# HOUSE BILL REPORT
# 2SSB 6228

**As Passed House - Amended:**
February 29, 2024

**Title:** An act relating to treatment of substance use disorders.

**Brief Description:** Concerning treatment of substance use disorders.

**Sponsors:** Senate Committee on Ways & Means (originally sponsored by Senators Dhingra, Hasegawa, Kuderer, Lovelett, Nobles, Randall, Shewmake, Valdez and Wilson, C.).

**Brief History:**
**Committee Activity:**
Health Care & Wellness: 2/20/24, 2/21/24 [DPA];
Appropriations: 2/23/24, 2/26/24 [DPA(APP w/o HCW)].
**Floor Activity:**
Passed House: 2/29/24, 84-8.

**Brief Summary of Second Substitute Bill**
**(As Amended by House)**

- 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 certain behavioral health agencies to provide patients seeking treatment for opioid use disorder or alcohol use disorder with education related to clinically appropriate pharmacological treatment options.
- 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.
- Requires the PEBB, private health insurers, and Medicaid managed care

*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.*

organizations to reimburse hospitals and psychiatric hospitals that bill on an outpatient basis for opioid overdose reversal medications dispensed or distributed to a patient and for the administration of long-acting injectable buprenorphine.

- Directs the Health Care Authority (Authority) 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.
- Directs the Authority to conduct a gap analysis of nonemergency transportation benefits for Medicaid enrollees.
- Requires the Authority to contract for the development of a training program for licensed social workers who practice in an emergency department with responsibilities related to involuntary civil commitments and requires that the social worker complete the training every three years.

## HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

**Majority Report:** Do pass as amended. Signed by 11 members: Representatives Riccelli, Chair; Bateman, Vice Chair; Bronoske, Davis, Macri, Mosbrucker, Orwall, Simmons, Stonier, Thai and Tharinger.

**Minority Report:** Do not pass. Signed by 1 member: Representative Schmick, Ranking Minority Member.

**Minority Report:** Without recommendation. Signed by 5 members: Representatives Hutchins, Assistant Ranking Minority Member; Caldier, Graham, Harris and Maycumber.

**Staff:** Chris Blake (786-7392).

## HOUSE COMMITTEE ON APPROPRIATIONS

**Majority Report:** Do pass as amended by Committee on Appropriations and without amendment by Committee on Health Care & Wellness. Signed by 19 members: Representatives Ormsby, Chair; Bergquist, Vice Chair; Gregerson, Vice Chair; Macri, Vice Chair; Berg, Callan, Chopp, Davis, Fitzgibbon, Lekanoff, Pollet, Riccelli, Ryu, Senn, Simmons, Slatter, Springer, Stonier and Tharinger.

**Minority Report:** Do not pass. Signed by 1 member: Representative Couture, Assistant Ranking Minority Member.

**Minority Report:** Without recommendation. Signed by 9 members: Representatives Corry, Ranking Minority Member; Chambers, Assistant Ranking Minority Member; Connors, Assistant Ranking Minority Member; Harris, Rude, Sandlin, Schmick, Stokesbary and Wilcox.

**Staff:** Andy Toulon (786-7178).

**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.

The American Society of Addiction Medicine Criteria.
The American Society for Addiction Medicine (ASAM) is a medical society that publishes criteria related to the placement, continued service, and transfer of patients with substance use disorders and co-occurring disorders. In 2020 the Health Care Authority (Authority) and the Office of the Insurance Commissioner were directed in legislation to adopt a single standard set of criteria to define medical necessity for substance use disorder treatment and to define substance use disorder levels of care in Washington by January 1, 2021, following an independent review of rules and practices. The ASAM's criteria was selected as this single standard in agency rules.

Nonemergency Transportation.
Under the Medicaid program, the Authority reimburses ground ambulance services for medically necessary ambulance transportation to the closest provider that can meet the client's needs. The Authority covers ground ambulance services for both emergency medical transportation and nonemergency medical transportation for basic life support, advanced life support, and specialty care transport. For nonemergency medical transportation, the Authority pays for ground ambulance transportation in several circumstances, including medically necessary ambulance transportation for both voluntary and involuntary behavioral health services. For voluntary behavioral health services, this includes taking the client to the hospital for a voluntary inpatient behavioral health stay. For involuntary behavioral health services, this includes transporting the client to and from certain locations including emergency room departments, court competency hearings, evaluation and treatment facilities, state hospitals, secured detoxification facilities, or crisis response centers.

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

Certain behavioral health agencies must provide patients seeking treatment for opioid use disorder or alcohol use disorder with education related to pharmacological treatment options specific to the patient's condition. The requirement applies to behavioral health agencies providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services, other than behavioral health agencies that are units within a hospital or psychiatric hospital. The education must include an unbiased explanation of all recognized forms of treatment approved by the federal Food and Drug Administration that are clinically appropriate for the patient. Behavioral health agencies may use patient-shared decision-making tools prepared by the Institute. If the patient chooses a pharmacological treatment option, the behavioral health agency must support the patient with the implementation of the treatment either by directly providing the medication or through a warm handoff referral.

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. If the behavioral health agency fails to meet the education and facilitation requirements, it 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.

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 according to directions must first engage in individualized, patient-centered shared decision-making with the patient. With the patient's consent, the withdrawal management provider may consult the prescribing health care provider. Withdrawal management providers may not categorically require all patients to discontinue all psychotropic medications.

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, hospitalization, or inpatient treatment, 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 Health Care Authority (Authority), in collaboration with 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 Authority must report to the appropriate legislative committees by December 1, 2024.

Reimbursement for Opioid Overdose Reversal Medications and Long-Acting Injectable Buprenorphine.
Insuring entities must reimburse hospitals and psychiatric hospitals that bill on an outpatient basis for opioid overdose reversal medications dispensed or distributed to a patient and for the administration of long-acting injectable buprenorphine. The Authority must establish

billing codes for hospitals and psychiatric hospitals that administer long-acting injectable buprenorphine on an outpatient basis for patients on medical assistance programs.

Use of American Society of Addiction Medicine Criteria.
The Office and the 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.

Transportation Study.
The Authority must conduct a gap analysis of nonemergency transportation benefits for Medicaid enrollees in Washington, Oregon, and other comparison states. The Authority must provide an analysis of the costs and benefits of available alternatives to the Governor and appropriate committees of the Legislature by December 1, 2024. The analysis must include the option of providing an enhanced nonemergency transportation benefit for persons being discharged from a behavioral health emergency services provider to the next level of care when such transportation is necessary to protect the enrollee from relapse or other discontinuity in care. The analysis must also evaluate the possibility of creating a network of peer-led, trauma-informed transportation providers to provide nonemergency transportation to patients receiving medical assistance who are traveling to receive behavioral health services.

Emergency Department Staff Training Regarding Civil Commitments.
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 licensed social workers who practice in an emergency department with responsibilities related to involuntary civil commitments. The training must include instruction emphasizing standards and procedures relating to the civil commitment of persons with substance use disorders and mental illness, including when to summon designated crisis responders.

Each hospital must ensure that, by July 1, 2026, or within three months of hire, all social workers and other personnel employed in the emergency department with responsibilities relating to involuntary civil commitments complete the training every three years.

Substance Use Disorder Professional Fees.
Between July 1, 2024, and July 1, 2029, the certification and certification renewal fee for applicants for certification as either a substance use disorder professional or substance use disorder professional trainee may not exceed $100.

**Appropriation:** None.

**Fiscal Note:** Available. New fiscal note requested on February 28, 2024.

**Effective Date:** The bill takes effect 90 days after adjournment of the session in which the bill is passed. However, the bill is null and void unless funded in the budget.

**Staff Summary of Public Testimony (Health Care & Wellness):**

(In support) Substance use disorder patients may face uncertainty about whether they can stay within a treatment program, what the costs will be, and how to build an outpatient support program if they are discharged due to inability to pay. The uncertainty prohibits patients from fully engaging in treatment due to the fear of being forced to leave at any moment which makes their time in treatment less effective. This bill will reduce the stress on patients, allow them to commit more fully to treatment, and lead to shorter lengths of stay which saves insurance companies money and opens up space for others to receive treatment.

(Opposed) The 14-day mandatory stay creates an assumption that the average length of stay will be longer and this could reduce capacity in the facilities for those that need access. Restricting utilization review prior to 14 days for inpatient and residential substance use disorder treatment could have significant implications for health plans and enrollees by hindering a timely assessment and intervention which could potentially delay access to necessary treatments or adjustments in care plans. A rigid 14-day timeline would not align with the actual clinical needs of individuals receiving this care. A more flexible approach is allowed under legislation passed in 2020 based on individual patient needs and clinical assessment and allows for better resource utilization and a more patient-centered substance use treatment model. The mandate for a specific number of authorized treatment days directly conflicts with the American Society of Addiction Medicine recommendation to tailor care to an individual's needs and puts Medicaid managed care organizations at risk of violating federal requirements to only pay for medically necessary care.

(Other) There is support for the changes to the preauthorization requirements and the clarification that providers must provide education and facilitation for a patient's chosen pharmacological treatment, rather than all types of treatment. The discharge reporting requirement will add to the administrative burdens placed on community behavioral health providers. As the behavioral health system struggles with workforce challenges, behavioral health providers seek to avoid additional administrative burdens, especially when there is no clear objective for how the information will be used. This bill could prevent behavioral health providers and payers from using alternative guidelines to treat patients suffering from addiction issues.

**Staff Summary of Public Testimony (Appropriations):**

(In support) None.

(Opposed) Hospitals offering certain psychiatric services are considered behavioral health organizations and are therefore subject to the bill's requirements and penalties. Several sections of the bill raise operational and cost concerns and have implications for dictating the practice of medicine in ways that are not tracking with what is deemed clinically appropriate, nor sensitive to available resources at this time. The version as it left the Senate was acceptable.

The way the bill is currently drafted lacks clarity regarding whether the 14-day authorization provisions apply to withdrawal management. Increases in the length of stay for some patients creates a capacity problem within the system and the potential that there will not be room for some people who need to get into a facility right away.

The intent of this bill is to ease access to residential treatment by reducing health plan prior authorizations with respect to medical necessity. Several states are facing large-scale fraud perpetrated by inpatient substance use disorder clinics. In California the estimated cost is $100 million, and the scheme is threatening the viability of the individual health insurance market in Alaska. Similar activities are occurring in New York and without clarification that the bill does not apply to withdrawal management, this bill could lead to the expansion of the fraud scheme here in Washington.

Provisions of the amended bill broadly require physicians and other practitioners to prescribe substance use disorder treatment in circumstances that may not be appropriate. These are big new concepts that significantly impact the practice of medicine across specialties and practice settings and do not reflect what is necessary to successfully support patients seeking substance use treatment.

(Other) The bill needs clarification that care guidelines which incorporate ASAM can be used so long as the guidelines incorporate the ASAM standards and are no more restrictive in care coverage. Some guidelines used by health plans may recommend a higher level due to other comorbidities and social determinants of health.

**Persons Testifying (Health Care & Wellness):** (In support) Aaryanna Gariss.

(Opposed) Jennifer Ziegler, Association of Washington Health Care Plans; Marissa Ingalls, Coordinated Care; and Tawnya Christiansen, Community Health Plan of Washington.

(Other) Donna Baker-Miller, MCG Health; and Joan Miller, Washington Council for Behavioral Health.

**Persons Testifying (Appropriations):** (Opposed) Katie Kolan, Washington State Hospital Association; Jennifer Ziegler, Association of Washington Health Care Plans; Gary Strannigan, Premera Blue Cross; and Sean Graham, Washington State Medical Association.

(Other) Donna Baker-Miller, Milliman Care Guidelines Health.

**Persons Signed In To Testify But Not Testifying (Health Care & Wellness):** None.

**Persons Signed In To Testify But Not Testifying (Appropriations):** None.