SENATE BILL REPORT
SB 6150

As Reported by Senate Committee On:
Health & Long Term Care, January 30, 2018
Ways & Means, February 6, 2018

Title: An act relating to opioid use disorder treatment, prevention, and related services.

Brief Description: Concerning opioid use disorder treatment, prevention, and related services.

Sponsors: Senators Cleveland, Rivers, Carlyle, Kuderer, Fain, Hasegawa, Mullet, Saldaña, Conway, Van De Wege, Chase, Keiser and Liias; by request of Governor Inslee.

Brief History:
Committee Activity: Health & Long Term Care: 1/15/18, 1/30/18 [DPS-WM, w/oRec]. Ways & Means: 2/05/18, 2/06/18 [DP2S].

Brief Summary of Second Substitute Bill

- Modifies the protocols for using medication-assisted treatment for opioid use disorder.
- Requires the Department of Social and Health Services (DSHS), the Health Care Authority (HCA), and the Department of Health (DOH) to partner on initiatives that promote a statewide approach in addressing opioid use disorder.
- Permits the Secretary of Health to issue a standing order for opioid reversal medication.
- Establishes new requirements for how electronic health records integrate with the prescription monitoring program (PMP) and how PMP data can be used.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 6150 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Kuderer, Vice Chair; Rivers, Ranking Member; Conway, Fain, Keiser, Mullet and Van De Wege.

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.

Minority Report: That it be referred without recommendation.
Signed by Senators Bailey and Becker.

Staff: LeighBeth Merrick (786-7445)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: That Second Substitute Senate Bill No. 6150 be substituted therefor, and the second substitute bill do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair; Braun, Ranking Member; Bailey, Becker, Billig, Brown, Carlyle, Conway, Darneille, Fain, Hasegawa, Hunt, Keiser, Mullet, Palumbo, Pedersen, Ranker, Rivers, Schoesler, Van De Wege, Wagoner and Warnick.

Staff: Sandy Stith (786-7710)

Background: Opioid Treatment Programs. Currently, the statute provides that there is no fundamental right to medication-assisted treatment for opioid use disorder; treatment should only be used for participants who are deemed appropriate to need this level of intervention; alternative options, like abstinence, should be considered when developing a treatment plan; and if medications are prescribed, follow up must be included in the treatment plan in order to work towards the primary goal of abstinence.

DSHS certifies opiate substitution treatment programs.

Hub and Spoke Model. Hubs are regional centers serving a defined geographical area that support spokes. Hubs are responsible for ensuring that medication assisted treatments are available. Spokes are facilities that provide behavioral health treatment and primary health care to patients referred to them by the hub.

Washington State Opioid Response Plan. Several state agency members of the Department of Health's Opioid Response Workgroup developed a statewide working plan for opioid response. On September 30, 2016, Governor Jay Inslee signed Executive Order 16-09, Addressing the Opioid Use Public Health Crisis, formally directing activities and state agencies in accordance with the Washington State Opioid Response Plan. In November 2016, state agency members revised the Washington State Opioid Response Plan to align with the executive order and activities directed by federal grants received in 2016.

PMP. DOH maintains a PMP to monitor the prescribing and dispensing of all Schedules II, III, IV, and V controlled substances. Information submitted for each prescription must include at least a patient identifier, the drug dispensed, the date of dispensing, the quantity dispensed, the prescriber, and the dispenser. With certain exceptions, prescription information submitted to DOH is confidential. The exceptions allow DOH to provide data in the PMP to:

- persons authorized to prescribe or dispense controlled substances;
- an individual who requests the individual's own records;
- health professional licensing, certification, or regulatory agencies;
- law enforcement officials who are engaged in bona fide specific investigations involving a designated person;

- authorized practitioners of DSHS and the HCA regarding Medicaid recipients;
- the director of the Department of Labor and Industries regarding workers' compensation claimants;
- the director of the Department of Corrections regarding committed offenders;
- entities under court order;
- DOH personnel for the purposes of assessing and administering the program;
- drug testing laboratory personnel in order to determine what medications a patient may be taking;
- a health care facility or provider group of five or more providers in order to provide medical or pharmaceutical care to the facility's patients; and public or private entities for statistical, research, or educational purposes after removing identifying information;
- local health officers of local health jurisdictions for the purposes of patient follow-up and care coordinating following a controlled substance overdose event; or
- the coordinated care electronic tracking program, referred to as the seven best practices in emergency medicine.

Summary of Bill (Second Substitute): DSHS is required to promote the use of medication therapies and other evidence-based strategies that address opioid use disorder, prioritize state resources for the provision of treatment and recovery support services that allow patients to maintain or begin medication therapies while engaging in services, and replicate approaches like the opioid hub and spoke treatment networks.

Opioid treatment programs that utilize medication assistance must educate pregnant clients about the effects that opioid use and medication therapy may have on their baby.

HCA is permitted to solicit, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis. By October 1, 2018, HCA must report to the Legislature their recommendations for addressing nonpharmacologic treatment options for acute, sub-acute, and chronic pain that is not related to cancer.

DOH must work with state agencies to develop a data collection plan for determining the number of opioid-related overdoses of non-English speakers, and submit the recommendations for implementation to the appropriate Legislative committees by December 31, 2018.

The HCA, DSHS, and DOH are authorized to partner on:

- developing a statewide approach to leverage Medicaid funding to treat opioid addiction and provide emergency overdose treatment;
- seeking alternative funding through a Medicaid demonstration waiver to fund an opioid response treatment for persons eligible for Medicaid or during the time of incarceration;
- promoting coordination between medication treatment prescribers and state-certified substance use disorder agencies;
- reviewing and promoting positive outcomes associated with accountable communities for health funded opioid projects and local law enforcement and human services opioid collaborations as set forth in the Washington State Opioid Response Plan;

- promoting access to all effective medications known to address opioid use disorder at state certified treatment programs;
- creating a plan for coordinated purchasing and distribution of opioid overdose reversal medication across the state; and
- establishing a plan to support medication therapies in emergency departments, and same-day referrals to substance use disorder treatment facilities and community-based medication-assisted treatment prescribers.

The Secretary of Health, or a designee, is authorized to issue a standing order for opioid reversal medication to any person at risk of experiencing an opioid related overdose or any person or entity in a position to assist a person at risk of experiencing an opioid-related overdose.

By December 1, 2018, all federally certified electronic health record (EHR) system vendors must ensure that their system can fully integrate with the PMP. Health care providers that use one of the three largest EHRs, as demonstrated by market share, must demonstrate that the EHR is able to integrate by July 1, 2019. DOH shall convene a workgroup to study EHR best practices, and the challenges of PMP integration, and report its findings to the Legislature by November 15, 2018.

DOH is required to establish a separate electronic emergency medical services data system for all licensed ambulance and aid services to report patient encounter data which would include information about fatal and non-fatal overdoses.

For the purposes of quality improvement, patient safety, and care coordination, the HCA director may access PMP information for members of HCA self-funded or self-insured health plans.

EFFECT OF CHANGES MADE BY WAYS & MEANS COMMITTEE (Second Substitute):

- Adds substance use disorder treatment facilities to the list of allied opioid use disorder community partners.
- Clarifies that treatment options available includes both controlled and non-controlled medications.
- Adds language that the EHRs' pricing must be in alignment with current industry pricing for PMP integration.
- Limits PMP integration requirements to the top three EHRs with the largest market share in the state, and extends the due date to July 1, 2019.
- Requires DOH and HCA to convene a stakeholder workgroup to study best practices regarding data sharing, and the challenges associated with PMP integration.
- Requires DOH to submit a report to the Legislature with the workgroup's findings by November 15, 2018.

EFFECT OF CHANGES MADE BY HEALTH & LONG TERM CARE COMMITTEE (First Substitute):

- Requires state agencies to develop a data collection plan for determining the number of opioid related overdoses for non-English speakers.
- Adds contingency sub-sections for subsections 2-5, in the event that HB 1388 is enacted and changes the authority of behavioral health from the Department of Social and Health Services to the health care authority.
- Expands the scope of the nonpharmacologic treatment recommendations for chronic pain to also include acute and sub-acute pain.

Appropriation: None.

Fiscal Note: Available.

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 Original Bill (Health & Long Term Care): *The committee recommended a different version of the bill than what was heard.* PRO: The bill is the next step needed to increase treatment options for people with opioid use disorder. It takes a comprehensive approach and does not duplicate what was passed in HB 1427 last session. New items include giving the health officer a standing order to prescribe naloxone, mandating electronic health record system vendors and health care facilities to use the PMP, and it establishes a statewide mandated electronic data system for emergency medical situations. Treatment needs to be readily available when an addict needs help and the bill provides treatment options for people with opioid-use disorder. The bill makes treatment of opioid use disorder normal and de-stigmatizes medication assistance. It would connect people to care when they need it such as people who are in prison. When people are released from prison they are highly likely to use and linking them to medication assisted treatment prior to their release is critical. The mandate for electronic health record systems to integrate with the PMP is critical so health care providers can intervene with people that maybe using opioids inappropriately. The PMP integration mandate is well-intended but it is costly to implement and maintain. It may be possible for hospitals and large health systems to integrate but it would be challenging for providers in rural areas where connection may be an issue and smaller clinics and dental practices. PMP access should be expanded to licensed behavioral health treatment providers. The bill creates more awareness about opioid use disorder and places a greater focus on non-pharmacologic treatment options. These treatment options are cost-effective alternatives to opioids. The bill should require prescribers to discuss alternative options for pain medication prior to issuing an opioid.

Persons Testifying (Health & Long Term Care): PRO: Senator Annette Cleveland, Prime Sponsor; Katie Kolan, Washington State Medical Association; Lisa Thatcher, Washington State Hospital Association; Nathan Schlicher, Washington State Medical Association; Susie Tracy, Evergreen Treatment Services; Curtis Eschels, Washington East Asian Medicine Association; Michelle Braun, citizen; Frank Dennis, citizen; Lori Grassi, Washington State Chiropractic Association; Melissa Johnson, Physical Therapy Association of Washington; Michael Hatchett, Washington Council for Behavioral Health; Mellani McAleenan, Washington State Dental Association; Tammy Moore, Summit Pacific Medical Center; Caleb Banta-Green, University of Washington, Alcohol and Drug Abuse Institute; John Wiesman,

Secretary of Health; Shannie Jenkins, citizen; Jon Tunheim, Thurston County Prosecutor; Dr. Charissa Fotinos, HCA; Jason McGill, Office of the Governor.

Persons Signed In To Testify But Not Testifying (Health & Long Term Care): No one.

Staff Summary of Public Testimony on First Substitute (Ways & Means): *The committee recommended a different version of the bill than what was heard.* PRO: This is probably one of the more important issues the Legislature will face this session. The Governor's proposal offers many opportunities to address this issue. Methods like hub and spoke allow medication assisted therapy to scale up over time. These types of treatment have shown a two to one return on investment, according to a recent WSIPP study. Other states have done similar things and have shown four times the savings as compared to states that have not provided treatment. We cannot ignore the importance of treatment. The areas of treatment highlighted in this bill and these areas are not mandatory. The are scalable and provide flexibility on the amount of money that can be spent. With the full package, we believe we can reduce the untreated population by up to 20 percent over the next ten years. While we are in favor, we do see this as a mandate on facilities to access the PMP information. There are currently two electronic health records in our state that can access the PMP. This only addresses the larger health system. There are over 100 EHR vendors in our state. It is a great idea, but when we try to figure out how it is going to happen, we do not know yet. There are also still problems with the health information exchange. We do not know the cost and we do not know if it can be done. So, we ask that you remove the obligation. We need data flowing seamlessly into the electronic health records. We suggest one amendment to promote prevention and some restrictions to the number of pills that can be prescribed on the first visit or first prescription. This will have no fiscal impact.

Persons Testifying (Ways & Means): PRO: Lisa Thatcher, Washington State Hospital Association; Jason McGill, Governor’s Office; Jonathan Nichols, Attorney General's Office; Katie Kolan, Washington State Medical Association.

Persons Signed In To Testify But Not Testifying (Ways & Means): No one.