Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 2642

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

Sponsors: Representatives Davis, Cody, Chopp, Harris, Leavitt, Caldier, Smith, Goodman, Orwall, Thai, Macri, Stonier, Schmick, Tharinger, Riccelli, Robinson, Griffey, Graham, Appleton, Callan, Irwin, Bergquist, Lekanoff, Barkis, Senn, Doglio, Walen, Peterson, Ormsby and Pollet.

Brief Summary of Bill

- Establishes minimum coverage times before prior authorization requirements may be enforced for services in a substance use disorder residential treatment facility or withdrawal management services in a withdrawal management program.
- Establishes timelines for substance use disorder facilities to submit admissions materials to payers and for payers to make medical necessity determinations.

Hearing Date: 1/29/20

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 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 managed care organizations which oversee the delivery of mental health and substance use disorder services for adults and children in a particular geographic region. Substance use disorder services are determined upon assessment of the client and may include outpatient

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treatment, withdrawal management 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 an approved treatment program.
- 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 Bill:

The Public Employees Benefits Board, School Employees Benefits Board, private health insurers, and Medicaid managed care organizations may not require prior authorization for a set amount of time for their enrollees receiving certain substance use disorder treatment services. The prior authorization limitation applies to: (1) the first two business days, excluding weekends and holidays, of services in a licensed substance use disorder residential treatment facility; and (2) the first five days, excluding weekends and holidays, of withdrawal management services in a licensed withdrawal management program. Once the specified time period has passed, the payer may initiate utilization management review procedures if the provider requests continuing substance use disorder treatment services.

Within two business days of admission, the facility providing services must provide the payer with notification of admission, initial assessment, and the initial treatment plan. If the payer determines within 24 hours of receiving the materials that that the admission to the facility was not medically necessary or clinically appropriate, the payer is not responsible for any payments to the facility beyond the initial two- or five-day admission period. If the payer determines that that the admission to the facility was not medically necessary or clinically appropriate more than 24 hours after receiving the materials, the payer must pay for any services provided by the facility from the receipt of the materials until the time that the review was completed.

The enrollee's use of stimulants may not be the sole reason for determining that admission to a withdrawal management facility is not medically necessary or clinically appropriate. The enrollee's decision to begin medication-assisted treatment for opioid use disorder may not be the sole reason for determining that admission to a withdrawal management facility is not medically necessary or clinically appropriate.

If a patient is at an addiction stabilization facility and the recommended plan of treatment is for placement in a different facility or lower level of care, the payer's care coordination unit must work with the facility to make arrangements for a seamless transfer to an appropriate and available facility as soon as possible. If an in-network, alternative provider is not available, the payer must continue to pay the facility until an alternative arrangement is made.

Appropriation: None.

Fiscal Note: Requested on January 22, 2020.

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