HOUSE BILL REPORT
HB 2642

As Reported by House Committee On:
Health Care & Wellness

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: 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].

Brief Summary of Substitute Bill

- Eliminates prior authorization requirements for substance use disorder services, except in certain cases.
- Establishes minimum coverage times before utilization review may be conducted for services in a substance use disorder residential treatment facility or a withdrawal management program.
- Establishes timelines for substance use disorder facilities 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 timely assessments and increasing successful transitions between different levels of appropriate care.

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 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).

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 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 a set amount of time for their enrollees receiving certain substance use disorder treatment services. The prior authorization limitation applies to: (1) the first two business days, excluding weekends and holidays, of services in a licensed substance use disorder residential treatment facility; and (2) the first three days, excluding weekends and holidays, of withdrawal management services in a licensed withdrawal management program. Once the specified time period has passed, the payer may initiate utilization management review procedures if the provider requests continuing substance use disorder treatment services.

A substance use disorder residential treatment facility or withdrawal management program must provide an enrollee's health plan with initial notice of the admission within 24 hours. Within two business days of admission, the facility providing services must provide the payer with notification of admission, initial assessment, and the initial treatment plan. If the payer determines within one business day of receiving the materials that that the admission to the facility was not medically necessary or clinically appropriate, the payer is not responsible for any payments to the facility beyond the initial two- or three-day admission period. If the payer determines that that the admission to the facility was not medically necessary or clinically appropriate more than one business day after receiving the materials, the payer must pay for any services provided by the facility from the receipt of the materials until the time that the review was completed.

If a payer covers out-of-network services and the patient is admitted to an out-of-network facility, the payer must reimburse for a covered, in-network mode of transportation to an in-network facility. Payers are not required to cover transportation from an out-of-state facility if the enrollee elects to transfer to an in-state, in-network facility. If the facility is not in the enrollee's network, the payer is not responsible for reimbursing an out-of-network facility at a greater rate than in-network facilities and that the facility may not balance bill.

If a patient is at an addiction stabilization facility and the recommended plan of treatment is for placement in a different facility or lower level of care, the payer's care coordination unit must work with the facility to make arrangements for a seamless transfer to an appropriate and available facility as soon as possible. If an in-network, alternative provider is not available, the payer must continue to pay the facility until an alternative arrangement is made.

The Health Care Authority must develop an action plan to support improved transitions through different levels of care for adults and adolescents, including addressing barriers to timely assessments and increasing successful transitions between different levels of appropriate care. 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 provider initial notification to health plans regarding an enrollee's admission to a facility;
- develop standardized definitions for placement criteria and levels of care to be used across regions;
- address concerns regarding the denial of withdrawal management services based upon a person's drug of choice;
- explore options to allow health plans 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
- establish the minimum amount of medical information necessary for utilization review.

Substitute Bill Compared to Original Bill:

The substitute bill reduces the minimum coverage that must be provided prior to conducting utilization review for withdrawal management programs from five days to three days.

Substance use disorder treatment facilities and withdrawal management programs must provide the payer with notice of admission within 24 hours of admission.

The substitute bill removes the prohibition on the use of stimulants and medication-assisted treatment for opioid use disorder as the sole grounds for finding an admission to not be medically necessary.

The substitute bill requires payers to pay for a covered, in-network mode of transportation to an in-network facility if the payer covers out-of-network services and the patient is admitted to an out-of-network facility. Payers are excluded from having to cover transportation from an out-of-state facility if the enrollee elects to transfer to an in-state, in-network facility. A payer is not responsible for reimbursing an out-of-network facility at a greater rate than in-network facilities and the out-of-network facility may not balance bill. The provisions of the bill do not apply to out-of-state facilities.

The substitute bill specifies that a seamless transfer to an appropriate level of care may include same-day or next-day appointments for outpatient care, but not non-treatment care such as housing services.

The substitute bill requires medical necessity reviews by payers to be based on American Society of Addiction Medicine criteria.

The substitute bill directs the Health Care Authority to develop an action plan to support improved transitions through different levels of care for adults and adolescents, including addressing barriers to timely assessments and increasing successful transitions between different levels of appropriate care.

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) 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.

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