HOUSE BILL REPORT
ESHB 2642

As Passed Legislature

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: House Committee on Health Care & Wellness (originally sponsored by 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 History:

Committee Activity:

Health Care & Wellness: 1/29/20, 2/7/20 [DPS];
Appropriations: 2/10/20, 2/11/20 [DPS(HCW)].

Floor Activity:

Passed House: 2/14/20, 94-4.
Senate Amended.
Passed Senate: 3/6/20, 48-0.
House Concurred.
Passed House: 3/10/20, 97-0.
Passed Legislature.

Brief Summary of Engrossed Substitute Bill

- Establishes minimum coverage times before utilization review may be conducted for withdrawal management or inpatient or residential substance use disorder treatment services.
- Establishes timelines for behavioral health agencies to submit admissions materials to payers and for payers to make medical necessity determinations.
- Directs the Health Care Authority to develop an action plan to support improved transitions between different levels of care, including addressing barriers to facilitating transfers to appropriate levels of care.

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

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 13 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, Chopp, Davis, Harris, Riccelli, Robinson, Stonier, Thai and Tharinger.

Staff: Chris Blake (786-7392).

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The substitute bill by Committee on Health Care & Wellness be substituted therefor and the substitute bill do pass. Signed by 27 members: Representatives Ormsby, Chair; Robinson, 1st Vice Chair; Bergquist, 2nd Vice Chair; Rude, Assistant Ranking Minority Member; Caldier, Chopp, Cody, Corry, Dolan, Dye, Fitzgibbon, Hansen, Hudgins, Kilduff, Kraft, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Schmick, Senn, Springer, Steele, Sullivan, Tarleton and Tharinger.

Minority Report: Do not pass. Signed by 5 members: Representatives Stokesbary, Ranking Minority Member; Chandler, Hoff, Sutherland and Ybarra.

Staff: Andy Toulon (786-7178).

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 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 Engrossed Substitute Bill:

The Public Employees Benefits Board, School Employees Benefits Board, private health insurers, and Medicaid managed care organizations may not require prior authorization for patients receiving withdrawal management or inpatient or residential substance use disorder treatment services. In addition, they may not conduct utilization review for: (1) at least two business days, excluding weekends and holidays, in a behavioral health agency for inpatient or residential substance use disorder treatment services; and (2) at least three days in a behavioral health agency for withdrawal management services. Once the specified time period has passed, the payer may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or a lower level of care.

A behavioral health agency must notify a patient's health plan of the admission within 24 hours. The behavioral health agency must provide the payer with its initial assessment and initial treatment plan for the patient within two business days, excluding weekends and holidays, for inpatient or residential substance use disorder treatment services, and within three days for withdrawal management services. The behavioral health agency must document the patient's need for continuing care and justification for level of placement using a standard set of criteria adopted by the Health Care Authority (Authority) and the Office of the Insurance Commissioner.

Upon receipt of materials from the behavioral health agency, a payer may initiate its medical necessity review process according to a standard set of criteria adopted by the Authority and the Office of the Insurance Commissioner. If the payer determines within one business day of receiving the materials that the admission to the facility was not medically necessary, the payer is not responsible for any payments to the behavioral health agency beyond the initial two- or three-day admission period. If the payer makes its medical necessity determination more than one business day after receiving the materials, the payer must pay for any services provided by the behavioral health agency from the time of admission of the patient until the time that the review is complete. If the treatment plan involves the transfer of the patient to a different facility or lower level of care, the payer's care coordination unit must work with the behavioral health agency to make arrangements for a seamless transfer and pay the agency until the transfer is complete. A seamless transfer may include appointments for same day or next day appointments for outpatient care, but excludes nontreatment services.

If the behavioral health agency is not in the patient's network, the health plan is not responsible for paying the agency at a greater rate than would be paid had the agency been in the patient's network. Behavioral health agencies may not balance bill.

The Authority must develop an action plan to support admission to and improved transitions between different levels of care for adults and adolescents, including addressing barriers to facilitating transfers to the appropriate level of care. The Authority must develop the action plan in partnership with the Office of the Insurance Commissioner, Medicaid managed care

organizations, commercial health plans, providers of substance use disorder services, and Indian health care agencies. The action plan must:

- develop systems to allow higher acuity withdrawal management facilities to bill for lower levels of care;
- develop protocols for substance use disorder treatment agencies to provide initial notification to fully insured health plans and managed care organizations regarding an enrollee's admission to an agency;
- facilitate direct transfers to withdrawal management and residential substance use disorder treatment from hospitals and jails;
- address concerns regarding the denial of withdrawal management services based upon a person's drug of choice;
- explore options to allow Medicaid managed care organizations to pay an administrative rate for an enrollee who remains in a higher level care than is necessary until a seamless transfer to an appropriate care level can be made and a similar reimbursement mechanisms for commercial health plans; and
- establish the minimum amount of medical information necessary for utilization review.

It is the stated policy that the state 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. The criteria must be comprehensive, widely understood and accepted in the field, and based on continuously updated research and evidence. By January 1, 2021, the Authority and the Office of the Insurance Commissioner must independently review their regulations and practices.

Appropriation: None.

Fiscal Note: Available.

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

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

(In support) There is not a lot of window to work with when a person with a substance use disorder admits that they need help, and once that window passes they could die. This bill recognizes that the decision to seek substance use disorder treatment is an act of great courage. People in active addiction have a window of willingness for care and if care is not provided within that window they may never have another opportunity to recover. Families with a loved one in active addiction pray for the day when they ask for help.

There are multiple barriers in the health system that make it nearly impossible to access inpatient substance use disorder treatment quickly. This bill will help persons in active addiction get into treatment quickly when they ask for help. For people whose children have lived with substance use disorder and are ready for treatment, the waiting periods for insurance can be a barrier that sends them back to addiction. It can take weeks by the time a person who is ready for substance use disorder treatment makes an appointment for an assessment, shows up for the assessment, and waits for the payer to decide if the person is

sick enough to receive that level of care, and the consequences of that waiting can be disastrous. Because of these barriers, there are no interfacility transfers to withdrawal management programs and in-patient substance use disorder treatment. If someone wants help and they don't have people willing to fight for them it is almost impossible to navigate the system. The intent of the bill is not to circumvent medical necessity or utilization review, but to give the individual an opportunity to be placed in a safe environment while the treatment program works to determine medical necessity and proper placement. There has to be a simpler, easier way to handle people in crisis. State dollars should be put into the substance use disorder system for people in crisis so that Medicaid is not a barrier.

Historically, people have been pre-authorized for residential treatment by a referral source such as a physician, outpatient provider, or detoxification center, which led to smooth transition to inpatient care, faster engagement in treatment, and better success. Under managed care, pre-authorization happens after the client has already arrived at a residential treatment facility and the process can take up to three days, which creates significant uncertainty for the patients and increases the chance that they will leave treatment prior to engagement. This creates a burden on providers to manage the pre-authorization process and provide uncompensated care during the preauthorization period if the case is declined. Most Medicaid plans are pretty good about giving people five to six days of detoxification services. This bill is for outlier plans that have particular barriers to getting treatment, such as fail first requirements. This is not an issue of services being abused and the bill will not impact the heavy screening criteria that providers have in place, so that providers will not haphazardly admit people who do not meet criteria. People who are incarcerated are not able to be assessed for care.

(Opposed) Federal law requires that the Medicaid program manage its medical necessity criteria and the parts of the bill that allow people to be admitted to a program whether or not they use stimulants alone or have an opioid use disorder removes a medical necessity requirement which puts Medicaid dollars at risk. Five days without prior authorization may be appropriate in some instances, but in some cases, it might not be medically appropriate. The move to Medicaid managed care organizations has required more rigorous medical necessity requirements. There is a lot of variation across the state in spending for different substance use disorder treatment services and there is an opportunity through utilization management review to standardize expectation across the state so that everyone has the same access to quality care and there are no disparities in care. Not doing utilization review can put insurers at risk of losing their National Committee for Quality Assurance accreditation.

(Other) This bill is more expansive than the 2018 bill. Health carriers and health plans need to be able to plan, coordinate, and ensure the proper utilization of services in the health care system and this is especially true in the substance use disorder sector where there have been issues with fraud by some facilities. Health carriers and health plans need the ability to refuse payment to facilities that are taking advantage of enrollees and the current draft might encourage this behavior.

Staff Summary of Public Testimony (Appropriations):

(In support) The bill is positive, but needs some refinements to ensure it does not adversely impact current reporting schedules and treatment services.

When one person sought treatment in the service overseas, he was provided treatment without a pre-authorization. There is currently a war when it comes to treating addiction. Many individuals show up for treatment and are turned away because they do not have a pre-authorization. They return to using drugs and sometimes end up dying.

The current system is being driven by insurance rather than by criteria for assessing treatment needs developed by the American Society of Addiction Medicine. It forces organizations to hire more staff to meet the requirements of managed care organizations than for providing patient care. The bill will increase access to care and prevent deaths resulting from a convoluted authorization system.

(Opposed) None.

Persons Testifying (Health Care & Wellness): (In support) Representative Davis, prime sponsor; Paulette Chaussee, Washington Recovery Alliance; Michael Roberts; Gillian Dupuis; Nick Federici, Pioneer Human Services; Scott Munson, Sundown M Ranch; Linda Grant, Evergreen Recovery Centers; and Melody McKee, Olalla Recovery Centers.

(Opposed) Charissa Fotinos, Health Care Authority.

(Other) Christine Brewer, Association of Washington Healthcare Plans.

Persons Testifying (Appropriations): Michael Transue, Seattle Drug and Narcotic Treatment Center; and Kelley Whitty-Sandaker, Sea-Mar Community Health Centers.

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

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