HOUSE BILL REPORT
HB 1331

As Reported by House Committee On:
Health Care & Wellness
Appropriations

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: Representatives Cody, Caldier, Harris, Stonier, Peterson, Irwin, Macri, Mosbrucker, Jinkins, Kilduff, Appleton, Ryu, Davis, Robinson, Eslick, Lekanoff, Thai, Tharinger, Walen, Bergquist, Kloba, Leavitt, Ormsby, Pollet and Wylie; by request of Office of the Governor.

Brief History:
Committee Activity:
Health Care & Wellness: 1/29/19, 2/8/19 [DPS];
Appropriations: 2/26/19, 2/28/19 [DP2S(w/o sub HCW)].

Brief Summary of Second Substitute Bill

- Modifies the protocols for using medications to treat opioid use disorder.
- Permits pharmacists to partially fill certain prescriptions upon patient request.
- Requires prescribers to discuss the risks of opioids with certain patients and provide the patient with the option to refuse an opioid prescription.
- Establishes new requirements for how electronic health records integrate with the prescription monitoring program (PMP) and how PMP data can be used.
- Requires the Health Care Authority and the Department of Health (DOH) to partner and work with other state agencies on initiatives that promote a statewide approach in addressing opioid use disorder.
- Permits the Secretary of the DOH to issue a standing order for opioid reversal medication and requires pharmacists to provide written instructions about responding to an opioid overdose when the medication is dispensed.
- Allows hospital emergency departments to dispense opioid overdose reversal medication when a patient is at risk of opioid overdose.
- Requires city and county jails to provide medication-assisted treatment to certain individuals with opioid use disorder, if funding is provided.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 15 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Caldier, Assistant Ranking Minority Member; Chambers, Davis, DeBolt, Harris, Jinkins, Maycumber, Riccelli, Robinson, Stonier, Thai and Tharinger.

Staff: Kim Weidenaar (786-7120).

Background:

Opioid Treatment Programs.
The Community Mental Health Services Act provides that: (1) there is no fundamental right to medication-assisted treatment (MAT) for opioid use disorder (OUD); (2) treatment should only be used for participants who are deemed appropriate to need this level of intervention; (3) alternative options, like abstinence, should be considered when developing a treatment plan; (4) the main goal of opiate substitution treatment is total abstinence, but recognizes additional goals of reduced morbidity and restoration of the ability to lead a productive and fulfilling life; and (5) if medications are prescribed, follow up must be included in the treatment plan in order to work towards the primary goal of abstinence.

The Department of Social and Health Services (DSHS) certifies opiate substitution treatment programs.

Medications to Treat Opioid Use Disorder.
Medications used to treat OUD, also referred to as MAT, is a form of treatment which uses medications approved by the United States Food and Drug Administration (FDA). Methadone, buprenorphine, and naltrexone are common medications used to treat OUD.

Opioid Overdose Reversal Medication.
A health care practitioner may prescribe, dispense, distribute, and deliver an opioid overdose medication: (1) directly to a person at risk of experiencing an opioid-related overdose; or (2) by collaborative drug therapy agreement, standing order, or protocol to a first responder, family member, or other person in a position to assist a person at risk of experiencing an opioid-related overdose. The practitioner must inform the recipient that as soon as possible after administration, the person at risk of experiencing an overdose should be transported to a hospital or a first responder should be summoned.

Any person or entity may lawfully possess, store, deliver, distribute, or administer an opioid overdose medication pursuant to a practitioner's prescription or order. A pharmacist may dispense an opioid overdose medication pursuant to such a prescription and may administer an opioid overdose medication. The pharmacist must provide written instructions on the proper response to an opioid-related overdose, including instructions for seeking immediate medical attention.

The following individuals are not subject to civil or criminal liability or disciplinary action under the Uniform Disciplinary Act for their authorized actions related to opioid overdose medications or the outcomes of their authorized actions if they act in good faith and with reasonable care: practitioners who prescribe, dispense, distribute, or deliver an opioid

overdose medication; pharmacists who dispense an opioid overdose medication; and persons who possess, store, distribute, or administer an opioid overdose medication.

Medications can be administered to rapidly restore breathing to an individual experiencing an opioid overdose. Narcan, naloxone, and evzio are common opioid overdose reversal medications.

State Opioid Response Plan.
Several state agency members of the Department of Health (DOH) Opioid Response Workgroup developed a statewide plan for opioid response. On September 30, 2016, the Governor signed Executive Order 16-09—Addressing the Opioid Use Public Health Crisis—formally directing activities and state agencies to act 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. The workgroup meets quarterly and updates the plan annually.

Prescription Monitoring Program.
The DOH maintains a prescription monitoring program (PMP) to monitor the prescribing and dispensing of all Schedule II, III, IV, and V controlled substances. Each time one of these drugs is dispensed, the dispenser must electronically submit the following information to the PMP:

- a patient identifier;
- the drug dispensed;
- the dispensing date;
- the quantity dispensed;
- the prescriber; and
- the dispenser.

Prescribers are not required to query the PMP prior to prescribing a controlled substance. Generally, prescription information submitted to the DOH is confidential; however, data in the PMP may be accessed by:

- a person authorized to prescribe or dispense a controlled substance or legend drug for the purpose of providing medical or pharmaceutical care for his or her patients;
- a person requesting his or her own PMP information;
- a health professional licensing, certification, or regulatory agency;
- an appropriate law enforcement or prosecutorial official;
- an authorized practitioner of the DSHS or the Health Care Authority regarding Medicaid recipients;
- the Director of the Department of Labor and Industries (or designee) regarding workers' compensation claimants;
- the Secretary of the Department of Corrections (DOC) (or designee) regarding offenders in the custody of the DOC;
- an entity under grand jury subpoena or court order;
- personnel of the DOH for administration of the PMP or the Uniform Controlled Substances Act;
- certain medical test sites licensed by the DOH;

- a health care facility or entity for the purpose of providing medical or pharmaceutical care to the patients of the facility or entity if the facility or entity is licensed by the DOH or operated by the federal government or federally recognized Indian tribe, and the facility or entity is a trading partner with the Health Information Exchange (HIE);
- a health care provider group of five or more providers for the purpose of providing medical or pharmaceutical care to the patients of the provider group if all of the providers in the group are licensed and the provider group is a trading partner with the HIE;
- the local health officer of a local health jurisdiction for the purposes of patient follow-up and care coordination following a controlled substance overdose event; and
- the coordinated care electronic tracking program, often referred to as the seven best practices in emergency medicine.

Opioid Prescribing Rules.
In 2017 the Legislature passed Engrossed Substitute House Bill 1427 requiring the Medical Quality Assurance Commission; the Board of Osteopathic Medicine and Surgery; the Nursing Care Quality Assurance Commission; the Dental Quality Assurance Commission; and the Podiatric Medical Board to adopt new rules for prescribing opioids by January 1, 2019. The rules establish prescribing and documentation guidelines for varying pain levels—acute, perioperative, subacute, and chronic—and require PMP checks, documentation justifying a prescription, one hour of opioid prescribing continuing education, and providing the patient with resources regarding risks of opioid use and how to safely dispose of the drugs. The rules do not apply to palliative care, in-patient hospital care, procedural medications, and cancer related treatments.

Criminal Justice Treatment Account.
The state funds substance use disorder treatment for certain offenders of the criminal justice system.

Emergency Medications at Hospital Pharmacies.
A hospital may allow prepackaged emergency medications for patients being discharged from the emergency department to be prescribed by practitioners with prescriptive authority and distributed by these practitioners and registered nurses when: (1) community pharmacies and outpatient hospital services are not available within 15 miles by road; or (2) in the judgment of a practitioner and consistent with hospital policies, the patient has no reasonable ability to reach a local community or outpatient pharmacy.

The director of the hospital pharmacy must develop policies and procedures regarding the types of emergency medications to be prepackaged and the criteria under which prepackaged emergency medications may be prescribed and distributed, in addition to other requirements.

Summary of Substitute Bill:

Opioid Use Disorder Treatment.

The state declares that substance use disorders are medical conditions and should be treated in a manner similar to other medical conditions by using interventions that are supported by evidence. This includes using medications approved by the United States Food and Drug Administration (FDA) for the treatment of Opioid use disorder (OUD). Providers must inform patients with OUD and substance use disorder of options to access FDA approved medications for the treatment of OUD and substance use disorder. Opioid use disorder treatment programs may order, possess, dispense, and administer opioid overdose reversal medication and medications approved by the FDA to treat OUD. Registered nurses and licensed practical nurses may dispense up to a 31-day supply of FDA approved medications to patients receiving OUD treatment.

Opioid Use Disorder Treatment for Pregnant and Parenting Individuals.
Opioid treatment programs that provide services to individuals who are pregnant must provide information about the effects opioid use and OUD medication may have on their baby. The Department of Health (DOH) must adopt rules requiring all opioid treatment programs to educate pregnant individuals about the risks to the parent and the fetus of not treating OUD. If a pregnant Medicaid client is identified at risk for OUD, the Health Care Authority (HCA), through the managed care organizations, must provide outreach to the individual. The HCA is required to provide recommendations to the Office of Financial Management by October 1, 2019, on how to better support individuals with OUD who have recently given birth, and newborns of individuals with OUD.

Opioid Prescribing.
Pharmacists are permitted to partially fill a Schedule II controlled substance prescription. The partial fill must be requested by the patient or the prescribing practitioner, and the total quantity dispensed in all partial fillings must not exceed the quantity prescribed. By January 1, 2020, the boards and commissions for the various prescribers must adopt or amend their rules to require opioid prescribers to inform patients of their right to refuse opioid prescriptions. If a patient indicates a desire to not receive an opioid, the prescriber must document the patients request and avoid ordering or prescribing opioids for the patient. The DOH must update its patient materials to reflect a patient's right to refuse an opioid prescription or order.

When prescribing an opioid for the first time during a patient's course of outpatient treatment, practitioners must have a discussion with the patient about the risks of opioids, and about pain management alternatives, and provide patients with a warning statement created by the DOH. Practitioners must document the discussion in the patient's health record. The DOH must review the science, data, and best practices regarding the use of opioids and their associated risks and update the warning as needed.

Electronic prescription systems are no longer required to be approved by the Pharmacy Commission. Pharmacists in charge are no longer required to establish or verify policies to ensure integrity and confidentiality of prescription information electronically transmitted, which employees no longer have to sign and comply with.

Prescription Monitoring Program.
Dispensers are required to submit the necessary prescription information to the prescription monitoring program (PMP) no later than one business day after the date the prescription is

dispensed, or as required by DOH rule, whichever is sooner. By January 1, 2021, all health care facilities, entities, offices, or provider groups with at least 10 providers must demonstrate that their federally certified electronic health record (EHR) system can fully integrate with the PMP. Electronic health record vendors that are fully integrated with the PMP are prohibited from charging an ongoing fee or a fee based on the number of transactions. The total costs for integration must not impose unreasonable costs on any health care providers and must be consistent with industry pricing. The DOH must:

- collaborate with health professional and facility associations, EHR vendors, and other stakeholders to assess the current status of EHR and PMP integration;
- provide recommendations for improving integration among small and rural health providers including establishing a financial assistance program;
- conduct security assessments of other commonly used platforms for integrating EHR and PMP; and
- evaluate options to identify patients in the PMP who do not wish to receive opioids or patients who have had an opioid-related overdose.

Prescription Monitoring Program data may be provided to:

- a health professional licensing, certification, or regulatory agency or entity for use in legal proceedings regarding the license;
- the HCA director, or designee, for Medicaid recipients and members of the HCA's self-funded and self-insured health plans;
- DOH personnel to assess the public health impacts of OUD and to identify possible interventions;
- a licensed, certified or accredited behavioral health facility;
- public or private entities for statistical research, or educational purposes after removing any unique identifiers;
- the Washington State Medical Association for use solely in its coordinated quality improvement program;
- the Department of Social and Health Services (DSHS), the Department of Labor and Industries, and the HCA for data analysis and research approved by Washington State Institutional Review Board for public health purposes to improve the prevention or treatment of substance use disorders; and
- the largest health professional associations representing each of the prescribing professions for the purposes of quality improvement.

The DOH may also enter into agreements to exchange PMP data with PMPs in other states.

State Opioid Response Plan.

The Secretary of the DOH is responsible for coordinating the statewide response plan and must work in partnership with the HCA to execute the plan. State agencies shall promote positive outcomes associated with the accountable communities of health, local law enforcement, and human service collaborations to address OUD. In addition the work already underway by the State Opioid Response Plan, the HCA, and the DOH are provided with additional directives.

The HCA is authorized to:

- work with other state agencies and stakeholders to develop value-based payment strategies for the ongoing care of persons with opioid and other substance use disorders;
- promote the use of medication assisted treatment (MAT) and other evidence-based strategies to address the opioid epidemic and by January 1, 2020, prioritize state resources be provided to treatment settings that allow patients to use MAT while engaging in services;
- seek, receive, and expend alternative sources of funding to support all aspects of the state's response to the opioid crisis;
- partner with the DSHS, Department of Corrections, the DOH, the Department of Children, Youth, and Families to develop a statewide approach to leveraging Medicaid funding to treat OUD and provide emergency overdose treatment;
- replicate effective approaches to broaden outreach and patient navigation with allied OUD community partners;
- work with the DOH to promote coordination between OUD treatment providers;
- work with stakeholders to develop a set of recommendations for the Governor and the Legislature regarding a standard set of services needed to support individuals with OUD in treatment programs and identify what is needed to implement the recommendations;
- partner with the DOH and other state agencies to replicate effective approaches for linking individuals who have had a non-fatal overdose with treatment opportunities, including connecting them to certified peer counselors;
- implement a law enforcement assisted diversion program in two or more geographic areas of the state;
- work with the DOH and managed care organizations to promote access to OUD medications at state-certified opioid treatment centers, and encourage the distribution of naloxone to patients who are at risk of an opioid overdose;
- work with the DOH, the accountable communities of health, and community stakeholders to develop a plan for coordinating purchasing and distributing opioid overdose reversal medication; and
- recommend coverage options for non-pharmacologic treatment options for acute, subacute, and chronic non-cancer pain.

The DOH is authorized to:

- display on its website a warning statement about the risks of opioids and information about the safe disposal of opioids;
- ensure training is available electronically and in a variety of media identifying a person suffering from an opioid-related overdose and the use of opioid overdose reversal medication;
- establish an electronic emergency medical services data system for all licensed ambulance and aid services to report patient encounter data including data on suspected drug overdoses to engage individuals in treatment or other support services through peer professionals, patient navigators, outreach workers, and other professionals as appropriate;
- work with state agencies to develop a plan to increase outreach and education about opioid overdoses to non-English speaking communities and submit the plan with to the appropriate legislative committees by July 1, 2020;

- coordinate with the HCA on a strategy to rapidly deploy a response team to a local community identified as having a high number of fentanyl-related or other drug overdoses; and
- work with the HCA to reduce barriers and promote the use of medication treatment therapies for OUD in emergency departments and same-day referrals to treatment programs.

Opioid Overdose Reversal Medication.
The secretary of the DOH, or 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. Prescribers and dispensers are authorized to provide opioid overdose reversal medication pursuant to a standing order or a collaborative drug therapy agreement to any person at risk of experiencing an opioid overdose or to any person in a position to assist a person at risk of experiencing an opioid overdose. When a pharmacist dispenses an opioid overdose reversal medication, the pharmacist must provide written instructions on the proper response to an opioid-related overdose which must include seeking medical attention.

Hospital emergency departments may dispense opioid overdose reversal medication when the practitioner determines the patient is at risk of an opioid overdose and it is authorized by the hospital's policies and procedures. The Pharmacy Commission prescription labeling requirements do not apply to opioid overdose reversal medications dispensed, distributed, or delivered from an emergency department.

Criminal Justice.
Any region or county that uses state criminal justice treatment account funds to support a therapeutic court must allow therapeutic court participants to use all medication approved by the FDA for the treatment of OUD as deemed medically appropriate. If treatment resources are not available or accessible within the jurisdiction, the HCA's designee must assist the court in acquiring the resource. Subject to appropriated funds or approval of a section 1115 demonstration waiver to fund opioid treatment medications to persons in the custody of jails, city and county jails in Washington provide medication for the treatment of OUD to individuals in the custody of the jail who were receiving medication for the treatment of OUD pursuant to a valid prescription immediately before incarceration or at least 30 days before release when treatment is determined to be medically appropriated, to the extent funds are allocated. City and county jails must make every possible effort to directly connect incarcerated individuals receiving medication for the treatment of OUD to an appropriate provider or treatment site.

Substitute Bill Compared to Original Bill:

The substitute bill:
- updates the definition of opioid-related overdose to remove "extreme physical illness" as a condition and include "non-responsiveness" as a condition;
- exempts the prepackaged opioid overdose reversal medications provided by emergency departments from certain Pharmacy Commission labeling requirements;

- adds patient navigators, outreach workers and other professionals as appropriate to the services that may be provided to an individual identified by the electronic emergency medical services data system;
- changes the date facilities, entities, and provider groups with 10 or more providers must integrate their electronic health record (EHR) with the prescription monitoring program (PMP) to January 1, 2021;
- adds offices and provider groups to facilities and entities that are required to integrate their EHR with the PMP;
- removes the requirement that EHRs must send information to the PMP using standards supported by the state Health Information Exchange (HEI), and replaces it with the requirement that EHRs must send PMP information without provider intervention using a mechanism approved by the Department of Health (DOH);
- removes the requirement that the health care facility or entity must be a trading partner with state's HIE to receive PMP patient data;
- permits PMP data with direct patient identifiers to be provided for research that has been approved by the Washington State Institutional review board and the DOH;
- permits PMP data to be provided to Labor and Industries and the Health Care Authority for certain circumstances;
- clarifies that PMP data reports provided to the prescriber associations may contain indirect patient identifiers;
- removes the requirement that therapeutic courts receiving criminal justice treatment accounts funds implement the National Association of Drug Court Professionals best practice standards by January 30, 2020;
- modifies the state's declaration regarding substance use disorder by removing references to co-occurring disorders, adding references to developmental disabilities, and specifying individuals with OUD and substance use disorder must be informed about Food and Drug Administration approved medications for the treatment of OUD and substance use disorder; and
- modifies the requirements on jails to provide medication assisted treatment (MAT) to persons in custody who were receiving medication for the treatment of OUD before incarceration or provide medication to persons in custody 30 days before release if treatment is determined to be medically necessary, so that jails must only provide MAT to the extent that funding is provided through either an appropriation or approval of a Section 1115 waiver.

Appropriation: None.

Fiscal Note: Available.

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

Staff Summary of Public Testimony:

(In support) This bill is very similar to last year's bill, but there are some critical additions related to pregnant and parenting women and several criminal justice programs. These are

important to reduce stigma and to make sure that treatment is available when people want to access it. There are still a few things that need to be worked out.

Through the opioid response workgroup there were a number of recommendations about how criminal justice could be involved, including implementing medication assisted treatment (MAT) into drug courts, which has been supported by the drug court professionals.

This bill does a lot to further support and improve care for vulnerable women, but it should be expanded to include pregnant individuals who present at the end of a pregnancy. Women who do not receive treatment during pregnancy for opioid use disorder often go into labor because of withdrawal their babies have complications, which often cost millions of dollars. On the contrary, women who are stabilized on MAT while pregnant have pregnancies without complications and babies who do not suffer from withdrawal symptoms, saving millions of dollars.

Opioid use has been declared an epidemic and an emergency. When someone presents and is ready to get treatment, they need to be connected with resources immediately. Often times when individuals are ready to seek treatment, they want one more party and go overboard and overdose. If people can be connected with treatment right away, this can be prevented. Unfortunately, there are often waiting periods, prior authorization requirements, or it is hard to find an open treatment center. This bill goes a long way to reduce stigma and provide treatment options.

This bill has many other beneficial provisions. The prescription monitoring program (PMP) is one of the most valuable tools to address the epidemic according to the Centers for Disease Control and Prevention and integration is an important aspect of this. However, requiring integration can be a burden to small group practices, like advanced registered nurse practitioners.

Notifying patients they can refuse an opioid prescription or order is also a good step as is support for non-pharmacological alternatives such as acupuncture. Investing in MAT in jails is very important and will save lives and money for the state as a whole. This bill also does a lot to increase access to naloxone across the state, which will to save lives.

(Opposed) Significant action has been taken by all parties involved and there are a lot of good things in this bill, but there are still a number of concerns regarding the mandate to integrate with the PMP if the entity has ten or more providers. The Department of Health's report on the PMP shows that there are still some significant barriers to integration, excluding internal information technology (IT) costs. Forty-seven other states use the same platform for their PMP, but Washington opted to create its own instead. Washington is only one of three state not sharing data with other states. People do not care about the choice of vender, but this mandate does not work.

The prescribing rules that went into effect on January 1, 2019, require checks of the PMP, so why continue to change the goalposts for providers. Integration is a financial and resource barrier for smaller providers, which would require these facilities to use precious resources on IT, rather than patient care, which harms patients.

In this state 41 hospitals have fully integrated, eight are in the process, and 54 have not been able to do so, 28 of which are critical access hospitals. Federal law will already require PMP checks beginning in 2021, so why is there so much concern about how to check the PMP rather than that if it is checked. When the Emergency Department electronic health record (EHR) system was integrated with the PMP there were state funds provided.

Many support and encourage the use of MAT in jails when possible. However, it is very costly and requires a lot of staff involvement and there are already staff shortages. Jails are only booking serious felonies and domestic violence cases because there is not enough staff to book everyone. Accordingly, while the policy of MAT in jails is supported, there needs to be state funding.

(Other) There are a lot of good things in this bill, but there are some concerns and some improvements could be made. This bill would be improved if mandatory e-prescribing was included in the bill. This would cut down on opioid related thefts.

Washington is the second state in the nation in terms of the number of PMP transactions integrated into electronic health records. When the Health Information Exchange (HIE) was created, a key provision was ensuring that cost was not a barrier. The community worked together to develop the fees for the HIE. There is one fee for all uses of the HIE and so for entities using other HIE services, the marginal costs for using the PMP is nothing. The HIE works hard to keep costs low and fees have not been raised in ten years. The HIE is committed to working with partners to solve the integration issues.

Oregon's PMP was integrated into the ECHO system at almost no cost. Oregon can search almost every other state's PMP. This bill instead would require a custom platform. The state should provide other means to connect to the PMP and support PMP use. Other states have done this at little or no cost to providers.

There is concern about the fiscal impact on counties, since there is no funding provided to provide MAT in jails, it is just an unfunded mandated. A number of counties have looked into providing MAT even before being required to, but it is very expensive and requires a lot of staff time.

Persons Testifying: (In support) Jason McGill, Office of the Governor; Jon Tunheim, Washington State Criminal Justice Taskforce and Washington Drug Court Professionals; Vania Rudolf, Swedish Medical Center; Shannie Jenkins; Devon Connor-Green, ARNPs United of Washington; Samantha Ritchie; Leslie Emerick, Washington East Asian Medicine Association; Brad Finegood, King County; Kelly Richbug, Office of the Attorney General; Cindy Grande; and Charissa Fontinos, Health Care Authority.

(Opposed) Katie Kolan and Nathan Schlicher, Washington State Medical Association; Jay Priebe, Washington State Medical Group Managers Association; and Dory Nicpon, Board of Judicial Administration.

(Other) Mark Johnson, Washington Retail Association; Dave Arbaugh, OCHIN; Juliana Roe, Washington State Association of Counties; Dennis Weber, Cowlitz; Lisa Thatcher,

Washington State Hospital Association; Emily Lovell, Washington State Dental Association; and Rick Rubin, OneHealthPort.

Persons Signed In To Testify But Not Testifying: Seth Dawson; Lis Houchen; Bob Cooper; Michael Hatchett; Andrea Davis; and Caitlin Safford.

HOUSE COMMITTEE ON APPROPRIATIONS

Majority Report: The second substitute bill be substituted therefor and the second substitute bill do pass and do not pass the substitute bill by Committee on Health Care & Wellness. Signed by 32 members: Representatives Ormsby, Chair; Bergquist, 2nd Vice Chair; Robinson, 1st Vice Chair; Stokesbary, Ranking Minority Member; MacEwen, Assistant Ranking Minority Member; Rude, Assistant Ranking Minority Member; Caldier, Chandler, Cody, Dolan, Dye, Fitzgibbon, Hansen, Hoff, Hudgins, Jinkins, Kraft, Macri, Mosbrucker, Pettigrew, Pollet, Ryu, Schmick, Senn, Springer, Stanford, Steele, Sullivan, Sutherland, Tarleton, Tharinger and Ybarra.

Staff: Andy Toulon (786-7178).

Summary of Recommendation of Committee On Appropriations Compared to Recommendation of Committee On Health Care & Wellness:

The Appropriations Committee recommended adding a provision which requires most prescriptions for controlled substances to be communicated electronically beginning January 1, 2021. The electronic systems that communicate prescription information between prescribers and dispensers are required to meet additional standards. Pharmacists and pharmacies are required to submit prescription information to the prescription monitoring program as soon as readily available after distributing a prescription and no later than one business day beginning January 1, 2021. The requirement that city and county jails must make every possible effort to directly connect incarcerated individuals receiving medication for the treatment of opioid use disorder to an appropriate provider or treatment site before release is changed to require city and county jails to only make reasonable efforts to connect incarcerated individuals to an appropriate provider or treatment site. The Health Care Authority (HCA) is allowed, rather than required, to replicate effective treatment approaches such as the opioid hub and spoke treatment networks to broaden outreach and patient navigation.

The Appropriations Committee recommended adding language providing that the bill is null and void if funding is not provided in the operating budget by June 30, 2019.

Appropriation: None.

Fiscal Note: Preliminary fiscal note available.

Effective Date of Second Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed, except section 16, relating to controlled substance prescriptions, which takes effect January 1, 2021. However, the bill is null and void unless funded in the budget.

Staff Summary of Public Testimony:

(In support) None.

(Opposed) Provisions in section 21(2) create an unfunded mandate on provider groups of 10 or more to connect through a custom build to the state's prescription monitoring program (PMP). The bill as amended does ask the state to identify a funding source to make those custom builds work. The state should identify that funding mechanism before a costly mandate is placed on small provider groups. The language in the Senate bill addresses this issue.

There are many good things in the bill, including the first part of section 21, which requires an assessment and recommendations for improving integration of data with the PMP and identifying a funding mechanism for this purpose. Changes to section 21(2) in the policy committee to move the date out for a mandate on providers was helpful; however, the requirements in subsection 2 should be completely removed from the bill.

(Other) There are many positive elements of this bill; however, there are problems with provisions related to the PMP. As drafted, the bill requires a costly customized approach to integrate with the state health information exchange. The state should allow providers to access this information without the need for a customized build, which is already done in a number of other states. Language accommodating for this has been included in the Senate version.

The current language requires city and county jails to make every possible effort to connect a person who is being released from the jail to treatment. A lot of things are possible, including many unreasonable things. The language should be revised to say that reasonable efforts must be made to connect individuals to treatment.

Revisions to the bill will allow for reduced costs. Section 7 should be clarified so that a patient and their doctor would determine the correct number of opioids for their medical needs and have that reflected in their prescription, rather than allowing for partial refills after the prescription has already been sent to the pharmacy. With regard to electronic prescribing, the United States Congress has recently enacted federal legislation mandating controlled substance prescriptions covered under Medicare Part D to be electronically transmitted starting on January 1, 2021. Section 15 should be modified to align with the federal mandate by changing "may" to "shall;" creating an effective date of January 1, 2021; and including a list of exemptions to mirror the federal legislation.

Section 20 should be modified to require the Department of Health to better integrate communications with electronic medical records and the PMP. This would save health care costs by allowing pharmacies and prescribers to communicate prescription information and decrease the time frame in which opioid prescriptions distributed to patients could be recorded. The language in sections 13 and 15 that eliminate the need for the Pharmacy Quality Assurance Commission to approve the systems used to transmit and receive electronically transmitted prescriptions are a positive change.

Persons Testifying: (Opposed) Katie Kolan, Washington State Medical Association; and Lisa Thatcher, Washington State Hospital Association.

(Other) Dave Arbaugh, Oregon Community Health Information Network; James McMahon, Washington Association of Sheriffs and Police Chiefs; and Jim Hedrick, Walgreens.

Persons Signed In To Testify But Not Testifying: None.