FINAL BILL REPORT
ESHB 2642

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Synopsis as Enacted

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).

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

Background:

The federal Substance Abuse and Mental Health Services Administration describes substance use disorder 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-

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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 and school employees receive health care through the School Employees Benefits Board. These entities are supported by the Health Care Authority and include plans that cover outpatient services and residential treatment for substance use disorders.

Summary:

The Public Employees Benefits Board, School Employees Benefits Board, private health insurers, and Medicaid managed care organizations (payers) may not require prior authorization for patients receiving withdrawal management services or inpatient or residential substance use disorder treatment services. In addition, payers may not conduct utilization review for: (1) at least two business days, excluding weekends and holidays, in a behavioral health agency for inpatient or residential substance use disorder treatment services; and (2) at least three days in a behavioral health agency for withdrawal management services. Once the specified time period has passed, the payer may initiate utilization management review procedures if the behavioral health agency continues to provide services or is in the process of arranging for a seamless transfer to an appropriate facility or a lower level of care.

A behavioral health agency must notify a patient's health plan of the admission within 24 hours. The behavioral health agency must provide the payer with its initial assessment and initial treatment plan for the patient within two business days, excluding weekends and holidays, for inpatient or residential substance use disorder treatment services, and within three days for withdrawal management services. The behavioral health agency must document the patient's need for continuing care and justification for level of placement using a standard set of criteria adopted by the Health Care Authority (Authority) and the Office of the Insurance Commissioner.

Upon receipt of materials from the behavioral health agency, a payer may initiate its medical necessity review process according to the standard set of criteria adopted by the Authority and the Office of the Insurance Commissioner. If the payer determines within one business day of receiving the materials that the admission to the facility was not medically necessary, the payer is not responsible for any payments to the behavioral health agency beyond the initial two- or three-day admission period. If the payer makes its medical necessity determination more than one business day after receiving the materials, the payer must pay for any services provided by the behavioral health agency from the time of admission of the patient until the time that the review is complete. If the treatment plan involves the transfer of the patient to a different facility or lower level of care, the payer's care coordination unit must work with the behavioral health agency to make arrangements for a seamless transfer and pay the agency until the transfer is complete. A seamless transfer may include appointments for same day or next day appointments for outpatient care, but excludes nontreatment services.

If the behavioral health agency is not in the patient's network, the health plan is not responsible for paying the agency at a greater rate than would be paid had the agency been in the patient's network. Behavioral health agencies may not balance bill.

By December 1, 2020, the Authority must develop an action plan to support admission to and improved transitions between different levels of care for adults and adolescents, including addressing barriers to facilitating transfers to the appropriate level of care. The Authority must develop the action plan in partnership with the Office of the Insurance Commissioner, Medicaid managed care organizations, commercial health plans, providers of substance use disorder services, and Indian health care agencies. 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 agencies to provide initial notification to fully insured health plans and managed care organizations regarding an enrollee's admission to an agency;
- facilitate direct transfers to withdrawal management and residential substance use disorder treatment from hospitals and jails;
- address concerns regarding the denial of withdrawal management services based upon a person's drug of choice;
- explore options to allow Medicaid managed care organizations to pay an administrative rate for an enrollee who remains in a level care that is higher than necessary until a seamless transfer to an appropriate care level can be made and a similar reimbursement mechanisms for commercial health plans; and
- establish the minimum amount of medical information necessary for utilization review.

It is the stated policy that the state adopt a single standard set of criteria to define medical necessity for substance use disorder treatment and to define substance use disorder levels of care. The criteria must be comprehensive, widely understood and accepted in the field, and based on continuously updated research and evidence. By January 1, 2021, the Authority and the Office of the Insurance Commissioner must independently review their regulations and practices.

Votes on Final Passage:

House	94	4	
Senate	48	0	(Senate amended)
House	97	0	(House concurred)

Effective: June 11, 2020