HOUSE BILL REPORT
HB 2319

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to substance use disorder treatment.

Brief Description: Concerning substance use disorder treatment.

Sponsors: Representatives Davis, Macri, Mosbrucker, Griffey, Stearns, Fosse, Ramel, Simmons, Nance, Kloba, Farivar, Bateman, Reed, Ryu, Chopp, Ortiz-Self, Eslick, Jacobsen, Goodman, Alvarado, Peterson, Pollet and Shavers.

Brief History:

Committee Activity:

Health Care & Wellness: 1/23/24, 1/31/24 [DPS].

Brief Summary of Substitute Bill

- Directs behavioral health agencies to submit policies to the Department of Health (Department) related to the transfer or discharge of a person without the person's consent and requires the Department to adopt a model policy based on the policies that it receives.
- Requires behavioral health agencies to provide patients seeking treatment for opioid use disorder or alcohol use disorder with education related to treatment options, including any available pharmacological treatments.
- Requires the length of an initial authorization for inpatient or residential substance use disorder treatment approved by the Public Employees Benefits Board (PEBB), private health insurers, and Medicaid managed care organizations to be no less than 14 days from the date of admission.
- Prohibits the PEBB, private health insurers, and Medicaid managed care organizations from considering a patient's length of abstinence when determining whether services are medically necessary if the abstinence is due to incarceration or hospitalization.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not part of the legislation nor does it constitute a statement of legislative intent.

- Directs the Office of the Insurance Commissioner to convene a workgroup of commercial health carriers, Medicaid managed care organizations, and behavioral health agencies to develop recommendations for streamlining the requirements and processes for the authorization and reauthorization of inpatient or residential substance use disorder treatment.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Hutchins, Assistant Ranking Minority Member; Bronoske, Caldier, Davis, Graham, Macri, Maycumber, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

Minority Report: Without recommendation. Signed by 2 members: Representatives Schmick, Ranking Minority Member; Harris.

Staff: Chris Blake (786-7392).

Background:

Behavioral Health Agency Credentialing.
Behavioral health agencies are licensed by the Department of Health to provide services related to the prevention, treatment of, and recovery from substance use disorders, mental health disorders, co-occurring disorders, or problem gambling and gambling disorders. A behavioral health agency must obtain a license for its main site and any branch sites that it operates as well as certification for the behavioral health services that it provides. A behavioral health agency may receive one or more of 16 different types of behavioral health certifications, including behavioral health outpatient intervention, assessment, and treatment; behavioral health outpatient crisis, observations, and intervention; designated crisis responder services; opioid treatment program; withdrawal management; behavioral health residential or inpatient interventions, assessment, and treatment; involuntary behavioral health residential or inpatient; and crisis stabilization unit and triage.

Utilization Management Review for Withdrawal Management Services and Inpatient or Residential Substance Use Disorder Treatment Services.
The Public Employees Benefits Board, private health insurers, and Medicaid managed care organizations (insuring entities) are prohibited from requiring enrollees to obtain prior authorization before seeking withdrawal management services or inpatient or residential services in a behavioral health agency.

Before conducting a utilization management review, an insuring entity must provide

coverage for an enrollee for:

- at least two days, excluding weekends and holidays, of inpatient or residential substance use disorder treatment; and
- at least three days of withdrawal management services.

After the initial waiting period, insuring entities may initiate a medical necessity review. If the insuring entity determines within one business day from the start of the medical necessity review period that the admission to the facility was not medically necessary, the health plan is not required to pay the facility for any services that are delivered after the start of the medical necessity review period. If the insuring entity's medical necessity review is completed more than one business day after the start of the medical necessity review period, then the insuring entity must pay for the services delivered from the time of admission until the time the medical necessity review is complete, and the behavioral health agency has been notified.

Summary of Substitute Bill:

Behavioral Health Agency Transfer and Discharge Policies.
By October 1, 2024, certain behavioral health agencies must submit to the Department of Health (Department) their policies related to the transfer or discharge of a person without the person's consent. Specifically, the submission requirement applies to policies regarding situations in which the agency transfers or discharges a person without the person's consent, therapeutic progressive disciplinary processes used by the agency, and procedures to assure a safe transfer and discharge when the person is discharged without the person's consent. The requirement applies to behavioral health agencies that provide voluntary inpatient or residential substance use disorder treatment services or withdrawal management services.

By April 1, 2025, the Department must adopt a model policy for the transfer or discharge of a person without the person's consent. The model policy must establish factors to be used in making decisions to transfer or discharge a person without the person's consent. Factors may include the person's medical condition, the clinical determination that the person no longer requires treatment or withdrawal management services, the risk of physical injury that the person presents, the extent to which the person's behavioral risks impact the recovery of other persons, and the extent to which a therapeutic progressive disciplinary process has been used. The Department must consider the policies that it receives when adopting the model policy.

Beginning July 1, 2025, behavioral health agencies must file a report with the Department each time a person is discharged or transferred without the person's consent or when a person leaves treatment prematurely. The report must describe the circumstances related to the departure, including whether the departure was voluntary or involuntary, the agency's use of a therapeutic progressive disciplinary process, the person's self-reported understanding of the reasons for the discharge, the efforts made to avoid the discharge, and

the efforts to establish a safe discharge plan prior to the person's departure. Patient health care information in the reports is exempt from disclosure under the Public Records Act. Hospitals and psychiatric hospitals are exempt from the reporting requirements.

Behavioral health agencies may not prohibit a person from receiving services at or being admitted to the agency solely because the person had previously released themselves from the facility before the completion of treatment. Hospitals and psychiatric hospitals are exempt from the prohibition.

Education for Opioid Use Disorder and Alcohol Use Disorder.
Behavioral health agencies must provide every patient seeking treatment for opioid use disorder or alcohol use disorder with education related to treatment options specific to the patient's condition. The education must include an unbiased explanation of all recognized forms of treatment approved by the federal Food and Drug Administration, including facilitating any appropriate pharmacological treatments. The behavioral health agency must support the patient with the implementation of the patient's chosen course of treatment in a manner that meets clinically accepted standards. Behavioral health agencies that do not comply with the education and facilitation requirements may not advertise that they treat opioid use disorder or alcohol use disorder, or treat patients for opioid use disorder or alcohol use disorder. Failure to meet the education and facilitation requirements may be an element of proof in a legal action related to failure to secure informed consent and may be the basis for disciplinary action.

The Addictions, Drug, and Alcohol Institute (Institute) at the University of Washington must create a patient-shared decision-making tool to assist behavioral health providers when discussing medication treatment options for patients with alcohol use disorder. The Institute must distribute the tool to behavioral health providers and instruct them on ways to incorporate it into their practices.

Health Coverage for Inpatient or Residential Substance Use Disorder Treatment Services.
Beginning January 1, 2025, if the Public Employees Benefits Board, private health insurers, and Medicaid managed care organizations (insuring entities) authorize an enrollee's admission to a behavioral health agency for inpatient or residential substance use disorder treatment services, the initial authorization must last at least 14 days from the date of the patient's admission. Subsequent reauthorizations must last for no less than seven days. The limitation does not apply to requests by the insuring entity for information to assist with a transfer to a more appropriate level of care.

When conducting an initial medical necessity review for inpatient or residential substance use disorder treatment services, insuring entities may not determine that a patient does not meet medical necessity standards based primarily on the patient's length of abstinence. If a patient's abstinence is due to incarceration or hospitalization, an insuring entity may not consider the length of abstinence in its medical necessity determination.

Insuring entities may not consider the patient's length of stay at a behavioral health agency when making decisions regarding the authorization to continue care at the agency.

The Office of the Insurance Commissioner (Office) must convene a work group of insuring entities and behavioral health agencies. The work group must develop recommendations for streamlining insuring entities' requirements and processes for the authorization and reauthorization of inpatient or residential substance use disorder treatment. The recommendations must include a universal format with common data requirements and a standardized form and simplified electronic process to be used for authorizations and reauthorizations. The Office must report to the appropriate legislative committees by December 1, 2024.

Continuation of Medications.
A behavioral health provider or behavioral health agency providing withdrawal management services that seeks to discontinue the use of or reduce the amounts of a medication that the patient has been using in accordance with the directions of a prescribing health care provider, must first consult the prescribing provider and engage in individualized, patient-centered shared decision-making. Withdrawal management providers may not categorically require all patients to discontinue all psychotropic medications.

Use of American Society of Addiction Medicine Criteria.
The Office and the Health Care Authority (Authority) must jointly determine whether to use updated versions of the American Society of Addiction Medicine (ASAM) criteria and the date upon which the updated version must begin being used by Medicaid managed care organizations, health carriers, and other relevant entities. The fourth edition of the ASAM criteria must be used beginning January 1, 2026, unless the Office and the Authority determine that it should not be used.

Substitute Bill Compared to Original Bill:

The substitute bill removes the prohibition against initiating utilization review prior to 28 days from admission and replaces it with the requirement that the length of the initial authorization not be less than 14 days from admission and that subsequent reauthorizations must be for at least 7 days prior to further reauthorization. Health plans and Medicaid managed care organizations may request information to assist with a patient transfer.

The substitute bill replaces the prohibition against health plans and Medicaid managed care organizations considering a patient's length of abstinence in medical necessity determinations with a prohibition against basing the medical necessity determination "primarily" on the length of abstinence. The consideration of a patient's length of abstinence may not be used in a medical necessity determination if the abstinence was due to incarceration or hospitalization.

The substitute bill directs the Office of the Insurance Commissioner (Office) to convene a work group of commercial health carriers, Medicaid managed care organizations, and behavioral health agencies to develop recommendations for streamlining the requirements and processes for the authorization and reauthorization of inpatient or residential substance use disorder treatment. The Office must report to the appropriate legislative committees by December 1, 2024.

The substitute bill allows a behavioral health provider to discontinue the usage of or reduce the dosage of a medication, if the provider consults with the prescribing provider and engages in individualized, patient-centered shared decision-making. Withdrawal management providers may not categorically require all patients to discontinue all psychotropic medications.

The substitute bill authorizes the Office and the Health Care Authority (Authority) to jointly determine whether to use updated versions of the American Society of Addiction Medicine (ASAM) criteria and the date upon which the updated version must begin being used by Medicaid managed care organizations, health carriers, and other relevant entities. The fourth edition of the ASAM criteria must be used beginning January 1, 2026, unless the Office and the Authority determine otherwise.

The substitute bill prohibits behavioral health agencies from not permitting a person to receive services or be admitted to the agency based solely on prior instances of the person having released themselves prior to completing treatment. Exempts hospitals and psychiatric hospitals from the prohibition.

The substitute bill modifies the requirement to provide patients with opioid use disorder (OUD) and alcohol use disorder (AUD) with counseling related to treatment options by: (1) applying it to patients seeking treatment for OUD and AUD; (2) limiting the counseling requirement to providing education on treatment options; and (3) changing the requirement to facilitate access to the course of treatment to a requirement to support the patient with the implementation of their chosen course of treatment in a manner that meets clinically accepted standards.

The substitute bill exempts hospitals and psychiatric hospitals from requirements to submit involuntary transfer and discharge policies and to report instances of involuntary transfer or discharge or preliminary self-release from treatment. Patient health care information contained in the reports of patients being transferred or discharged without their consent or releasing themselves prior to completing treatment is exempt from the Public Records Act. The reporting requirement is delayed from April 1, 2025, until July 1, 2025.

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) Only a third of patients on Medicaid with opioid use disorder have access to medications and it is even lower for alcohol use disorder. This bill attempts to increase penetration rates for medications for substance use disorder. There are providers who oppose the use of medications for opioid use disorder, despite that being the gold standard of care and they discharge patients without letting them access those medications.

Patients have been discharged from inpatient addiction treatment for reasons such as falling asleep in groups, dress code violations, and sharing shampoo. Persons are being discharged without an aftercare plan. If there is a plan for change and treatment, recovery will happen. This bill will help the homeless.

Imposing an arbitrary time on someone who enters into residential treatment is monetarily costly due to the repeated process of admitting and establishing care, but even more costly to people who are pushed out of the door at a vulnerable time. Behavioral health agencies know what is going on with patients, yet they are regularly told that the patients are not a risk to themselves, or others and they are arbitrarily required to discharge patients. This bill makes it easier for patients to get into and stay in substance use disorder treatment. This bill makes it easier for providers who have to do reauthorizations for care every seven days. The utilization reviews are often very cumbersome and time consuming and frequently get denied. People are being turned down for care and being cut off while still establishing a support system.

There have been denials based on a patient's length of abstinence where insurance companies decide that treatment is not medically necessary based on a couple of weeks of abstinence. Imagine not wanting to drink or use drugs and needing residential treatment and being forced to relapse just to get the insurance coverage. Many patients who have been in jail or detoxed on their own are denied by their insurance companies if they have not used substances.

(Opposed) A couple of the provisions will move Washington further away from high quality care, including prohibiting payers from conducting reviews in the first 28 days of treatment. Without reviews in the first 28 days of treatment, the government and the health plans have no ability to see what is happening in treatment in the first month of care which is a critical moment to get people started on effective treatment, including medications. Restricting utilization review prior to 28 days could have significant implications and the limitation may hinder timely assessment and intervention and delay access to other necessary treatments or adjustments to care plans. Individuals may experience disruptions in their continuum of care through premature discharges or unnecessary extensions which can cause heightened stress and uncertainty and potentially exacerbate their condition.

Treatment durations should always be based on individual patient needs and clinical assessment that allows for better resource utilization and improved patient outcomes. The 28-day provision is in direct conflict with the American Society for Addiction Medicine's provisions and the language should be adjusted to ensure that Washington is following the latest in clinical care methods.

For the plan year 2022, less than 5 percent of the requests for residential treatment were denied, and for some carriers there were no denials before 28 days. The denials happen for a range of reasons, including electronic prior authorization issues, incomplete information, lack of medical necessity, and lack of Medicare coverage.

If a provider is prohibited from stopping a medication just because another doctor has prescribed it, then this takes rights away from the other provider. The way that the bill is written would not allow a provider to take a patient off methadone, even if that is what the patient wants.

(Other) It was not the bill's intent to cover hospitals, so they should be exempted. The bill intends to let patients know that other options exist for treatment and there may need to be an amendment to make sure that intent is recognized.

Persons Testifying: (In support) Representative Lauren Davis, prime sponsor; Shaena Garberich, Oxford Fundraising Chapter 30; Joe Barrett, Key Recovery and Life Skills Center; Teri Hardy, Valley Cities; Paulette Chaussee, Washington Recovery Alliance; Lindsey Arrington, Hope Soldiers; and Jennifer Hutchinson.

(Opposed) Jessica Molberg, Coordinated Care; Eileen Newton, Evergreen Recovery Centers; Jennifer Ziegler, Association of Washington Health Care Plans; and Sasha Waring.

(Other) Katie Kolan, Washington State Hospital Association.

Persons Signed In To Testify But Not Testifying: None.