
HOUSE BILL 1464

State of Washington

67th Legislature

2021 Regular Session

By Representatives Davis and Cody

1 AN ACT Relating to removing health care coverage barriers to
2 accessing substance use disorder treatment services; and amending RCW
3 41.05.526, 48.43.761, and 71.24.618.

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

5 **Sec. 1.** RCW 41.05.526 and 2020 c 345 s 2 are each amended to
6 read as follows:

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

15 (2)(a) ((A)) When an enrollee is admitted under subsection (1) of
16 this section, a health plan offered to employees and their covered
17 dependents under this chapter issued or renewed on or after January
18 1, 2021, must:

19 (i) Provide coverage for no less than two business days,
20 excluding weekends and holidays, in a behavioral health agency that

1 provides inpatient or residential substance use disorder treatment
2 prior to conducting a utilization review; and

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

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

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

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

26 (iii) After the time period in (a) of this subsection and receipt
27 of the material provided under (c)(ii) of this subsection, the plan
28 may initiate a medical necessity review process. Medical necessity
29 review must be based on the standard set of criteria established
30 under RCW 41.05.528. If the health plan determines within one
31 business day from the start of the medical necessity review period
32 and receipt of the material provided under (c)(ii) of this subsection
33 that the admission to the facility was not medically necessary and
34 advises the agency of the decision in writing, the health plan is not
35 required to pay the facility for services delivered after the start
36 of the medical necessity review period, subject to the conclusion of
37 a filed appeal of the adverse benefit determination. If the health
38 plan's medical necessity review is completed more than one business
39 day after ~~((the))~~ the start of the medical necessity review period
40 and receipt of the material provided under (c)(ii) of this

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

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

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

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

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

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

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

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

34 (8) For instances in which an enrollee elects a planned or
35 scheduled admission to inpatient or residential substance use
36 disorder treatment services in a behavioral health agency licensed or
37 certified under RCW 71.24.037, a health plan may apply utilization
38 management procedures, including prior authorization, prior to
39 admission to treatment.

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

6 **Sec. 2.** RCW 48.43.761 and 2020 c 345 s 3 are each amended to
7 read as follows:

8 (1) Except as provided in subsection (2) of this section, a
9 health plan issued or renewed on or after January 1, 2021, may not
10 require an enrollee to obtain prior authorization for withdrawal
11 management services or inpatient or residential substance use
12 disorder treatment services in a behavioral health agency licensed or
13 certified under RCW 71.24.037 unless it is a planned or scheduled
14 admission as provided in subsection (8) of this section.

15 (2)(a) ((A)) When an enrollee is admitted under subsection (1) of
16 this section, a health plan issued or renewed on or after January 1,
17 2021, must:

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

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

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

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

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

7 (iii) After the time period in (a) of this subsection and receipt
8 of the material provided under (c)(ii) of this subsection, the plan
9 may initiate a medical necessity review process. Medical necessity
10 review must be based on the standard set of criteria established
11 under RCW 41.05.528. If the health plan determines within one
12 business day from the start of the medical necessity review period
13 and receipt of the material provided under (c)(ii) of this subsection
14 that the admission to the facility was not medically necessary and
15 advises the agency of the decision in writing, the health plan is not
16 required to pay the facility for services delivered after the start
17 of the medical necessity review period, subject to the conclusion of
18 a filed appeal of the adverse benefit determination. If the health
19 plan's medical necessity review is completed more than one business
20 day after ~~((the))~~ the start of the medical necessity review period
21 and receipt of the material provided under (c)(ii) of this
22 subsection, the health plan must pay for the services delivered from
23 the time of admission until the time at which the medical necessity
24 review is completed and the agency is advised of the decision in
25 writing.

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

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

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

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

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

1 (6) When the treatment plan approved by the health plan involves
2 transfer of the enrollee to a different facility or to a lower level
3 of care, the care coordination unit of the health plan shall work
4 with the current agency to make arrangements for a seamless transfer
5 as soon as possible to an appropriate and available facility or level
6 of care. The health plan shall pay the agency for the cost of care at
7 the current facility until the seamless transfer to the different
8 facility or lower level of care is complete. A seamless transfer to a
9 lower level of care may include same day or next day appointments for
10 outpatient care, and does not include payment for nontreatment
11 services, such as housing services. If placement with an agency in
12 the health plan's network is not available, the health plan shall pay
13 the current agency until 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 instances in which an enrollee elects a planned or
17 scheduled admission to inpatient or residential substance use
18 disorder treatment services in a behavioral health agency licensed or
19 certified under RCW 71.24.037, a health plan may apply utilization
20 management procedures, including prior authorization, prior to
21 admission to treatment.

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

27 **Sec. 3.** RCW 71.24.618 and 2020 c 345 s 4 are each amended to
28 read as follows:

29 (1) Beginning January 1, 2021, except as provided in subsection
30 (2) of this section, a managed care organization may not require an
31 enrollee to obtain prior authorization for withdrawal management
32 services or inpatient or residential substance use disorder treatment
33 services in a behavioral health agency licensed or certified under
34 RCW 71.24.037 unless it is a planned or scheduled admission as
35 provided in subsection (8) of this section.

36 (2)(a) Beginning January 1, 2021, when an enrollee is admitted
37 under subsection (1) of this section, a managed care organization
38 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) The managed care organization may not require an enrollee to
9 obtain 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. Once the times specified in (a)
12 of this subsection have passed, the managed care organization may
13 initiate utilization management review procedures if the behavioral
14 health agency continues to provide services or is in the process of
15 arranging for a seamless transfer to an appropriate facility or lower
16 level of care under subsection (6) of this section.

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

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

29 (iii) After the time period in (a) of this subsection and receipt
30 of the material provided under (c)(ii) of this subsection, the
31 managed care organization may initiate a medical necessity review
32 process. Medical necessity review must be based on the standard set
33 of criteria established under RCW 41.05.528. If the health plan
34 determines within one business day from the start of the medical
35 necessity review period and receipt of the material provided under
36 (c)(ii) of this subsection that the admission to the facility was not
37 medically necessary and advises the agency of the decision in
38 writing, the health plan is not required to pay the facility for
39 services delivered after the start of the medical necessity review
40 period, subject to the conclusion of a filed appeal of the adverse

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

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

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

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

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

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

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

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

3 (8) For instances in which an enrollee elects a planned or
4 scheduled admission to inpatient or residential substance use
5 disorder treatment services in a behavioral health agency licensed or
6 certified under RCW 71.24.037, a managed care organization may apply
7 utilization management procedures, including prior authorization,
8 prior to admission to treatment.

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

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