SENATE BILL REPORT
SSB 5380

As Amended by House, April 16, 2019

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: Senate Committee on Health & Long Term Care (originally sponsored by Senators Cleveland, Rivers, Frockt, Walsh, Keiser, King, Randall, O'Ban, Conway, Darneille, Saldaña, Das, Dhingra, Hunt, Wilson, C. and Zeiger; by request of Office of the Governor).

Brief History:
Committee Activity: Health & Long Term Care: 1/25/19, 2/08/19 [DPS-WM].
Ways & Means: 2/19/19, 2/26/19 [DPS (HLTC)].
Floor Activity:
Passed Senate: 3/07/19, 47-0.
Passed House: 4/16/19, 96-2.

Brief Summary of First 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 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.

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.

- Requires therapeutic courts that receive funding from the state's Criminal Justice Treatment Account and city and county jails to provide medication assisted treatment.

SENATE COMMITTEE ON HEALTH & LONG TERM CARE

Majority Report: That Substitute Senate Bill No. 5380 be substituted therefor, and the substitute bill do pass and be referred to Committee on Ways & Means.

Signed by Senators Cleveland, Chair; Randall, Vice Chair; O'Ban, Ranking Member; Becker, Dhingra, Frockt, Keiser and Van De Wege.

Staff: LeighBeth Merrick (786-7445)

SENATE COMMITTEE ON WAYS & MEANS

Majority Report: Do pass.

Signed by Senators Rolfes, Chair; Frockt, Vice Chair, Operating, Capital Lead; Mullet, Capital Budget Cabinet; Braun, Ranking Member; Brown, Assistant Ranking Member, Operating; Honeyford, Assistant Ranking Member, Capital; Bailey, Becker, Billig, Carlyle, Conway, Darneille, Hasegawa, Hunt, Keiser, Liias, Palumbo, Pedersen, Rivers, Schoesler, Van De Wege, Wagoner, Warnick and Wilson, L..

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.

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

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

State Opioid Response Plan. Several state agency members of the 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. All schedule II, III, IV, and V controlled substance prescriptions and dispensing is monitored by DOH through a PMP. 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 the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) regarding Medicaid recipients;
- the director of the Department of Labor and Industries regarding workers' compensation claimants;
- the director of the Department of Corrections (DOC) 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, 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.

Opioid Prescribing Rules. In 2017, the Legislature passed ESHB 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.

Summary of First 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. All

individuals should be offered evidence-based treatments such as medications approved by the FDA for the treatment of OUD, behavioral counseling, and social supports. Providers must inform patients with OUD of options to access FDA approved medications for the treatment of OUD. OUD 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 opioid use disorder medication may have on their baby. 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 opioid use disorder. If a pregnant Medicaid client is identified at risk for opioid use disorder, HCA, through the managed care organizations, must provide outreach to the individual. 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. Electronic prescription systems are no longer required to be approved by the Pharmacy Commission. 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 DOH. Practitioners must document the discussion in the patient's health record.

Prescription Monitoring Program. Dispensers are required to submit the necessary prescription information to the PMP no later than one business day after the date the prescription is dispensed. DOH must collaborate with health professional and facility associations, vendors, and others to:

- assess the current status of EHR and PMP integration;
- study best practices regarding data sharing with other states;
- provide alternatives to PMP integration with EHRs in addition to the state health information exchange model;
- provide recommendations for improving integration among small and rural health providers including exploring a financial assistance options;
- conduct security assessments of other commonly used platforms for integrating EHR and PMP;
- evaluate options to identify patients in the PMP who do not wish to receive opioids or patients who have had an opioid-related overdose;
- recommend options for increasing accessibility of the stand-alone PMP portal;
- formulate a strategy to integrate PMP/EHRs in advance of federal mandates;

- and include the result of the collaboration in DOH's annual PMP/EHR integration report to the legislature.

PMP 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 member of HCA's self-funded and self-insured health plans;
- DOH personnel to assess the public health impacts of opioid use disorder and to identify possible interventions;
- a licensed, certified or accredited behavioral health provider;
- public or private entities for statistical, research, or educational purposes after removing any unique identifiers;
- the Washington State Medical Association for uses solely in its coordinated quality improvement program;
- DSHS, L&I, and 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.

PMP data with direct and indirect patient identifiers may be provided for research that has been approved by the Washington state institutional review board and by the department through a data-sharing agreement.

State Opioid Response Plan. The secretary of DOH is responsible for coordinating the statewide response plan and must work in partnership with 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, HCA and DOH are provided with additional directives.

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 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 DSHS, DOC, DOH, 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 DOH to promote coordination between OUD treatment providers;

- work with stakeholders to develop a set of recommendations for the Governor and 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 DOH and other state agencies to replicate effective approaches for linking individuals who have a 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 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 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 nonpharmacologic treatment options for acute, subacute, and chronic noncancer pain.

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 such as patient navigators, outreach works, peer professionals, and other appropriate professionals;
- 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 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 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 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 the 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 provide prepackaged 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 prepackaged medications are exempt from the Pharmacy Commission's labeling requirements.

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 medications approved by the FDA for the treatment of OUD as medically appropriate. HCA may assist the courts with acquiring the medication. Plans submitted for criminal justice treatment account funds must include current evidence-based practices in SUD. By January 1, 2021, city and county jails in Washington must adopt requirements for addressing the behavioral health needs of incarcerated individuals with OUD, which must include providing MAT.

Appropriation: The bill contains a section or sections to limit implementation to the availability of amounts appropriated for that specific purpose.

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: This bill is substantially similar to last year's bill with updates based on the stakeholder work that was done in the interim. The criminal justice professionals appreciate the provisions related to integrated of medication assisted treatment into the therapeutic courts. The aspects of the bill addressing the need for specialized services for pregnant and parenting women are critical in helping pregnant women with SUD access services when they are near labor. There is demand for these services and a gap in the current system that leaves many new parents without treatment options. This bill helps reduce the stigma related to OUD by acknowledging it is a chronic medical disorder, and helps incarcerated people with OUD get access to treatment. The majority of people with OUD will enter the criminal justice system. This is an opportune time to connect them to treatment. MAT dramatically improves the quality of life for individuals, and helps prevent overdoses and relapse. Drug courts want the strongest possible mandate for incorporating MAT into their system. The PMP integration requirements are a positive step forward in addressing the need to increase PMP utilization. A number of people report that they do not feel like they have the option to refuse an opioid, this bill helps address this by requiring the prescribers to offer the patient the option to refuse. The electronic prescribing rules will help decrease opioid from diversion. The non-pharmacologic treatment options will help prevent people from becoming addicted to opioids in the first place. Acupuncture and physical therapy should be included in the non-pharmacologic work. The requirement for DOH to evaluate other PMP integration requirements is a good starting point. The PMP/EHR integration requirements are

concerning, especially for small provider requirements. The bill should incorporate changes that require HCA to strengthen opioid prescribing guidelines for Medicaid clients, prior authorization and step therapy for MAT should not be permitted; and regulations should be adjusted to allow more flexibility in using telemedicine to prescribe MAT.

CON: The PMP/EHR integration mandates impose a huge financial impact on small medical groups. Larger organizations have already been able to integrate because they have the infrastructure to support it. Other states are able to provide integration between PMP and EHRs that are much less costly and workable. There needs to be a workgroup to determine if there is another integration approach that is more cost-effective and feasible. Funding should be provided to help small provider with integration costs. Jails are currently under-resourced and without funding, they will not be able to provide MAT as required by the bill.

OTHER: We strongly support all of the pieces in the legislation except for the PMP/EHR integration requirement. Other states are able to integrate their PMP systems into EHRs at a very low cost to the health care providers, but they way Washington's PMP is configured requires a custom build which is costly. Funding needs to be provided in order for the courts and jails to be able to provide MAT.

Persons Testifying (Health & Long Term Care): PRO: Senator Annette Cleveland, Prime Sponsor; Lis Houchen, Regional Director, National Association of Chain Drug Stores; Michael Hatchett, Policy Analyst, Washington Council for Behavioral Health; Leslie Emerick, Washington East Asian Medicine Association; Roxanne Karpen, Nurse Manager, Sound Integrated Health; Atif Mian, Medical Director, Sound Integrated Health Medical Director; Jason McGill, Office of Governor Jay Inslee; Jon Tunheim, Honorable Thurston County Prosecutor and Chair of the Opioid Criminal Justice Taskforce; Dr. James Walsh, Swedish Ballard Hospital; Dr. Charissa Fotinos, Behavioral Health Medical Director, Health Care Authority; Melissa Johnson, Physical Therapy Association of Washington; Kelly Richburg, Attorney General's Office; Dr. Cindy Grande, Opioid service provide; Dr. Marc Stern, Co-Author, Opioid Use Disorder Treatment in Jail report; Devon Connor-Green, ARNPs United of Washington State; Gail McGaffick, Washington State Podiatric Medical Association; Bob Cooper, Washington Association of Drug Courts; Andrea Davis, Coordinated Care.

CON: Katie Kolan, Washington State Medical Association; Nathan Schlicher, citizen; Jason Priebe, Washington State Medical Group Management Association; James McMahan, Washington Association Sheriffs and Police Chiefs.

OTHER: Lisa Thatcher, Washington State Hospital Association; David Knutson, Community Health Network; Jennifer Stoll, OCHIN; Mark Johnson, Washington Retail Association; Dory Nicpon, Board for Judicial Administration.

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

Staff Summary of Public Testimony on First Substitute (Ways & Means): PRO: Speaking specifically to Section 26, we love this section, especially its mandate that medication assisted treatment (MAT) be used in drug courts that accept the Criminal Justice Treatment Account (CJTA) funds. We urge you to keep this mandate in the bill. It would

also be nice if the amount the Governor swept from the CJTA not be swept and be kept for treatment and recovery and that be used for more successes in state drug courts. We are in strong support of this bill with one small change suggested. We recommend electronic e-prescribing as a requirement, not an option. We think this would reduce fraud and misuse of the program. We are in support of this bill, especially Sections 13 and 15, especially the elimination of the PQAC. We oppose some cost savings initiatives and hope we can propose some changes, in moving toward seven-day fills. We would like clarifying language in Section 7, to recommend that the initial fill for an opioid be no more than seven days. We recommend an effective date of January 1, 2021, for Section 15 and changing this section to read "shall" instead of "may" consistent with the federal mandate on Medicare Part D. I will submit these amendments to staff. This bill has passed two years in a row with strong bipartisan support. We have improved it over the interim. We agree with the jails that some resources are necessary. We are committed to pursuing a waiver to fund those services. We currently have about 100 moms and babies on a waiting list. We would like to eliminate that by expanding four residential treatment centers, in addition to how we practice medicine for this population. We propose expanding the Law Enforcement Assisted Diversion (LEAD) through a grant program. We would prefer to have additional dollars for the jails. We may need to try for a waiver first. We believe most jails are offering this now. There was a study done last July that interviewed 33 jails across the state. At that time, 14 were providing MAT. I recognize both the staff and budget challenges. LEAD has been a successful program in Seattle. Recognizing treatment issues before people are incarcerated will help.

CON: We have concerns, specifically with regard to Section 33. We like the bill in general, but we have concerns with the fiscal impact this specific section would have on counties. There is little to no funding for mandated services such as MAT. This is an expensive proposition for county jails. While it is probably a good idea, it requires ongoing, sustainable funding. Hoping for an 1115 waiver, using CJTA funds that are already spread thin, or encouraging counties to look for alternative funding streams will not help bridge gaps in resources. We ask that you provide actual funding for this, otherwise it is an unfunded mandate for counties. We support MAT. We just do not have the resources at the local levels to meet this requirement. We would love to be able to do this, but would ask that you make this subject to appropriation. We believe MAT to be a successful intervention. However, every interaction with a prisoner in a jail requires at least one police officer. With MAT, as they receive that treatment, we have to divert staff. When we divert them out of their traditional roles to do this, it means there is something else we cannot do. What we have seen in other instances, when we have had to divert staff has resulted in things like severe booking restrictions or holding staff over from one shift to the next so they have enough personnel.

OTHER: We are supportive of generally everything in the bill, but have similar concerns as the counties do with Section 33. Our concerns with MAT for city jails mirrors the counties and we would as that you model the language in HB 1331, which specifies this would be subject to appropriation. Otherwise, we are supportive.

Persons Testifying (Ways & Means): PRO: Mark Johnson, Washington Retail; Bob Cooper, Washington State Association of Drug Courts; Jim Hedrick, Walgreens; Jason McGill, Governor's Office; Dr. Charissa Fotinos, Health Care Authority, Director, Behavioral Health Medical.

CON: James McMahan, Washington Association Sheriffs and Police Chiefs.

OTHER: Juliana Roe, Washington State Association of Counties; Sharon Swanson, Association of Washington Cities.

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

EFFECT OF HOUSE AMENDMENT(S):

- Requires certain prescriptions to be submitted electronically beginning January 1, 2021.
- Requires entities or facilities with ten or more prescribers to integrate their EHRs with the PMP beginning January 1, 2021, unless DOH grants a waiver or the entity/facility is a critical access hospital.
- Modifies the PMP/EHR integration issues that DOH is required to collaborate with stakeholders on.
- Includes physician assistants in the prescriber feedback reports the largest health professional association representing each of the prescribing professions may provide.
- Modifies the state's declaration for substance use disorder and opioid use disorder treatment.
- Requires DOC to develop policies to prioritize services based on available grant funding and funds appropriated specifically for opioid use disorder treatment.
- Removes the requirement that HCA must comply with applicable federal law regarding its section 1115 demonstration waiver application.
- Removes the requirement that HCA must replicate effective opioid use disorder treatment approaches, such as hub and spoke treatment networks.
- Requires HCA to work with stakeholders to recommend strategies to increase the number of waivered health care providers approved for prescribing, and to lower the cost of FDA approved products for the treatment of opioid use disorder.
- Prohibits HCA from promoting the use of supervised injection sites as a form of treatment for opioid use disorder.
- Prohibits HCA from partnering with any agency that supervises the injection of illicit drugs.
- Modifies the requirements for city and county jails to provide MAT to persons in custody who were receiving medication for the treatment of opioid use disorder 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.
- Modifies the requirements on city and county jails to make every possible effort to directly connect incarcerated individuals receiving MAT for opioid use disorder to an appropriate provider or treatment site before release. Instead, city and county jails are required to only make reasonable efforts to connect incarcerated individuals to an appropriate provider or treatment site.
- Requires Medicaid and all state regulated plans to provide coverage without prior authorization for at least one FDA approved product for the treatment of opioid use disorder in the drug classes opioid agonists, opioid antagonists, and opioid partial agonists.

- Adds a null and void clause. The bill is null and void unless funded in the budget.