FINAL BILL REPORT
2SSB 6228

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Synopsis as Enacted

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.).

Senate Committee on Health & Long Term Care
Senate Committee on Ways & Means
House Committee on Health Care & Wellness
House Committee on Appropriations

Background: Substance Use Disorder. A substance use disorder (SUD) is a diagnosis of a pathological pattern of behavior in which a person continues to use a substance despite experiencing significant substance-related problems, causing a cluster of cognitive, behavioral, and and physiological symptoms.

Health Plans. Three categories of health plans available in Washington, among others, are:
- Medicaid plans administered by managed care organizations (MCOs) which contract with the Health Care Authority (HCA) to provide publicly-funded insurance to enrollees who qualify based on income, age, or disability, the cost of which is divided by the state and federal governments as described by a negotiated agreement referred to as the Medicaid State Plan;
- insurance provided to public employees, school employees, and their families and dependents administered by the Public Employees Benefits Board (PEBB) and School Employees Benefits Board (SEBB); and
- private health plans sold by health carriers to individual consumers.

Utilization Management and Substance Use Disorders. Utilization management is a managed care technique which allows a health insurance company to manage the cost of health care benefits by assessing the appropriateness of care using evidence-based techniques or guidelines. When the assessment is required before care is started as a prerequisite to payment it is referred to as prior authorization. According to Washington

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law, health plans issued under Medicaid, PEBB, SEBB, and by commercial health carriers may not require prior authorization for withdrawal management services or inpatient or residential SUD treatment services. Instead, coverage must be covered for no less than two business days, excluding weekends and holidays, in an inpatient or residential SUD treatment facility, or for no less than three days in a facility which provides withdrawal management. At this point the health plan may initiate a utilization management review of the medical necessity for care. Medical necessity review must be based on a standard set of statewide criteria, which is *The ASAM Criteria* published by the American Society of Addiction Medicine.

The American Society of Addiction Medicine and The ASAM Criteria. The American Society for Addiction Medicine is a medical society with over 7500 members, known for publishing *The ASAM Criteria,* which is the most widely used comprehensive set of standards for placement, continued service, and transfer of patients with SUDs and co-occurring disorders. In 2020, HCA and the Office of the Insurance Commissioner were directed in legislation to adopt a single standard set of criteria to define medical necessity for SUD treatment and to define SUD levels of care in Washington by January 1, 2021, following an independent review of rules and practices. *The ASAM Criteria* was selected as this single standard in rules adopted December 24, 2020.

Substance Use Disorder Professionals and Trainees. A substance use disorder professional (SUDP) is a professional certified in SUD counseling. SUDPs must hold an associates degree or have completed 90 quarter or 60 semester college credits, including 45 quarter or 30 semester credit hours in topics related to SUD counseling. An SUDP must additionally undergo up to 2500 hours of supervised training, undergo a character and fitness review, and pass a jurisprudential exam. Alternative training and educational requirements are available. An SUDP trainee is a person who declares they are enrolled in an approved educational program and is working to gain the education and experience required for SUDP certification.

Fees for Substance Use Disorder Professional and Trainee Certification. Washington law requires the cost of professional licensing to be fully borne by the members of that profession, including the cost of investigations and discipline in response to adverse information and complaints. Exceptions in law to this principle have been infrequently made, including for certified peer specialists, certified peer specialist trainees, and midwives. According to the Department of Health's website the total fee to certify as an SUDP is currently $555 and the renewal cost is $300. The fee to certify as an SUDP trainee is $110 and the renewal cost is $90.

Summary: When a health plan or MCO issued on or after January 1, 2025, conducts a utilization management review which authorizes inpatient or residential SUD treatment, the health plan or MCO must authorize treatment for a minimum 14-day period from the start of treatment. Any subsequent authorization must be for a minimum of seven days of treatment. The health plan or MCO may not consider the person's length of stay in treatment

at a behavioral health agency when authorizing continuing care at the behavioral health agency.

HCA and the Office of the Insurance Commissioner (OIC) may jointly determine when updates to *The ASAM Criteria* must be applied as the single standard set of criteria to determine medical necessity for SUD treatment in Washington, in place of the previous edition. No health plan or MCO may make a determination that a person does not meet medical necessity criteria based primarily on the person's length of abstinence from substance use. If the abstinence was due to incarceration, inpatient treatment, or hospitalization, it may not be considered.

The certification fee for an SUPD or SUPD trainee is capped at $100 for five years, from July 1, 2024 through July 1, 2029, subject to amounts appropriated for the specific purpose.

A behavioral health agency (BHA) which provides voluntary inpatient or residential SUD treatment or withdrawal management services must submit its policies regarding involuntary transfer or discharge of a patient to DOH by October 1, 2024. A BHA which provides these services may not disqualify a person from admission to the agency based solely on prior instances of the person leaving the agency against clinical advice. DOH must adopt a model patient involuntary transfer or discharge policy for BHAs which provide these services by April 1, 2025, including use of therapeutic progressive disciplinary procedures. A BHA which provides these services must report each instance of involuntary transfer or discharge of a patient, or of a voluntary departure against clinical advice, to DOH using a standard form to be developed by DOH, beginning July 1, 2025. These reports are exempted from public disclosure.

The Addictions, Drug & Alcohol Institute at the University of Washington (ADAI) must create a shared decision-making tool to assist providers with discussing medication treatment options with patients related to alcohol use disorders. ADAI must conduct regular evaluations to update the tool.

A BHA which treats patients for an alcohol or opioid use disorder must provide patients with unbiased education related to clinically appropriate pharmacological treatment options. If the patient chooses the medication treatment option, the BHA must provide the medication directly or by a warm handoff referral.

A withdrawal management provider must make a good faith effort to consult a patient's health care provider and engage in individualized, nonjudgmental shared decision-making before assisting a patient in discontinuing or reducing the dosage of a prescribed medication. The provider is prohibited from categorically requiring patients to discontinue all psychotropic medications.

HCA must contract with the Washington Association of Designated Crisis Responders (WADCR) to develop a training for emergency department social workers with

responsibilities related to involuntary civil commitment by July 1, 2025, to be delivered by WADCR. All such emergency department social workers must receive this training by July 1, 2026, or within three months of hire, and repeat the training every three years thereafter.

Health carriers and MCOs must reimburse hospitals and psychiatric hospitals for the outpatient services of dispensing opioid overdose reversal medication and administering long-acting injectable buprenorphine, separate from any bundled payment arrangements, effective January 1, 2025.

HCA, in collaboration with OIC and in consultation with MCOs, health plans, and SUD residential and inpatient providers must convene a work group and submit recommendations to the Legislature by December 1, 2024, relating to standardizing clinical documentation requirements for initial authorization and concurrent utilization review for residential SUD treatment.

HCA must conduct a feasibility study for creating a network of peer-led trauma informed nonemergency transportation providers for behavioral health services clients under Medicaid and provide it to the Legislature by December 1, 2024.

HCA must provide a gap analysis to the Governor and Legislature by December 2, 2024, of nonemergency transportation benefits provided to Medicaid enrollees in Washington, Oregon, and other comparison states. The gap analysis must consider the costs and benefits of available alternatives and the option for an enhanced nonemergency transportation benefit for persons being discharged from a behavioral health emergency services provider to the next level of care.

Votes on Final Passage:

Senate	49	0	
House	84	8	(House amended)
Senate	49	0	(Senate concurred)

Effective: June 6, 2024