HOUSE BILL REPORT
2SSB 6228

As Reported by House Committee On:
Health Care & Wellness

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].

Brief Summary of Second Substitute Bill
(As Amended by Committee)

- 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 health care providers, hospitals, and 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.
- Requires the PEBB, private health insurers, and Medicaid managed care organizations to reimburse hospitals and psychiatric hospitals that bill for opioid overdose reversal medications dispensed or distributed to a

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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.

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.
- Directs the Authority to contract with organizations to: convene focus groups to make recommendations on improving experiences and outcomes for civil commitment patients, and develop a proposal for a statewide network of secure, trauma-informed transport for civil commitment patients.
- Requires the Authority to contract for the development of a training program for licensed social workers and other personnel who practice in an emergency department with responsibilities related to involuntary civil commitments and requires the staff to 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).

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 and medical providers 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, as well as physicians, osteopathic physicians, advanced registered nurse practitioners, physician assistants, and hospitals. 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 and medical providers may use patient-shared decision-making tools prepared by the Institute. If the patient chooses a pharmacological treatment option, the behavioral health or medical provider must support the patient with the implementation of the treatment.

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 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 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 Studies.

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.

The Authority must contract with an organization to develop a proposal for a statewide network of secure, trauma-informed transport for civilly committed patients that is provided by a nonambulance service and available in each behavioral health administrative services organization. The contracted organization must consult with people with lived experiences of receiving transport in connection with a civil commitment. The Authority must issue a report to the Governor and the relevant committees of the Legislature on the recommendations by September 1, 2025.

Civil Commitment Focus Group.
The Authority is directed to contract with a peer-led organization to convene focus groups of people with lived experience of being civilly committed to make recommendations about how to make the process less traumatic and improve experiences and outcomes for patients. The focus groups should include individuals who have been civilly committed based on a mental disorder and based on substance use disorder. The Authority must issue a report to the Governor and the relevant committees of the Legislature on the recommendations by September 1, 2025.

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 and other personnel 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. In addition, the training must include instruction on the careful documentation of patient behaviors and statements made outside of the presence of a designated crisis responder which may be relevant to potential civil commitment.

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.

Amended Bill Compared to Second Substitute Bill:

The amended bill directs behavioral health agencies to submit policies to the Department of Health (Department) related to the transfer or discharge of a person without their consent and requires the Department to adopt a model policy based on the submitted policies. Behavioral health agencies must report to the Department each time a person is discharged or transferred without their consent, or they leave treatment prematurely.

The amended bill requires that certain medical and behavioral health providers provide patients seeking treatment for opioid use disorder or alcohol use disorder with education regarding pharmacological treatment options. The requirement applies to physicians, osteopathic physicians, advanced registered nurse practitioners, physician assistants, hospitals, and behavioral health agencies providing voluntary inpatient or residential substance use disorder treatment services or withdrawal management services. The Addictions, Drug, and Alcohol Institute at the University of Washington must create a patient-shared decision-making tool for use in discussions of medication treatment options for alcohol use disorder.

The amended bill requires that if a behavioral health provider providing withdrawal management services seeks to discontinue usage or reduce the dosage of a medication for a patient, then the withdrawal management provider must engage in individualized, shared decision-making with the patient and, with the patient's consent, make a good faith effort to consult the prescribing health care provider.

The amended bill removes the provision eliminating the limit on the number of times that a credential may be renewed for certain behavioral health professionals practicing in a trainee or associate capacity.

The amended bill directs the Health Care Authority (Authority) to contract with a peer-led organization to conduct focus groups with people with lived experience of being civilly committed for behavioral health conditions. The focus group must discuss ways to make the process less traumatic and ways to improve experiences and outcomes. The Authority must submit a report by September 1, 2024.

The amended bill directs the Authority to contract with an organization for the development of a proposal for a statewide network of secure, trauma-informed transport for patients who have been civilly committed for behavioral health conditions. The Authority must submit a report with recommendations by September 1, 2024.

The amended bill directs the Authority to contract with an association that represents designated crisis responders to develop and deliver a training program for social workers and other hospital staff who practice in an emergency department with responsibilities related to civil commitments. The training must include instruction on standards and procedures related to the civil commitment of persons with behavioral health conditions and when to summon designated crisis responders. By July 1, 2026, hospitals must ensure that the staff receive the training within three months of hire and every three years.

The amended bill requires the Public Employees Benefits Board, private health insurers, and Medicaid managed care organizations to reimburse hospitals that bill for opioid overdose reversal medications and long-acting injectable buprenorphine.

The amended bill replaces the direction to the Authority to develop standardized clinical documentation requirements for initial and concurrent utilization management review for residential substance use disorder treatment with a work group convened by the Authority to develop recommendations to streamline the requirements and processes with a report due December 1, 2024.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 21, 2024.

Effective Date of Amended Bill: 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:

(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.

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