating any appropriate pharmacological treatments.

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

31 (i) Advertise that it treats opioid use disorder or alcohol use
32 disorder; or

33 (ii) Treat patients for opioid use disorder or alcohol use
34 disorder, regardless of the form of treatment that the patient
35 chooses.

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

1 (ii) Failure to meet the education and facilitation requirements
2 of (a) of this subsection may be the basis of a disciplinary action
3 under this section.

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

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

18 (2) This section does not apply to hospitals licensed under
19 chapter 70.41 RCW and psychiatric hospitals licensed under chapter
20 71.12 RCW.

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

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

30 (2)(a) A health plan offered to employees and their covered
31 dependents under this chapter issued or renewed on or after January
32 1, 2021, must:

33 (i) Provide coverage for no less than two business days,
34 excluding weekends and holidays, in a behavioral health agency that
35 provides inpatient or residential substance use disorder treatment
36 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)(i) The health plan may not require an enrollee to obtain
5 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. ((Onee))

8 (ii)(A) Except as provided in (b)(ii)(B) of this subsection, once
9 the times specified in (a) of this subsection have passed, the health
10 plan may initiate utilization management review procedures if the
11 behavioral health agency continues to provide services or is in the
12 process of arranging for a seamless transfer to an appropriate
13 facility or lower level of care under subsection (6) of this section.

14 (B)(I) For a health plan issued or renewed on or after January 1,
15 2025, for inpatient or residential substance use disorder treatment
16 services, after the times specified in (a) of this subsection have
17 passed, if a health plan authorizes services pursuant to the initial
18 medical necessity review process permitted under (c)(iii) of this
19 subsection, the length of the initial authorization may not be less
20 than 14 days from the date that the patient was admitted to the
21 behavioral health agency. Any subsequent reauthorization that the
22 health plan approves after the first 14 days must continue for no
23 less than seven days prior to requiring further reauthorization.

24 (II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a
25 health plan from requesting information to assist with a transfer as
26 permitted under this subsection (2)(b)(ii).

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

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

38 (iii) After the time period in (a) of this subsection and receipt
39 of the material provided under (c)(ii) of this subsection, the plan
40 may initiate a medical necessity review process. Medical necessity

1 review must be based on the standard set of criteria established
2 under RCW 41.05.528. In a review for inpatient or residential
3 substance use disorder treatment services, a health plan may not make
4 a determination that a patient does not meet medical necessity
5 criteria based primarily on the patient's length of abstinence. If
6 the patient's abstinence from substance use was due to incarceration
7 or hospitalization, a health plan may not consider the patient's
8 length of abstinence in determining medical necessity. If the health
9 plan determines within one business day from the start of the medical
10 necessity review period and receipt of the material provided under
11 (c)(ii) of this subsection that the admission to the facility was not
12 medically necessary and advises the agency of the decision in
13 writing, the health plan is not required to pay the facility for
14 services delivered after the start of the medical necessity review
15 period, subject to the conclusion of a filed appeal of the adverse
16 benefit determination. If the health plan's medical necessity review
17 is completed more than one business day after (~~{the}~~) the start of
18 the medical necessity review period and receipt of the material
19 provided under (c)(ii) of this subsection, the health plan must pay
20 for the services delivered from the time of admission until the time
21 at which the medical necessity review is completed and the agency is
22 advised of the decision in writing.

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

28 (b) For a health plan issued or renewed on or after January 1,
29 2025, for inpatient or residential substance use disorder treatment
30 services, the health plan may not consider the patient's length of
31 stay at the behavioral health agency when making decisions regarding
32 the authorization to continue care at the behavioral health agency.

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

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

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

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

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

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

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

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

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

31 (2)(a) A health plan issued or renewed on or after January 1,
32 2021, must:

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

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

1 (b)(i) The health plan may not require an enrollee to obtain
2 prior authorization for the services specified in (a) of this
3 subsection as a condition for payment of services prior to the times
4 specified in (a) of this subsection. (~~Onee~~)

5 (ii)(A) Except as provided in (b)(ii)(B) of this subsection, once
6 the times specified in (a) of this subsection have passed, the health
7 plan may initiate utilization management review procedures if the
8 behavioral health agency continues to provide services or is in the
9 process of arranging for a seamless transfer to an appropriate
10 facility or lower level of care under subsection (6) of this section.

11 (B)(I) For a health plan issued or renewed on or after January 1,
12 2025, for inpatient or residential substance use disorder treatment
13 services, after the times specified in (a) of this subsection have
14 passed, if a health plan authorizes services pursuant to the initial
15 medical necessity review process permitted under (c)(iii) of this
16 subsection, the length of the initial authorization may not be less
17 than 14 days from the date that the patient was admitted to the
18 behavioral health agency. Any subsequent reauthorization that the
19 health plan approves after the first 14 days must continue for no
20 less than seven days prior to requiring further reauthorization.

21 (II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a
22 health plan from requesting information to assist with a transfer as
23 permitted under this subsection (2)(b)(ii).

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

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

35 (iii) After the time period in (a) of this subsection and receipt
36 of the material provided under (c)(ii) of this subsection, the plan
37 may initiate a medical necessity review process. Medical necessity
38 review must be based on the standard set of criteria established
39 under RCW 41.05.528. In a review for inpatient or residential
40 substance use disorder treatment services, a health plan may not make

1 a determination that a patient does not meet medical necessity
2 criteria based primarily on the patient's length of abstinence. If
3 the patient's abstinence from substance use was due to incarceration
4 or hospitalization, a health plan may not consider the patient's
5 length of abstinence in determining medical necessity. If the health
6 plan determines within one business day from the start of the medical
7 necessity review period and receipt of the material provided under
8 (c)(ii) of this subsection that the admission to the facility was not
9 medically necessary and advises the agency of the decision in
10 writing, the health plan is not required to pay the facility for
11 services delivered after the start of the medical necessity review
12 period, subject to the conclusion of a filed appeal of the adverse
13 benefit determination. If the health plan's medical necessity review
14 is completed more than one business day after (~~{the}~~) the start of
15 the medical necessity review period and receipt of the material
16 provided under (c)(ii) of this subsection, the health plan must pay
17 for the services delivered from the time of admission until the time
18 at which the medical necessity review is completed and the agency is
19 advised of the decision in writing.

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

25 (b) For a health plan issued or renewed on or after January 1,
26 2025, for inpatient or residential substance use disorder treatment
27 services, the health plan may not consider the patient's length of
28 stay at the behavioral health agency when making decisions regarding
29 the authorization to continue care at the behavioral health agency.

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

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

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

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

39 (6) When the treatment plan approved by the health plan involves
40 transfer of the enrollee to a different facility or to a lower level

1 of care, the care coordination unit of the health plan shall work
2 with the current agency to make arrangements for a seamless transfer
3 as soon as possible to an appropriate and available facility or level
4 of care. The health plan shall pay the agency for the cost of care at
5 the current facility until the seamless transfer to the different
6 facility or lower level of care is complete. A seamless transfer to a
7 lower level of care may include same day or next day appointments for
8 outpatient care, and does not include payment for nontreatment
9 services, such as housing services. If placement with an agency in
10 the health plan's network is not available, the health plan shall pay
11 the current agency until a seamless transfer arrangement is made.

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

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

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

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

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

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

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

35 (b) (i) The managed care organization may not require an enrollee
36 to obtain prior authorization for the services specified in (a) of
37 this subsection as a condition for payment of services prior to the
38 times specified in (a) of this subsection. (~~Onee~~)

1 (ii)(A) Except as provided in (b)(ii)(B) of this subsection, once
2 the times specified in (a) of this subsection have passed, the
3 managed care organization may initiate utilization management review
4 procedures if the behavioral health agency continues to provide
5 services or is in the process of arranging for a seamless transfer to
6 an appropriate facility or lower level of care under subsection (6)
7 of this section.

8 (B)(I) Beginning January 1, 2025, for inpatient or residential
9 substance use disorder treatment services, after the times specified
10 in (a) of this subsection have passed, if a managed care organization
11 authorizes services pursuant to the initial medical necessity review
12 process permitted under (c)(iii) of this subsection, the length of
13 the initial authorization may not be less than 14 days from the date
14 that the patient was admitted to the behavioral health agency. Any
15 subsequent reauthorization that the managed care organization
16 approves after the first 14 days must continue for no less than seven
17 days prior to requiring further reauthorization.

18 (II) Nothing in (b)(ii)(B)(I) of this subsection (2) prohibits a
19 managed care organization from requesting information to assist with
20 a transfer as permitted under this subsection (2)(b)(ii).

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

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

33 (iii) After the time period in (a) of this subsection and receipt
34 of the material provided under (c)(ii) of this subsection, the
35 managed care organization may initiate a medical necessity review
36 process. Medical necessity review must be based on the standard set
37 of criteria established under RCW 41.05.528. In a review for
38 inpatient or residential substance use disorder treatment services, a
39 managed care organization may not make a determination that a patient
40 does not meet medical necessity criteria based primarily on the

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

19 (3) (a) The behavioral health agency shall document to the managed
20 care organization the patient's need for continuing care and
21 justification for level of care placement following the current
22 treatment period, based on the standard set of criteria established
23 under RCW 41.05.528, with documentation recorded in the patient's
24 medical record.

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

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

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

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

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

39 (6) When the treatment plan approved by the managed care
40 organization involves transfer of the enrollee to a different

1 facility or to a lower level of care, the care coordination unit of
2 the managed care organization shall work with the current agency to
3 make arrangements for a seamless transfer as soon as possible to an
4 appropriate and available facility or level of care. The managed care
5 organization shall pay the agency for the cost of care at the current
6 facility until the seamless transfer to the different facility or
7 lower level of care is complete. A seamless transfer to a lower level
8 of care may include same day or next day appointments for outpatient
9 care, and does not include payment for nontreatment services, such as
10 housing services. If placement with an agency in the managed care
11 organization's network is not available, the managed care
12 organization shall pay the current agency at the service level until
13 a seamless transfer arrangement is made.

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

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

21 NEW SECTION. **Sec. 9.** (1) The insurance commissioner shall
22 convene a work group consisting of commercial health carriers,
23 medicaid managed care organizations, and behavioral health agencies
24 that provide inpatient or residential substance use disorder
25 treatment services. The work group shall develop recommendations for
26 streamlining commercial health carrier and medicaid managed care
27 organization requirements and processes related to the authorization
28 and reauthorization of inpatient or residential substance use
29 disorder treatment. The recommendations must include a universal
30 format accepted by all health carriers and medicaid managed care
31 organizations for behavioral health agencies to use for service
32 authorization and reauthorization requests with common data
33 requirements and a standardized form and simplified electronic
34 process. The insurance commissioner shall submit the recommendations
35 of the work group to the appropriate policy committees of the
36 legislature by December 1, 2024.

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

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

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

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

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

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

35 When updated versions of the ASAM Criteria, treatment criteria
36 for addictive, substance related, and co-occurring conditions,
37 inclusive of adolescent and transition age youth versions, are
38 published by the American society of addiction medicine, the health

1 care authority and the office of the insurance commissioner shall
2 jointly determine whether to use the updated version, and, if so, the
3 date upon which the updated version must begin to be used by medicaid
4 managed care organizations, carriers, and other relevant entities.
5 Both agencies shall post notice of their decision on their websites.
6 For purposes of the ASAM Criteria, 4th edition, medicaid managed care
7 organizations and carriers shall begin to use the updated criteria no
8 later than January 1, 2026, unless the health care authority and the
9 office of the insurance commissioner jointly determine that it should
10 not be used.

11 **Sec. 13.** RCW 42.56.360 and 2023 sp.s. c 1 s 23 are each amended
12 to read as follows:

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

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

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

20 (c) Information and documents created specifically for, and
21 collected and maintained by a quality improvement committee under RCW
22 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee
23 under RCW 4.24.250, or by a quality assurance committee pursuant to
24 RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW
25 43.70.056, for reporting of health care-associated infections under
26 RCW 43.70.056, a notification of an incident under RCW 70.56.040(5),
27 and reports regarding adverse events under RCW 70.56.020(2)(b),
28 regardless of which agency is in possession of the information and
29 documents;

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

36 (ii) If a request for such information is received, the
37 submitting entity must be notified of the request. Within ten
38 business days of receipt of the notice, the submitting entity shall
39 provide a written statement of the continuing need for

1 confidentiality, which shall be provided to the requester. Upon
2 receipt of such notice, the department of health shall continue to
3 treat information designated under this subsection (1)(d) as exempt
4 from disclosure;

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

8 (e) Records of the entity obtained in an action under RCW
9 18.71.300 through 18.71.340;

10 (f) Complaints filed under chapter 18.130 RCW after July 27,
11 1997, to the extent provided in RCW 18.130.095(1);

12 (g) Information obtained by the department of health under
13 chapter 70.225 RCW;

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

16 (i) Cardiac and stroke system performance data submitted to
17 national, state, or local data collection systems under RCW
18 70.168.150(2)(b);

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

22 (k) Data and information exempt from disclosure under RCW
23 43.371.040;

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

29 (m) Data submitted to the data integration platform under RCW
30 71.24.908.

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

33 (3)(a) Documents related to infant mortality reviews conducted
34 pursuant to RCW 70.05.170 are exempt from disclosure as provided for
35 in RCW 70.05.170(3).

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

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

6 (4) Information and documents related to maternal mortality
7 reviews conducted pursuant to RCW 70.54.450 are confidential and
8 exempt from public inspection and copying.

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

12 NEW SECTION. **Sec. 14.** If specific funding for the purposes of
13 this act, referencing this act by bill or chapter number, is not
14 provided by June 30, 2024, in the omnibus appropriations act, this
15 act is null and void.

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