SENATE BILL REPORT
ESHB 2642

As Reported by Senate Committee On:
Behavioral Health Subcommittee to Health & Long Term Care, February 27, 2020

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: Passed House: 2/14/20, 94-4.
Committee Activity: Behavioral Health Subcommittee to Health & Long Term Care: 2/21/20, 2/27/20 [DPA-WM].

Brief Summary of Amended Bill

- Prohibits health plans and managed care organizations from requiring prior authorization for payment for admission to residential substance use disorder treatment or withdrawal management services and provides requirements for the initiation of a utilization review.
- Requires the Health Care Authority and Office of the Insurance Commissioner to adopt a single set of criteria for the use of health plans and behavioral health service agencies to conduct substance use disorder treatment utilization reviews and to determine levels of care.
- Directs the Health Care Authority to develop an action plan to improve the transition of substance use disorder treatment clients between levels of care.

SENATE COMMITTEE ON BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM 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.

Majority Report: Do pass as amended and be referred to Committee on Ways & Means.

Signed by Senators Dhingra, Chair; Wagoner, Ranking Member; Darneille, Frockt and O'Ban.

Staff: Kevin Black (786-7747)

Background: Substance Use Disorders. A substance use disorder is a condition that occurs when the recurrent use of alcohol or drugs causes clinically and functionally significant impairment. Recommended treatment for a substance use disorder may vary, but includes outpatient treatment, medication-assisted therapy, or residential treatment. The kinds of available treatment to an individual may vary depending upon the person's type of health coverage:

- Persons covered by Medicaid 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 (HCA). 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.

Utilization Management. Utilization management (UM) is the evaluation of medical necessity, appropriateness, and efficiency in the use of health care services. Prior authorization or prospective review is a form of UM conducted at the outset of care in order to eliminate or reduce unnecessary services. The outcome of prior authorization can be approval of care recommended by an evaluating provider, denial of coverage for recommended care, or the placement of limitations on recommended care.

American Society of Addiction Medicine Criteria and Levels of Care. ASAM is a professional society of addiction medicine professionals, including physicians, clinicians, and associated professionals. ASAM produces educational materials and reference manuals to guide the practice of substance use disorder treatment. The ASAM criteria is a widely-used, comprehensive set of guidelines for placement, continued stay, and transfer or discharge of clients who have substance use disorders and co-occurring conditions. These criteria are used by trained and licensed substance use disorder professionals to determine an appropriate ASAM level of care for a client on a continuum that runs from early intervention to, in increasing levels of intensity, outpatient services, intensive outpatient/partial hospitalization, residential/inpatient services, and medically managed intensive inpatient services.

Use of ASAM Criteria in Washington. The Office of the Insurance Commissioner (OIC) has adopted ASAM criteria by regulation as defining source document to determine medical necessity for substance use disorder treatment for health carriers in Washington. The Department of Health requires all licensed substance use disorder professionals and substance use disorder trainees to receive education and training on ASAM criteria. The HCA uses ASAM criteria to determine eligibility for supported employment services, community support services, and the chemical-using pregnant women program. Enacted statutes require use of ASAM criteria to determine effective treatment plans for persons with opioid treatment disorder and require education about ASAM criteria as a component of required training for co-occurring disorder specialists.

Summary of Amended Bill: Effective January 1, 2021, health plans offered to public employees, Medicaid enrollees, or on the commercial market are prohibited from requiring prior authorization for residential substance use disorder treatment services or withdrawal management services provided by a behavioral health service agency located within Washington State.

Health plans and Medicaid managed care organizations (MCOs) must cover residential substance use disorder treatment for at least two days excluding weekends and holidays, and must cover withdrawal management services for at least three days, before conducting a utilization review. If the health plan determines that the enrollee's admission was not medically necessary it must still pay for the treatment days expended before the utilization review, and for additional days if the denial comes more than one business day after the start of the utilization review period. The health plan or MCO must provide an adverse benefit determination to the agency in writing during this period or pay for the days of treatment until it is provided.

When a health plan enrollee is admitted to a out-of-network treatment facility within Washington, the health plan or MCO is not responsible for reimbursing the facility at a higher rate than it pays for in-network services and the facility may not balance bill the client.

If the utilization review results in approval of treatment provided at a different facility or at a lower level of care, the health plan or MCO must make arrangements for the seamless transfer of the enrollee to an appropriate and available facility or lower level of care. The plan must continue to cover the cost of care during the seamless transfer period and an MCO must provide payment at the service level. A seamless transfer may include same-day or next-day appointments for outpatient care and this requirement does not obligate payment for nontreatment services such as housing.

The admitting facility must notify the health plan or MCO within 24 hours of the admission and provide sufficient information to enable the utilization review within two business days, excluding weekends and holidays. These requirements do not prevent the health plan or MCO from denying coverage based on insurance fraud.

HCA and the Office of the Insurance Commissioner must review their regulations and practices by January 1, 2021, to designate a single standard set of criteria to define medical

necessity for substance use disorder treatment and to define substance use disorder levels of care for use by health plans, MCOs, and behavioral health service agencies. These criteria must be used for utilization reviews under this act. HCA may make rules to promulgate this standard.

HCA must collaborate with the Office of the Insurance Commissioner, Medicaid managed care organizations, commercial health plans, substance use disorder treatment providers, and Indian health care providers to develop an action plan to support improved transitions between levels of care for both adults and adolescents. The action plan must include: identification of barriers; specific actions to remove barriers and help persons successfully transition between levels of care; allowing higher acuity facilities to bill for lower levels of care; establishing an administrative rate for substance use disorder treatment providers; standardizing forms of communication between health plans and substance use disorder treatment providers; and addressing denials of withdrawal management services based on the client's drug of choice. HCA must develop options by December 1, 2020.

EFFECT OF BEHAVIORAL HEALTH SUBCOMMITTEE TO HEALTH & LONG TERM CARE COMMITTEE AMENDMENT(S):

- Requires HCA and the Office of the Insurance Commissioner to adopt a single set of criteria to define medical necessity and levels of care for substance use disorder treatment for use by health plans, MCOs, and behavioral health service agencies, and removes references to ASAM criteria.
- Removes requirements for coverage of transportation between substance use disorder treatment facilities.
- Requires a health plan or MCO to provide timely notice to a behavioral health service agency in writing of an adverse benefit determination to avoid liability for payment.
- Specifies that an MCO's obligation to pay for treatment during a seamless transfer must be at the service level.
- Standardizes terminology and makes technical corrections.

Appropriation: None.

Fiscal Note: Available. New fiscal note requested on February 20, 2020.

Creates Committee/Commission/Task Force that includes Legislative members: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony on Engrossed Substitute House Bill: *The committee recommended a different version of the bill than what was heard.* PRO: This bill recognizes that individuals in addiction have a window of willingness that is fleeting. If we do not provide them access to care within that window, we may never get a second chance. The system is clunky, with paperwork and assessments that must be conducted only in an outpatient setting, prohibiting seamless transitions from jail or medical beds. The bill is designed to be centered around patients and families in crisis. Addiction providers and health plans have worked tirelessly to come to an agreement. We are seeking an amendment to incorporate final changes. Imagine your child is wasting away and withdrawn from their

family. You have done everything you can do to help them and finally they tell you they are ready. Then you have to struggle with insurance companies and they tell you to wait three days for prior authorization. There is no truth to the popular belief that if someone wants help they can just get it. It is near impossible to navigate the system without someone fighting for you. When people do get help at the right time, they can and do recover. We need to reduce barriers to treatment. I am a grieving mother living a nightmare. I told my son we could handle this as a family but our insurance company told us they would not offer him a treatment bed for 29 days. He turned gray and detoxed in my living room. After 25 days he lost hope and died by suicide. The insurance company meets its own access to care standard less than half the time and does not have enough doctors. This law will save lives. When my daughter was ready and willing the barriers to accessing inpatient addiction treatment caused her to be discharged without a plan for detox or treatment. When we got her into detox months later, she begged to be transferred directly to an inpatient facility, but the detox was unable to navigate the hurdles. Please do not let it be too late for someone else's child. The inpatient residential substance abuse facility I own was always full until January 2020 when the managed care organizations took over behavioral health authorizations. I have waiting lists of people wanting to get in but I can not keep the beds full because we lose patients while they wait to get insurance company authorizations. If there is a wait for an appointment, may people will not make it there. As a provider it does not create a bonus for us to have to discharge someone after just three days. There is little transparency when we get an adverse determination. Some insurance companies are way worse than others about denials.

OTHER: We are working on technical changes with the prime sponsor which we are hope to get resolved related to out-of-network transportation and medical necessity standards.

Persons Testifying: PRO: Representative Lauren Davis, Prime Sponsor; Paulette Chaussee, Washington Recovery Alliance; Rachel Smith, citizen; Gillian Dupuis, citizen; Dennis Neal, Northwest Resources II; Scott Munson, Sundown M Ranch; Melody McKee, Olalla Recovery Centers.

OTHER: Christine Brewer, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: No one.