CERTIFICATION OF ENROLLMENT

SECOND SUBSTITUTE SENATE BILL 6228

68th Legislature
2024 Regular Session

Passed by the Senate March 5, 2024
Yeas 49 Nays 0

President of the Senate

Passed by the House February 29, 2024
Yeas 84 Nays 8

Speaker of the House of Representatives

Approved

Governor of the State of Washington

CERTIFICATE

I, Sarah Bannister, Secretary of the Senate of the State of Washington, do hereby certify that the attached is **SECOND SUBSTITUTE SENATE BILL 6228** as passed by the Senate and the House of Representatives on the dates hereon set forth.

Secretary

FILED

Secretary of State
State of Washington

SECOND SUBSTITUTE SENATE BILL 6228

AS AMENDED BY THE HOUSE

Passed Legislature - 2024 Regular Session

State of Washington 68th Legislature 2024 Regular Session

By Senate Ways & Means (originally sponsored by Senators Dhingra, Hasegawa, Kuderer, Lovelett, Nobles, Randall, Shewmake, Valdez, and C. Wilson)

READ FIRST TIME 02/05/24.

1 AN ACT Relating to treatment of substance use disorders; amending
2 RCW 71.24.037, 41.05.526, 48.43.761, 71.24.618, 43.70.250, 41.05.527,
3 48.43.762, and 42.56.360; adding new sections to chapter 71.24 RCW;
4 adding a new section to chapter 28B.20 RCW; adding a new section to
5 chapter 41.05 RCW; adding a new section to chapter 48.43 RCW; adding
6 a new section to chapter 71.05 RCW; adding a new section to chapter
7 74.09 RCW; creating new sections; and providing an expiration date.

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

9 NEW SECTION. **Sec. 1.** (1) The legislature finds that ensuring
10 that individuals with substance use disorders can enter into and
11 complete residential addiction treatment is an important public
12 policy objective. Substance use disorder providers forcing patients
13 to leave treatment prematurely and insurance authorization barriers
14 both present impediments to realizing this goal.
15 (2) The legislature further finds that patients with substance
16 use disorders should be provided information regarding and access to
17 the full panoply of treatment options for their condition, as would
18 be the case with any other life-threatening disease.
19 Pharmacotherapies are incredibly effective and severely underutilized
20 tools in the treatment of opioid use disorder and alcohol use
21 disorder. The federal food and drug administration has approved three

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

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

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

(1)(a) By October 1, 2024, each licensed or certified behavioral health agency providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services shall submit to the department any policies that the agency maintains regarding the transfer or discharge of a person without the person's consent from a facility providing those services. The policies that agencies must submit include any policies related to situations in which the agency transfers or discharges a person without the person's consent, therapeutic progressive disciplinary processes that the agency maintains, and procedures to assure safe transfers and discharges when a patient is discharged without the patient's consent. Behavioral health agencies that do not maintain such policies must provide an attestation to this effect.

(b) By April 1, 2025, the department shall adopt a model policy for licensed or certified behavioral health agencies providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services to consider when adopting policies related to the transfer or discharge of a person without the person's consent from a facility providing those services. In developing the model policy, the department shall consider the policies submitted by agencies under (a) of this subsection and establish factors to be used in making a decision to transfer or discharge a person without the person's consent. Factors may include, but are not limited to, the person's medical condition, the clinical determination that the person no longer requires treatment or withdrawal management services at the facility, the risk of physical

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

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

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

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

31 (4) This section does not apply to hospitals licensed under
32 chapter 70.41 RCW and psychiatric hospitals licensed under chapter
33 71.12 RCW.

34 <u>NEW SECTION.</u> **Sec. 3.** A new section is added to chapter 28B.20
35 RCW to read as follows:

36 The addictions, drug, and alcohol institute at the University of
37 Washington shall create a patient shared decision-making tool to
38 assist behavioral health and medical providers when discussing
39 medication treatment options for patients with alcohol use disorder.

1 The institute shall distribute the tool to behavioral health and
2 medical providers and instruct them on ways to incorporate the use of
3 the tool into their practices. The institute shall conduct regular
4 evaluations of the tool and update the tool as necessary.

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

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

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

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

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

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

37 (6) No licensed or certified behavioral health agency may
38 advertise or represent itself as a licensed or certified behavioral

1 health agency if approval has not been granted or has been denied,
2 suspended, revoked, or canceled.

3 (7) Licensure or certification as a behavioral health agency is
4 effective for one calendar year from the date of issuance of the
5 license or certification. The license or certification must specify
6 the types of services provided by the behavioral health agency that
7 meet the standards adopted under this chapter. Renewal of a license
8 or certification must be made in accordance with this section for
9 initial approval and in accordance with the standards set forth in
10 rules adopted by the secretary.

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

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

20 (10) Licensed or certified behavioral health agencies may not
21 provide types of services for which the licensed or certified
22 behavioral health agency has not been certified. Licensed or
23 certified behavioral health agencies may provide services for which
24 approval has been sought and is pending, if approval for the services
25 has not been previously revoked or denied.

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

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

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

39 (14) Each licensed or certified behavioral health agency shall
40 file with the department or the authority upon request, data,

1 statistics, schedules, and information the department or the
2 authority reasonably requires. A licensed or certified behavioral
3 health agency that without good cause fails to furnish any data,
4 statistics, schedules, or information as requested, or files
5 fraudulent returns thereof, may have its license or certification
6 revoked or suspended.

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

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

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

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

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

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

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

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

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

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

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

1 (i) Advertise that it treats opioid use disorder or alcohol use
2 disorder; or
3 (ii) Treat patients for opioid use disorder or alcohol use
4 disorder, regardless of the form of treatment that the patient
5 chooses.
6 (c)(i) Failure to meet the education requirements of (a) of this
7 subsection may be an element of proof in demonstrating a breach of
8 the duty to secure an informed consent under RCW 7.70.050.
9 (ii) Failure to meet the education and facilitation requirements
10 of (a) of this subsection may be the basis of a disciplinary action
11 under this section.
12 (d) This subsection does not apply to licensed behavioral health
13 agencies that are units within a hospital licensed under chapter
14 70.41 RCW or a psychiatric hospital licensed under chapter 71.12 RCW.

15 NEW SECTION. **Sec. 5.** A new section is added to chapter 71.24
16 RCW to read as follows:
17 (1) If a behavioral health provider or licensed or certified
18 behavioral health agency that provides withdrawal management services
19 to a patient seeks to discontinue usage or reduce dosage amounts of a
20 medication, including a psychotropic medication, that the patient has
21 been using in accordance with the directions of a prescribing health
22 care provider, the withdrawal management provider shall engage in
23 individualized, patient-centered, shared decision making, using
24 nonjudgmental and compassionate communication and, with the consent
25 of the patient, make a good faith effort to consult the prescribing
26 health care provider. A withdrawal management provider may not, by
27 philosophy or practice, categorically require all patients to
28 discontinue all psychotropic medications, including benzodiazepines
29 and medications for attention deficit hyperactivity disorder.
30 (2) This section does not apply to hospitals licensed under
31 chapter 70.41 RCW and psychiatric hospitals licensed under chapter
32 71.12 RCW.

33 **Sec. 6.** RCW 41.05.526 and 2020 c 345 s 2 are each amended to
34 read as follows:
35 (1) Except as provided in subsection (2) of this section, a
36 health plan offered to employees and their covered dependents under
37 this chapter issued or renewed on or after January 1, 2021, may not
38 require an enrollee to obtain prior authorization for withdrawal

management services or inpatient or residential substance use disorder treatment services in a behavioral health agency licensed or certified under RCW 71.24.037.

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

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

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

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

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

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

(ii) The behavioral health agency under (a) of this subsection must provide the health plan with its initial assessment and initial

treatment plan for the enrollee within two business days of admission, excluding weekends and holidays, or within three days in the case of a behavioral health agency that provides withdrawal management services.

(iii) After the time period in (a) of this subsection and receipt of the material provided under (c)(ii) of this subsection, the plan may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after ((~~[the]~~)) the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

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

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

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

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

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

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

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

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

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

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

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

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

1 (i) Provide coverage for no less than two business days, 2 excluding weekends and holidays, in a behavioral health agency that 3 provides inpatient or residential substance use disorder treatment 4 prior to conducting a utilization review; and

5 (ii) Provide coverage for no less than three days in a behavioral 6 health agency that provides withdrawal management services prior to 7 conducting a utilization review.

8 (b)(i) The health plan may not require an enrollee to obtain 9 prior authorization for the services specified in (a) of this 10 subsection as a condition for payment of services prior to the times 11 specified in (a) of this subsection.

12 (ii) Once the times specified in (a) of this subsection have 13 passed, the health plan may initiate utilization management review 14 procedures if the behavioral health agency continues to provide 15 services or is in the process of arranging for a seamless transfer to 16 an appropriate facility or lower level of care under subsection (6) 17 of this section. For a health plan issued or renewed on or after 18 January 1, 2025, if a health plan authorizes inpatient or residential 19 substance use disorder treatment services pursuant to (a)(i) of this 20 subsection following the initial medical necessity review process 21 under (c)(iii) of this subsection, the length of the initial 22 authorization may not be less than 14 days from the date that the 23 patient was admitted to the behavioral health agency. Any subsequent 24 reauthorization that the health plan approves after the first 14 days 25 must continue for no less than seven days prior to requiring further 26 reauthorization. Nothing prohibits a health plan from requesting 27 information to assist with a seamless transfer under this subsection.

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

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

39 (iii) After the time period in (a) of this subsection and receipt 40 of the material provided under (c)(ii) of this subsection, the plan

may initiate a medical necessity review process. Medical necessity review must be based on the standard set of criteria established under RCW 41.05.528. In a review for inpatient or residential substance use disorder treatment services, a health plan may not make a determination that a patient does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a health plan may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the health plan's medical necessity review is completed more than one business day after ((~~[the]~~)) the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the health plan must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

does not meet medical necessity criteria based primarily on the patient's length of abstinence. If the patient's abstinence from substance use was due to incarceration, hospitalization, or inpatient treatment, a managed care organization may not consider the patient's length of abstinence in determining medical necessity. If the health plan determines within one business day from the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection that the admission to the facility was not medically necessary and advises the agency of the decision in writing, the health plan is not required to pay the facility for services delivered after the start of the medical necessity review period, subject to the conclusion of a filed appeal of the adverse benefit determination. If the managed care organization's medical necessity review is completed more than one business day after ((~~[the]~~)) the start of the medical necessity review period and receipt of the material provided under (c)(ii) of this subsection, the managed care organization must pay for the services delivered from the time of admission until the time at which the medical necessity review is completed and the agency is advised of the decision in writing.

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

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

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

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

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

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

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

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

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

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

(2) This section expires June 1, 2025.

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

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

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

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

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

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

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

NEW SECTION. **Sec. 13.** The health care authority shall provide a gap analysis of nonemergency transportation benefits provided to medicaid enrollees in Washington, Oregon, and other comparison states selected by the health care authority and provide an analysis of the costs and benefits of available alternatives to the governor and appropriate committees of the legislature by December 1, 2024, including the option of an enhanced nonemergency transportation benefit for persons being discharged from a behavioral health emergency services provider to the next level of care in circumstances when a prudent layperson acting reasonably would believe such transportation is necessary to protect the enrollee from relapse or other discontinuity in care that would jeopardize the health or safety of the enrollee. In recognizing that some behavioral health patients are not well-served by the current nonemergency transportation system for medical assistance patients due to inflexible rules, the authority shall also evaluate the possibility of creating a network of peer-led, trauma-informed transportation providers that could provide nonemergency transportation to youth and adult medical assistance patients traveling to receive behavioral health services.

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

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

(2) The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination

fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. Any and all fees or assessments, or both, levied on the state to cover the costs of the operations and activities of the interstate health professions licensure compacts with participating authorities listed under chapter 18.130 RCW shall be borne by the persons who hold licenses issued pursuant to the authority and procedures established under the compacts. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the cost of regulating licensed volunteer medical workers in accordance with RCW 18.130.360, except as provided in RCW 18.79.202. In no case may the secretary impose any certification, examination, or renewal fee upon a person seeking certification as a certified peer specialist trainee under chapter 18.420 RCW or, between July 1, 2025, and July 1, 2030, impose a certification, examination, or renewal fee of more than $100 upon any person seeking certification as a certified peer specialist under chapter 18.420 RCW. Subject to amounts appropriated for this specific purpose, between July 1, 2024, and July 1, 2029, the secretary may not impose any certification or certification renewal fee on a person seeking certification as a substance use disorder professional or substance use disorder professional trainee under chapter 18.205 RCW of more than $100.

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

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

The authority must contract with an association that represents designated crisis responders in Washington to develop and begin delivering by July 1, 2025, a training program for social workers licensed under chapter 18.225 RCW who practice in an emergency department with responsibilities related to civil commitments under this chapter. The training must include instruction emphasizing standards and procedures relating to the civil commitment of persons with substance use disorders and mental illness, including which clinical presentations warrant summoning a designated crisis responder. The training must emphasize the manner in which a patient with a primary substance use disorder may present as a risk of harm

to self or others, or gravely disabled. Each hospital shall ensure that, by July 1, 2026, or within three months of hire, all social workers employed in the emergency department with responsibilities relating to civil commitments under this chapter complete the training every three years.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Information and documents created specifically for, and collected and maintained by a quality improvement committee under RCW 43.70.510, 70.230.080, or 70.41.200, or by a peer review committee under RCW 4.24.250, or by a quality assurance committee pursuant to

RCW 74.42.640 or 18.20.390, or by a hospital, as defined in RCW 43.70.056, for reporting of health care-associated infections under RCW 43.70.056, a notification of an incident under RCW 70.56.040(5), and reports regarding adverse events under RCW 70.56.020(2)(b), regardless of which agency is in possession of the information and documents;

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

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

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

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

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

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

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

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

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

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

1 (l) Medical information contained in files and records of members
2 of retirement plans administered by the department of retirement
3 systems or the law enforcement officers' and firefighters' plan 2
4 retirement board, as provided to the department of retirement systems
5 under RCW 41.04.830; and
6 (m) Data submitted to the data integration platform under RCW
7 71.24.908.
8 (2) Chapter 70.02 RCW applies to public inspection and copying of
9 health care information of patients.
10 (3)(a) Documents related to infant mortality reviews conducted
11 pursuant to RCW 70.05.170 are exempt from disclosure as provided for
12 in RCW 70.05.170(3).
13 (b)(i) If an agency provides copies of public records to another
14 agency that are exempt from public disclosure under this subsection
15 (3), those records remain exempt to the same extent the records were
16 exempt in the possession of the originating entity.
17 (ii) For notice purposes only, agencies providing exempt records
18 under this subsection (3) to other agencies may mark any exempt
19 records as "exempt" so that the receiving agency is aware of the
20 exemption, however whether or not a record is marked exempt does not
21 affect whether the record is actually exempt from disclosure.
22 (4) Information and documents related to maternal mortality
23 reviews conducted pursuant to RCW 70.54.450 are confidential and
24 exempt from public inspection and copying.
25 (5) Patient health care information contained in reports
26 submitted under section 2(2) of this act are confidential and exempt
27 from public inspection.

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

--- END ---