H-4618.1

SECOND SUBSTITUTE HOUSE BILL 2572

State of Washington 65th Legislature 2018 Regular Session

By House Appropriations (originally sponsored by Representatives Cody, Macri, Jinkins, Kagi, Wylie, Slatter, Tharinger, Ormsby, and Robinson)

READ FIRST TIME 02/06/18.

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

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

6 NEW SECTION. **Sec. 1.** (1) The legislature finds that:
7 (a) Substance use disorders are on the rise in Washington,
8 affecting victims, families, and communities throughout the state;
9 (b) Access to effective treatment is a necessary component to
10 helping individuals recover from substance use disorders; and
11 (c) When individuals are ready for treatment, they should be able
12 to obtain it with minimal barriers relating to health care coverage.
13 (2) The legislature therefore intends to ensure that there is no
14 wrong door for individuals accessing substance use disorder treatment
15 services by requiring coverage, and prohibiting prior authorization,
16 for certain substance use disorder treatment services.

17 NEW SECTION. **Sec. 2.** A new section is added to chapter 41.05
18 RCW to read as follows:
19 (1) To the extent that the following services are covered
20 benefits, a health plan, must cover inpatient hospital

1 detoxification, residential subacute detoxification, inpatient
2 hospital substance use disorder treatment, residential substance use
3 disorder treatment, partial hospitalization substance use disorder
4 treatment, and intensive outpatient substance use disorder treatment
5 for the first twenty-four hours after an enrollee presents for any of
6 these services or is referred for any of these services, without
7 imposing utilization management review limitations on coverage,
8 including prior authorization requirements.

9 (a) If located in Washington, the treatment facility or program
10 must be licensed or certified by the department of health to deliver
11 the level of care being sought by the enrollee. If located in other
12 states, the facility or program must be licensed or certified by the
13 state agency with the authority to issue credentials for the level of
14 care being sought by the enrollee.

15 (b) If an enrollee presents without a referral from a hospital or
16 provider, the treatment facility or program must make a good faith
17 effort to confirm and document that a third party did not induce the
18 enrollee to seek treatment in exchange for payment of goods,
19 nonmedical or mental health services, or moneys, provided either to
20 the enrollee or the third party.

21 (2) The treatment facility or program must provide an enrollee's
22 health plan with notice of admission as soon as practicable after
23 admitting the enrollee, but not later than twenty-four hours after
24 admission. The time of notification does not reduce the requirements
25 established in subsection (1) of this section.

26 (a) The facility's initial assessment, basis for referral, and
27 initial planned services must accompany the notice.

28 (b) Upon receipt of notice of admission and the passage of the
29 first twenty-four hours, as required under subsection (1) of this
30 section, the health plan may initiate its utilization review of the
31 member's need for services, and the remainder of the enrollee's
32 services may be subject to utilization management, including prior
33 authorization, as required by the enrollee's health coverage.

34 (c) If the treatment facility or program is a contracted facility
35 participating in the health plan's provider network, the health plan
36 must conduct any prior authorization or other utilization management
37 review necessary to determine the covered length of stay and course
38 of treatment, as permitted under the enrollee's health plan, on an
39 urgent, expedited basis within twenty-four hours of receipt of all
40 necessary documentation.

1 (3) If the treatment facility or program is not a contracted
2 facility participating in the health plan's provider network, the
3 health plan must inform the enrollee and the enrollee's attending
4 physician that the facility is not in the health plan's provider
5 network, and whether out-of-network coverage is available. Nothing in
6 this section requires a carrier to include out-of-network coverage in
7 a health plan.
8 (a) If the health plan covers out-of-network services, and the
9 enrollee is admitted to an out-of-network facility or program located
10 in Washington, the health plan must pay for a covered mode of
11 transfer to an in-network facility or program without requiring
12 payment or cost sharing from the enrollee. Transport must be provided
13 by an in-network provider.
14 (b) A health plan is not required to cover transportation from an
15 out-of-state treatment program or facility if the enrollee elects to
16 transfer to an in-state, in-network treatment program or facility.
17 (4)(a) If a health plan determines that the admission to
18 inpatient substance use disorder treatment was not medically
19 necessary or clinically appropriate, the health plan is not required
20 to pay the facility or program for the services delivered after the
21 initial twenty-four hour admission period, subject to the conclusion
22 of any filed appeals of the adverse benefit determination.
23 (b) If the patient evaluation and plan of care conducted at the
24 facility under (a) of this subsection and the health plan's
25 utilization review process identify a need for services other than
26 those available at the inpatient substance use disorder treatment
27 facility or program, the health plan in collaboration with the
28 facility must fully coordinate the arrangements for assuring that the
29 enrollee obtains the proper medically necessary or clinically
30 appropriate care. To fully coordinate these arrangements, a health
31 plan may need to identify and contact an available program or
32 facility that offers the medically necessary or clinically
33 appropriate care, assist with arranging the admission or initial
34 appointment between the enrollee and the provider, assist with the
35 transfer of health records including the initial evaluation and plan
36 of care, and conduct other activities to facilitate a seamless
37 transition for the enrollee into the appropriate care.
38 (5) A health plan must use evidence-based criteria for assessing
39 the medical necessity and clinical appropriateness of an enrollee's
40 need for substance use disorder residential treatment.

1 (6) This section does not restrict the right of enrollees to seek
2 emergency medical care requiring stabilization or acute
3 detoxification services from any emergency room or urgent care center
4 without prior authorization.

5 NEW SECTION. **Sec. 3.** A new section is added to chapter 48.43
6 RCW to read as follows:
7 (1) To the extent that the following services are covered
8 benefits, a health plan, as defined in RCW 48.43.005, must cover
9 inpatient hospital detoxification, residential subacute
10 detoxification, inpatient hospital substance use disorder treatment,
11 residential substance use disorder treatment, partial hospitalization
12 substance use disorder treatment, and intensive outpatient substance
13 use disorder treatment for the first twenty-four hours after an
14 enrollee presents for any of these services or is referred for any of
15 these services, without imposing utilization management review
16 limitations on coverage, including prior authorization requirements.
17 (a) If located in Washington, the treatment facility or program
18 must be licensed or certified by the department of health to deliver
19 the level of care being sought by the enrollee. If located in other
20 states, the facility or program must be licensed or certified by the
21 state agency with the authority to issue credentials for the level of
22 care being sought by the enrollee.
23 (b) If an enrollee presents without a referral from a hospital or
24 provider, the treatment facility or program must make a good faith
25 effort to confirm and document that a third party did not induce the
26 enrollee to seek treatment in exchange for payment of goods,
27 nonmedical or mental health services, or moneys, provided either to
28 the enrollee or the third party.
29 (2) The treatment facility or program must provide an enrollee's
30 health plan with notice of admission as soon as practicable after
31 admitting the enrollee, but not later than twenty-four hours after
32 admission. The time of notification does not reduce the requirements
33 established in subsection (1) of this section.
34 (a) The facility's initial assessment, basis for referral, and
35 initial planned services must accompany the notice.
36 (b) Upon receipt of notice of admission and the passage of the
37 first twenty-four hours, as required under subsection (1) of this
38 section, the health plan may initiate its utilization review of the
39 member's need for services, and the remainder of the enrollee's

1 services may be subject to utilization management, including prior
2 authorization, as required by the enrollee's health coverage.

3 (c) If the treatment facility or program is a contracted facility
4 participating in the health plan's provider network, the health plan
5 must conduct any prior authorization or other utilization management
6 review necessary to determine the covered length of stay and course
7 of treatment, as permitted under the enrollee's health plan, on an
8 urgent, expedited basis within twenty-four hours of receipt of all
9 necessary documentation.

10 (3) If the treatment facility or program is not a contracted
11 facility participating in the health plan's provider network, the
12 health plan must inform the enrollee and the enrollee's attending
13 physician that the facility is not in the health plan's provider
14 network, and whether out-of-network coverage is available. Nothing in
15 this section requires a carrier to include out-of-network coverage in
16 a health plan.

17 (a) If the health plan covers out-of-network services, and the
18 enrollee is admitted to an out-of-network facility or program located
19 in Washington, the health plan must pay for a covered mode of
20 transfer to an in-network facility or program without requiring
21 payment or cost sharing from the enrollee. Transport must be provided
22 by an in-network provider.

23 (b) A health plan is not required to cover transportation from an
24 out-of-state treatment program or facility if the enrollee elects to
25 transfer to an in-state, in-network treatment program or facility.

26 (4)(a) If a health plan determines that the admission to
27 inpatient substance use disorder treatment was not medically
28 necessary or clinically appropriate, the health plan is not required
29 to pay the facility or program for the services delivered after the
30 initial twenty-four hour admission period, subject to the conclusion
31 of any filed appeals of the adverse benefit determination.

32 (b) If the patient evaluation and plan of care conducted at the
33 facility under (a) of this subsection and the health plan's
34 utilization review process identify a need for services other than
35 those available at the inpatient substance use disorder treatment
36 facility or program, the health plan in collaboration with the
37 facility must fully coordinate the arrangements for assuring that the
38 enrollee obtains the proper medically necessary or clinically
39 appropriate care. To fully coordinate these arrangements, a health
40 plan may need to identify and contact an available program or

facility that offers the medically necessary or clinically appropriate care, assist with arranging the admission or initial appointment between the enrollee and the provider, assist with the transfer of health records including the initial evaluation and plan of care, and conduct other activities to facilitate a seamless transition for the enrollee into the appropriate care.

(5) A health plan must use evidence-based criteria for assessing the medical necessity and clinical appropriateness of an enrollee's need for substance use disorder residential treatment.

(6) This section does not restrict the right of enrollees to seek emergency medical care requiring stabilization or acute detoxification services from any emergency room or urgent care center without prior authorization.

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

(1) To the extent that the following services are covered benefits, a behavioral health organization must cover inpatient hospital detoxification, residential subacute detoxification, inpatient hospital substance use disorder treatment, residential substance use disorder treatment, partial hospitalization substance use disorder treatment, and intensive outpatient substance use disorder treatment for the first twenty-four hours after a client presents for any of these services or is referred for any of these services, without imposing utilization management review limitations on coverage, including prior authorization requirements.

(a) If located in Washington, the treatment facility or program must be licensed or certified by the department of health to deliver the level of care being sought by the client. If located in other states, the facility or program must be licensed or certified by the state agency with the authority to issue credentials for the level of care being sought by the client.

(b) If a client presents without a referral from a hospital or provider, the treatment facility or program must make a good faith effort to confirm and document that a third party did not induce the client to seek treatment in exchange for payment of goods, nonmedical or mental health services, or moneys, provided either to the client or the third party.

(2) The treatment facility or program must provide a client's behavioral health organization with notice of admission as soon as

1 practicable after admitting the client, but not later than twenty-
2 four hours after admission. The time of notification does not reduce
3 the requirements established in subsection (1) of this section.
4 (a) The facility's initial assessment, basis for referral, and
5 initial planned services must accompany the notice.
6 (b) Upon receipt of notice of admission and the passage of the
7 first twenty-four hours, as required under subsection (1) of this
8 section, the behavioral health organization may initiate its
9 utilization review of the client's need for services, and the
10 remainder of the client's services may be subject to utilization
11 management, including prior authorization, as required by the
12 client's coverage through the behavioral health organization.
13 (c) If the treatment facility or program is a contracted facility
14 participating in the behavioral health organization provider network,
15 the behavioral health organization must conduct any prior
16 authorization or other utilization management review necessary to
17 determine the covered length of stay and course of treatment on an
18 urgent, expedited basis within twenty-four hours of receipt of all
19 necessary documentation.
20 (3) If the treatment facility or program is not a contracted
21 facility participating in the behavioral health organization's
22 provider network, the behavioral health organization must inform the
23 client and the client's attending physician that the facility or
24 program is not in the behavioral health organization's provider
25 network, and whether out-of-network coverage is available. Nothing in
26 this section requires a behavioral health organization to include
27 out-of-network coverage.
28 (a) If the behavioral health organization covers out-of-network
29 services, and the client is admitted to an out-of-network facility or
30 program located in Washington, the behavioral health organization
31 must pay for a covered mode of transfer to an in-network facility or
32 program without requiring payment or cost sharing from the client.
33 Transport must be provided by an in-network provider.
34 (b) A behavioral health organization is not required to cover
35 transportation from an out-of-state treatment program or facility if
36 the client elects to transfer to an in-state, in-network treatment
37 program or facility.
38 (4)(a) If a behavioral health organization determines that the
39 admission to inpatient substance use disorder treatment was not
40 medically necessary or clinically appropriate, the behavioral health

organization is not required to pay the facility or program for the services delivered after the initial twenty-four hour admission period, subject to the conclusion of any filed appeals of the adverse benefit determination.

(b) If the patient evaluation and plan of care conducted at the facility or program under (a) of this subsection and the behavioral health organization's utilization review process identify a need for services other than those available at the inpatient substance use disorder treatment facility or program, the behavioral health organization in collaboration with the facility or program must fully coordinate the arrangements for assuring that the client obtains the proper medically necessary or clinically appropriate care. To fully coordinate these arrangements, a behavioral health organization may need to identify and contact an available program or facility that offers the medically necessary or clinically appropriate care, assist with arranging the admission or initial appointment between the client and the provider, assist with the transfer of health records including the initial evaluation and plan of care, and conduct other activities to facilitate a seamless transition for the client into the appropriate care.

(5) A behavioral health organization must use evidence-based criteria for assessing the medical necessity and clinical appropriateness of a client's need for substance use disorder residential treatment.

(6) This section does not restrict the right of clients to seek emergency medical care requiring stabilization or acute detoxification services from any emergency room or urgent care center without prior authorization.

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