HOUSE BILL REPORT
HB 2572

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to removing health coverage barriers to accessing substance use disorder treatment services.

Brief Description: Removing health coverage barriers to accessing substance use disorder treatment services.

Sponsors: Representatives Cody, Macri, Jinkins, Kagi, Wylie, Slatter, Tharinger, Ormsby and Robinson.

Brief History:
Committee Activity:
Health Care & Wellness: 1/19/18, 2/2/18 [DPS].

Brief Summary of Substitute Bill

- Requires insurers and behavioral health organizations to cover certain substance use disorder treatments for 24 hours without utilization management review limitations.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 16 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Slatter, Stonier and Tharinger.

Staff: Chris Blake (786-7392).

Background:

The federal Substance Abuse and Mental Health Services Administration describes substance use disorders as a condition that occurs when the recurrent use of alcohol or drugs causes clinically and functionally significant impairment. Recommended treatment for substance use disorders may vary depending on an assessment of the individual, but may include

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outpatient treatment, medication-assisted therapy, or residential treatment. The kinds of available treatment varies depending on the person's type of health coverage:

- Persons covered by medical assistance programs receive coverage through behavioral health organizations which oversee the delivery of mental health and substance use disorder services for adults and children in a particular geographic region. By 2020 the responsibility for providing these services will transfer to Medicaid managed care organizations. Substance use disorder services are determined upon assessment of the client and may include outpatient treatment, detoxification services, residential treatment, and opiate substitution treatment services.
- The federal Patient Protection and Affordable Care Act requires most individual and small group market health plans to provide coverage for mental health and substance use disorder treatment services. Under state rules implementing the federal requirement, this coverage must include outpatient and inpatient care to evaluate, diagnose, and treat a substance use disorder. State law also requires most state-regulated health plans to cover the treatment of substance use disorders as provided by a treatment plan approved by the Department of Social and Health Services.
- State employees receive health care through the Public Employees Benefits Board, an entity within the Health Care Authority. Coverage options include a managed care organization plan and a self-insured health plan, known as the Uniform Medical Plan. Both plans cover outpatient services and residential treatment for substance use disorders.

Summary of Substitute Bill:

The Public Employees Benefits Board, private health insurers, and behavioral health organizations (payors) must provide coverage, without utilization management review limitations, for the first 24 hours after an enrollee or client presents or is referred for the following services:

- inpatient hospital detoxification;
- residential subacute detoxification;
- inpatient hospital substance use disorder treatment;
- residential substance use disorder treatment;
- partial hospitalization substance use disorder treatment; or
- intensive outpatient substance use disorder treatment.

The treatment facility or program must provide the relevant payor with notice of admission as soon as practicable, but no later than 24 hours after admission. The notice must be accompanied by the facility or program's initial assessment, basis for referral, and initial planned services. The payor may initiate utilization review activities once 24 hours have passed. Any services received by the enrollee or client after the first 24 hours have passed may be subject to utilization management review.

If the treatment facility or program is in the payor's provider network, utilization management review may occur on an urgent, expedited basis within 24 hours of the receipt of all documentation to determine the length of stay and course of treatment. If the treatment facility or program is not in the payor's network, the payor must inform the enrollee or client

and his or her attending physician that the facility or program is not in the payor's network and whether out-of-network coverage is available. If the payor covers out-of-network services and the enrollee or client is admitted to an out-of-network facility or program, the payor must pay for a covered mode of transfer to an in-network facility or program without requiring payment or cost sharing from the enrollee or client. A payor is not required to cover transportation from an out-of-state treatment facility or program if the enrollee or client chooses to transfer to an in-state, in-network provider.

A payor, upon determining that admission to inpatient substance use disorder treatment was not medically necessary or clinically appropriate, is not required to not pay the facility or program for services offered after the first 24 hours. If the patient's evaluation, plan of care, and utilization review identify a need for services other than those at the inpatient substance use disorder treatment facility or program, the payor and the facility or program must coordinate arrangements to assure that the enrollee obtains the proper medically necessary or clinically appropriate treatment. Coordination may require a payor to identify and contact available facilities or programs that offer the medically necessary or clinically appropriate care, assist with arranging admissions or initial appointments, assist with the transfer of health records, and conduct other activities to facilitate a seamless transition into the appropriate care.

If an enrollee or client presents at a treatment facility or program 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 enrollee or client to seek treatment in exchange for money, payment of goods, or services.

Enrollees and clients are not restricted from seeking emergency medical care requiring stabilization or acute detoxification services from an emergency department or urgent care center without prior authorization.

Legislative findings are made relating to the increase in substance use disorders and the need for access to treatment with minimal barriers.

Substitute Bill Compared to Original Bill:

The substitute bill removes the underlying provisions of the bill, except for the legislative findings. Common requirements for the Public Employees Benefits Board, private health insurers, and behavioral health organizations (payors) are established related to substance use disorder coverage.

The substitute bill requires payors to cover, without utilization management review limitations, the first 24 hours of the following services: (1) inpatient hospital detoxification; (2) residential subacute detoxification; (3) inpatient hospital substance use disorder treatment; (4) residential substance use disorder treatment; (5) partial hospitalization substance use disorder treatment; and (6) intensive outpatient substance use disorder treatment. Treatment facilities and programs must provide notice of admission to the enrollees as soon as practicable, but no later than 24 hours following admission.

The substitute bill requires treatment facilities and programs to confirm and document that enrollees and clients who present without a referral from a hospital or provider were not induced by a third party.

The substitute bill requires payors to inform enrollees or clients and the attending physician if a treatment facility or program is out-of-network. Payors must pay for a transfer to an in-network facility without payment or cost-sharing from enrollees or clients.

The substitute bill allows a payor, upon finding that admission to inpatient substance use disorder treatment was not medically necessary or clinically appropriate, to not pay the facility or program for services offered after the first 24 hours. If the utilization review finds that services other than those at the inpatient substance use disorder treatment facility or program are needed, the payor and the facility or program must coordinate arrangements to assure that the enrollee obtains the proper medically necessary or clinically appropriate.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This bill is effective in focusing on people when they are ready to get to treatment. All of the research shows that the first hurdle for treating a person with a substance use disorder is the willingness to seek treatment. If a person shows up for treatment and is then sent away, the likelihood of him or her returning is greatly reduced. Loved ones should have minimal barriers so they can get treatment when they say they are ready. The decision to seek treatment is difficult and often involves breaking contact with friends and family, leaving home, and dropping everything to commit to treatment. Subjecting patients to additional barriers such as preauthorization during what is a limited window of opportunity when a person with a substance use disorder wants help can hinder and discourage those seeking help for their substance use disorder.

This bill is efficient because it addresses people through their insurance. Any effort that thoughtfully removes barriers to treatment on demand is good for both individuals and the behavioral health system as a whole. Many patients are told by detoxification providers that they must wait for an assessment from a doctor and an authorization from the insurer with additional preauthorization required to go from the detoxification facility to an inpatient facility. If treatment options are not readily available, the addiction pulls people back into actively using drugs. Removing preauthorization after a health care provider deems detoxification and treatment to be medically necessary and requiring insurance plans to cover these acute stabilization services gets the patient the care they need with little or no delay. It is challenging to find a secure detoxification facility with available space, that is in network, and is approved.

The providers who deal with these issues every day are able to make the decision on whether or not people are presenting in a manner that shows a medically necessary situation requiring immediate treatment. This bill ensures that medical necessity will be determined by licensed treatment providers working with the patient while ensuring that behavioral health organizations and the health plans are informed of the patient's admission and treatment plan.

Every month 10,000 people go through Washington emergency departments with a primary or secondary diagnosis of substance use disorder. This bill will relieve much of the pressure where people have to use health care of last resort in hospital emergency departments. People at emergency departments have been refused treatment.

There are timing issues related to the bill that need to be perfected. There should be some clarifications such as excluding weekends and holidays from the number of days and having a definition of "utilization review procedures."

(Opposed) None.

(Other) People with substance use disorders need to have access to effective treatments with minimal barriers, but the current gaps in access are not due to administrative barriers. The primary barriers are that treatment is not offered in accessible ways and there is a scarcity of providers for the range of treatments. Evidence supports that sustained long-term treatment for substance use disorders typically provided in outpatient settings is the most effective option and 14 days of treatment is typically insufficient and intensive treatment services do not generally lead to better outcomes. The bill would encourage the use of short-term intensive treatments even for patients who should be treated in other care settings, leaving fewer spots available for people who actually need the more intensive services. This bill will divert more resources, workforce, and investment to provide these higher intensity short-term treatments which are not associated with best outcomes. Suspending the utilization review and prior authorization requirements for 14 days interferes with the ability of managed care plans to work with providers to assess whether the care and treatment being proposed is the right care and treatment. Drug utilization and prior authorization makes sure that the member is going to a network facility to reduce the costs to the patient and the insurer. The way the bill is framed allows unfettered access to any type of facility without regard to the quality, network status, and the ability of the patient to continue to receive necessary coverage. This bill has no protection against the practice of "patient brokering" where patients are induced to go to certain facilities. Limiting prior authorization expands the essential health benefits which the state will be required to cover. Other options should be considered such as increasing integration of treatment availability in primary care, improving access to long-term outpatient treatment options, and increasing the supply of trained professionals.

Persons Testifying: (In support) Len McComb, Washington State Hospital Association; Michael Transue, Seattle Drug and Narcotic Center; Paulette Chaussee; Michelle Karrer; Katie Kolan, Washington State Medical Association; Michael Hatchett, Washington Council for Behavioral Health; and Brad Banks, County Behavioral Health Organizations.

(Other) Meg Jones, Association of Washington Healthcare Plans; and Ryan Caldeiro, Kaiser Permanente of Washington.

Persons Signed In To Testify But Not Testifying: None.