Multiple Agency Fiscal Note Summary

Bill Number: 2489 E S HB AMS WM S5789.1	**Title:** Opioid use disorder

Estimated Cash Receipts

Agency Name	2017-19		2019-21		2021-23	
	GF- State	Total	GF- State	Total	GF- State	Total
Washington State Health Care Authority	0	4,942,000	0	9,408,000	0	9,348,000
Department of Social and Health Services	0	2,503,000	0	12,206,000	0	12,206,000
Total $	**0**	**7,445,000**	**0**	**21,614,000**	**0**	**21,554,000**

Estimated Expenditures

Agency Name	2017-19			2019-21			2021-23		
	FTEs	GF-State	Total	FTEs	GF-State	Total	FTEs	GF-State	Total
Washington State Health Care Authority	.0	1,214,000	6,156,000	.0	2,904,000	12,312,000	.0	2,964,000	12,312,000
Department of Social and Health Services	2.5	4,371,000	6,874,000	5.5	10,350,000	22,556,000	5.5	10,350,000	22,556,000
Department of Health	7.9	1,417,000	1,783,000	13.3	2,126,000	2,832,000	12.7	2,126,000	2,707,000
Department of Corrections	Non-zero but indeterminate cost and/or savings. Please see discussion.								
University of Washington	.0	41,150	41,150	.0	0	0	.0	0	0
Total	**10.4**	**$7,043,150**	**$14,854,150**	**18.8**	**$15,380,000**	**$37,700,000**	**18.2**	**$15,440,000**	**$37,575,000**

Estimated Capital Budget Impact

NONE

Prepared by: Devon Nichols, OFM	**Phone:** (360) 902-0582	**Date Published:** Final 3/ 7/2018

* See Office of the Administrator for the Courts judicial fiscal note

** See local government fiscal note

FNPID: 52914

FNS029 Multi Agency rollup

Individual State Agency Fiscal Note

Bill Number:	Title:	Agency:
2489 E S HB AMS WM S5789.1	Opioid use disorder	107-Washington State Health Care Authority

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

ACCOUNT	FY 2018	FY 2019	2017-19	2019-21	2021-23
General Fund-Federal 001-2		4,942,000	4,942,000	9,408,000	9,348,000
Total $		4,942,000	4,942,000	9,408,000	9,348,000

Estimated Expenditures from:

	FY 2018	FY 2019	2017-19	2019-21	2021-23
Account					
General Fund-State 001-1	0	1,214,000	1,214,000	2,904,000	2,964,000
General Fund-Federal 001-2	0	4,942,000	4,942,000	9,408,000	9,348,000
Total $	0	6,156,000	6,156,000	12,312,000	12,312,000

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Travis Sugarman	Phone: 786-7446	Date: 03/01/2018
Agency Preparation:	Hanh OBrien	Phone: 360-725-1447	Date: 03/05/2018
Agency Approval:	Rene Newkirk	Phone: 360-725-1307	Date: 03/05/2018
OFM Review:	Robyn Williams	Phone: (360) 902-0575	Date: 03/05/2018

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

See attached narrative.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

See attached narrative.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

See attached narrative.

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years					
A-Salaries and Wages					
B-Employee Benefits					
C-Professional Service Contracts					
E-Goods and Other Services					
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services		6,156,000	6,156,000	12,312,000	12,312,000
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total:	$0	$6,156,000	$6,156,000	$12,312,000	$12,312,000

Part IV: Capital Budget Impact

None

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

See attached narrative.

Bill Number: 2489 ESHB AMS WM S5789 HCA Request #: 18-152

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

This bill is agency-requested legislation from the Health Care Authority (HCA), Department of Social and Health Services (DSHS), Department of Health (DOH), and the Governor's office related to the opioid use.

Bill details

Section 1 Declares opioid use disorder as a public health crisis.
Requires state agencies to:

- Increase access to evidence-based opioid use disorder treatment services
- Promote coordination of services within the substance use disorder treatment and recovery support system
- Strengthen partnerships between opioid use disorder treatment providers and their allied community partners
- Expand the use of the state prescription drug monitoring program (PMP), and
- Support comprehensive school and community-based substance use prevention services.

Requires agencies administer state purchased health care programs to:

- Coordinate activities to implement this act and the state interagency opioid working plan
- Explore opportunities to address the opioid epidemic, and
- Provide status updates as directed by the joint legislature executive committee on health care oversight to promote legislative and executive coordination.

Section 2 amends RCW 71.24.585 to:

- Authorize HCA to seek, receive and expend sources of funding alternative to existing funding provided for the Medicaid program, which may include
    - A section 1115 demonstration waiver from the federal Centers of Medicare and Medicaid Services (CMS) to fund opioid response treatment for persons eligible for Medicaid at or during the time of incarceration; and
    - Soliciting and receiving private funds, grants and donations.
- Require HCA to collaborate with DSHS, Department of Corrections (DOC), DOH and other state agencies identified by HCA to develop a statewide approach to leveraging Medicaid funding to treat opioid addiction and emergency overdose treatment.
- Require DSHS to partner with HCA to promote coordination between prescribers and treatment agencies to increase patient choice, improve patient care, and strengthen relationships between providers.
- Require HCA to review and promote positive outcomes associated with the Accountable Communities of Health (ACH) (opioid related projects underway pursuant to the current 1115 demonstration waiver).
- Require DSHS to collaborate with DOH and other state agencies to create a program with a goal to connect certified peer counselors to patients with non-fatal overdoses within forty-eight hours of overdose.
- Require HCA to work with other state agencies, including DOH, to increase outreach and education about opioid overdoses to non-English-speaking communities. DOH must submit a report on data collection by December 31, 2018.

Section 3 amends RCW 71.24.595 to require DSHS to partner with HCA, and Medicaid managed care organizations to eliminate barriers and promote access to the use of medication assisted therapies (MAT) for the treatment of opioid use disorder (OUD).

Section 4 adds a new section to chapter 71.24 RCW to require DSHS to partner with HCA, ACH, and others to develop a plan for the coordinated purchasing and distribution of opioid overdose reversal medications.

Section 5 adds a new section to chapter 71.24 RCW to require DSHS to partner with HCA, ACH, and others to develop strategies to support rapid-response teams in areas of high opioid-related overdose and to promote use of MAT in emergency department settings following an overdose.

Sections 10 through 13 require HCA to perform the requirements of 2 through 5 to take account of the Behavioral Health Administration (BHA) transfer to HCA should it occur.

Section 15 amends RCW 70.225.040 to require DOH to provide PMP data for HCA's self-funded or self-insured health plans.

Section 21 adds a new section to chapter 74.09 RCW to require HCA to research and recommend non-pharmacological treatments for acute, subacute, and chronic non-cancer pain and to report to the Governor and legislature by October 1, 2018.

New Section 34 states Sections 2 through 5 of this act take effect only if neither 1388 SHB nor 5259 SSB is signed into law.

New Section 35 states Sections 10 through 13 of this act take effect only if 1388 SHB or 5259 SSB is signed into law.

The effect of changes made by the amended engrossed substitute bill includes:

- New Sections 25 through 31 require prescribers to take a one-time continuing education (CE) on best practices of opioid prescribing by the end of the first full CE reporting period after 1/1/2019 or initial licensure, and allow the boards or commissions to adopt additional CE requirements if necessary;
- HB 2489 was formerly the companion bill to SB 6150.

II. B - Cash Receipts Impact

There will be an impact on federal funding required for this bill. HCA anticipates that the proposed increase in Medicaid rates to Medicare rates for MAT for the treatment of OUD will be eligible for a weighted average Federal Medical Assistance Percentage (FMAP) of 80.28% in FY 2019, 76.89% in FY 2020, and 75.92% 2021 and forward, based on the October 2017 Forecast.

Cash Receipts			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
001	GF-Federal Medicaid Title XIX	C	-	4,942,000	4,734,000	4,674,000	4,674,000	4,674,000
Total			-	**4,942,000**	**4,734,000**	**4,674,000**	**4,674,000**	**4,674,000**
Biennial total				**4,942,000**		**9,408,000**		**9,348,000**

Bill Number: 2489 ESHB AMS WM S5789 HCA Request #: 18-152

II. C - Expenditures

The fiscal impact to HCA is related to the proposed increase in Medicaid rates to Medicare rates for MAT for the treatment of OUD. The standard Medicaid rates for MAT are about 55 percent of the comparable Medicare rates. The assumption is that an increase to Medicare pricing will encourage more physicians to participate in treating Medicaid eligible persons with OUD. To estimate the utilization of MAT services HCA looked at claims information from state fiscal year (SFY) 2017. The average growth in the month number of Medicaid eligibles receiving MAT was 4 percent. HCA increased the SFY 2017 utilization by 4 percent per month to estimate SFY 2018. The rate increase is expected to increase the number of people able to obtain treatment by 50 percent in SFY 2019. The estimated incremental cost for SFY 2019 is $6,156,000 in total funds ($1,214,000 GF-S). The forecasted total cost for SFY 2020 to SFY 2023 is assumed to remain constant. At this time, there are some known changes to the FMAP being paid by the federal government. The FMAP changes for the Expansion and SCHIP populations are reflected in the SFY 2020 estimate. These changes will result in the state funds increasing to $1,482,000 by SFY 2021 and remaining constant thereafter.

An increase in administrative costs is not expected. HCA assumes the requirements in this bill for HCA to perform could be accomplished with existing resources.

Section 2(8) requires DSHS to coordinate with DOH and other state agencies to create a program with a goal to connect certified peer counselors to patients with non-fatal overdoses within forty-eight hours of overdose. HCA assumes this will be a coordinated effort with DSHS, DOH and other state agencies. The cost to implement this program have not been identified. HCA assumes a decision package will be submitted if there is a fiscal impact resulting from implementing this requirement.

By Fund:

Expenditures			FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
001	GF-State	1	-	1,214,000	1,422,000	1,482,000	1,482,000	1,482,000
001	GF-Federal Medicaid Title XIX	C	-	4,942,000	4,734,000	4,674,000	4,674,000	4,674,000
Total			-	**6,156,000**	**6,156,000**	**6,156,000**	**6,156,000**	**6,156,000**
Biennial Total				**6,156,000**		**12,312,000**		**12,312,000**

By Object:

Objects		FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
N	Grants, Benefits Services	-	6,156,000	6,156,000	6,156,000	6,156,000	6,156,000
Total		-	**6,156,000**	**6,156,000**	**6,156,000**	**6,156,000**	**6,156,000**

Part IV: Capital Budget Impact

None

Part V: New Rule Making Required

HCA may write rules on the use of non-pharmacological treatment for acute, subacute, and chronic non-cancer pain depending on the results of the review and reports in Section 19.

Individual State Agency Fiscal Note

Bill Number:	Title:	Agency:
2489 E S HB AMS WM S5789.1	Opioid use disorder	300-Department of Social and Health Services

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

ACCOUNT	FY 2018	FY 2019	2017-19	2019-21	2021-23
General Fund-Federal 001-2		2,503,000	2,503,000	12,206,000	12,206,000
Total $		2,503,000	2,503,000	12,206,000	12,206,000

Estimated Expenditures from:

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years	0.0	4.9	2.5	5.5	5.5
Account					
General Fund-State 001-1	0	4,371,000	4,371,000	10,350,000	10,350,000
General Fund-Federal 001-2	0	2,503,000	2,503,000	12,206,000	12,206,000
Total $	0	6,874,000	6,874,000	22,556,000	22,556,000

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Travis Sugarman	Phone: 786-7446	Date: 03/01/2018
Agency Preparation:	Sara Corbin	Phone: 360-902-8194	Date: 03/06/2018
Agency Approval:	David Daniels	Phone: 360-902-8177	Date: 03/06/2018
OFM Review:	Devon Nichols	Phone: (360) 902-0582	Date: 03/07/2018

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

Declares that opioid use disorder is a public health crisis, and requires state agencies to:
(2) Promote coordination of services within the substance use disorder treatment and recovery support system. Requires the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to create a program to connect certified peer counselors with individuals who have had a nonfatal overdose within the past 48 hours;
(3) Strengthen partnerships between opioid use disorder treatment providers and their allied community partners; and
(5) Support comprehensive school and community-based substance use prevention services. Requires that agencies administer state purchased health care programs to: (1) Coordinate activities to implement this act and the state interagency opioid working plan; (2) Explore opportunities to address the opioid epidemic; and (3) Provide status updates as directed by the joint legislative executive committee on health care oversight to promote legislative and executive coordination.

Changes the name of the community mental health services act to the community behavioral health services act.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

Federal funds are Title XIX.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

Section 1 New Section declares opioid use disorder as a public health crisis. This bill has a fiscal impact on the Department of Social and Health Services (DSHS), Department of Health (DOH), Department of Corrections (DOC), and the Health Care Authority (HCA). This bill directs state agencies to increase access to treatment, promote coordination of services, strengthen partnerships, support school and community based programs, and to expand the Prescription Drug Monitoring (PDM). This act leverages the direction provided by the Washington state interagency opioid working plan and declares that HCA and DSHS shall coordinate activities to implement this act, explore opportunities, and to provide status updates to the legislative executive committee on health care oversight.

Section 2 amends RCW 71.24.585 and 2017 c 297 s 12 as it eliminates and changes language and declares medications used to treat opioid use disorder are the most effective intervention to reduce deaths. Declares recognition of approved medications as evidence based for the treatment of opioid use disorder. It directs agencies to promote evidence-based strategies used to address priority opioids and will now prioritize state resources toward entities that allow the uses of medication-assisted treatment (MAT). HCA is granted authority to seek and use alternative sources of funding in response to the opioid crisis. In fiscal year 2019, DSHS will need .5 FTE and $1,300,000 Total Funds ($1,128,000 GF-State) to manage and implement the MAT Capacity Tracking Tool. In fiscal year 2020 and ongoing, DSHS will need .5 FTE and $1,316,000 Total Funds ($1,142,000 GF-State).

Section 2(6)(a) Requires DSHS, DOH, DOC, and HCA to develop a statewide approach to leveraging Medicaid funding. It gives authority to seek an 1115 demonstration waiver and allows for any grants, private funds, and/or donations to be used toward the opioid crisis.
It also directs DSHS to replicate effective approaches such as the hub and spoke treatment networks. In fiscal year 2019, DSHS will need 1.0 FTE to run the program at headquarters and $4,629,300 Total Funds ($2,315,000 GF-State) to add 4 new hub and spoke locations. In fiscal year 2020 and ongoing, DSHS will need 1.0 FTE and $4,661,000 Total Funds ($2,331,000 GF-State). The bill also declares the DSHS, DOH, and HCA to promote coordination between MAT prescribers and substance use disorder agencies.

Section 3 amends RCW 71.24.595 and 2017 c 297 s 16 which directs DHSH, DOH, HCA and Managed Care Organizations to eliminate barriers and promote access to Methadone, buprenorphine, naltrexone, and naloxone.

Section 4 New Section, Directs DSHS, DOH, HCA, the accountable communities of health (ACH), community partners, and the University of Washington (UW) alcohol and addiction institute to develop a coordinated plan towards coordinated purchasing and distribution of opioid overdose reversal medication (Naloxone).

Section 5 New Section directs DSHS, DOH, HCA, the ACHs, hub and spoke networks, and drug task forces to develop a strategy to support rapid response teams. It also directs DSHS, DOH, and HCA to reduce barriers to MAT and same-day referrals in local emergency rooms. In fiscal year 2019 and ongoing, DSHS will need 1.0 FTE and $138,000 Total Funds ($121,000 GF-State) to hire a headquarters program coordinator and to contract with local partners such as on-call nurse care managers, prescribers, drug task force members, and substance use disorder (SUD) peers. In fiscal year 2018, DSHS will need 3.0 FTE (Program Specialist, Office Assistant, and Management Analyst) and $806,300 Total GF-State to pursue a Medicaid state plan amendment for SUD peer support services and to update curriculum and deliver training/continuing education to develop an SUD peer support program. In fiscal year 2020 and ongoing, DSHS will need 3.0 FTE (Program Specialist, Office Assistant, and Management Analyst) and $5,162,000 Total Funds ($1,580,000 GF-State) to support SUD peer support services.

Section 7 amends RCW 71.24.560 and 2017 c 297 s 11 to include language around opioid use medications in the treatment of opioid use disorder and the effects on women who are pregnant and parenting.

Section 9 amends RCW 69.41.095 and 2015 c 205 s 2 to updates language and adds current opioid terms. This section grants providers, practitioners, and pharmacists the ability to write a standing orders and revises language so that it encourages less restrictive guidelines surrounding opioid reversal medications. It also directs agencies to develop training for providers and the general public that gives information on how to administer opioid reversal medication and describes ways to recognize opioid-related overdoses.

Section 10 amends RCW 71.24.585 and 2017 c 297 s 12 and declares that the main goals of treatment for persons with opioid use disorder are the cessation of unprescribed opioid use, reduced morbidity, and restoration of the ability to lead a productive and fulfilling life.

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years		4.9	2.5	5.5	5.5
A-Salaries and Wages		342,000	342,000	806,000	806,000
B-Employee Benefits		134,000	134,000	304,000	304,000
C-Professional Service Contracts					
E-Goods and Other Services		30,000	30,000	66,000	66,000
G-Travel		3,000	3,000	6,000	6,000
J-Capital Outlays		21,000	21,000		
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services		6,337,000	6,337,000	21,360,000	21,360,000
P-Debt Service					
S-Interagency Reimbursements		2,000	2,000	4,000	4,000
T-Intra-Agency Reimbursements		5,000	5,000	10,000	10,000
9-					
Total:	$0	$6,874,000	$6,874,000	$22,556,000	$22,556,000

III. B - Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2018	FY 2019	2017-19	2019-21	2021-23
WMS Band 1	6,030		4.9	2.5	5.5	5.5
Total FTEs			4.9	2.5	5.5	5.5

III. C - Expenditures By Program (optional)

Program	FY 2018	FY 2019	2017-19	2019-21	2021-23
BHA - Alcohol and Substance Abuse (070)		6,874,000	6,874,000	22,556,000	22,556,000
Total $		6,874,000	6,874,000	22,556,000	22,556,000

Part IV: Capital Budget Impact

None

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

None

Individual State Agency Fiscal Note

Bill Number:	Title:	Agency:
2489 E S HB AMS WM S5789.1	Opioid use disorder	303-Department of Health

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Expenditures from:

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years	0.0	15.8	7.9	13.3	12.7
Account					
General Fund-State 001-1	0	1,417,000	1,417,000	2,126,000	2,126,000
Health Professions Account-State 02G-1	0	366,000	366,000	706,000	581,000
Total $	0	1,783,000	1,783,000	2,832,000	2,707,000

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☒ Requires new rule making, complete Part V.

Legislative Contact:	Travis Sugarman	Phone: 786-7446	Date: 03/01/2018
Agency Preparation:	Donna Compton	Phone: (360) 236-4538	Date: 03/05/2018
Agency Approval:	Ryan Black	Phone: (360) 236-4530	Date: 03/05/2018
OFM Review:	Bryce Andersen	Phone: (360) 902-0580	Date: 03/06/2018

Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

This version of the fiscal note has changed from the previous version FN18-141, ESHB 2489. The fiscal impact change is due to the addition of the WaTech registration fee being included in total fiscal note estimate.

Section 2(8): Amends RCW 71.24.585, Opioid Use Disorder Treatment, requiring the Department of Social and Health Services (DSHS) and the Health Care Authority (HCA) to create a program to connect certified peer counselors with individuals who have had a non-fatal overdose within forty-eight hours.

Section 2(9): Amends RCW 71.24.585, Opioid Use Disorder Treatment, requiring state agencies to develop a data collection plan for determining the number of opioid related overdoses for non-English speakers. The Department of Health (department) must submit a report on the data collection plan with implementation recommendations by December 31, 2018.

Section 10(8): Amends RCW 71.24.585 requiring the DSHS and the HCA to create a program to connect certified peer counselors with individuals who have had a non-fatal overdose within forty-eight hours.

Section 14: Amends RCW 70.225.010, Prescription Monitoring Program (PMP), providing new definitions for "prescriber" and "requestor."

Section 15(3)(f): Amends RCW 70.225.040 to allow the release of information to the HCA director or designee regarding members of HCA's self-funded or self-insured health plans for the purpose of quality improvement, patient safety, and care coordination only.

Section 17(1): Adds a new language to chapter 70.225 RCW putting requirements of vendors that sell federally certified electronic health records for use in the state of Washington to ensure their system can integrate with the prescription drug monitoring program utilizing the state health information exchange.

Section 17(2): Adds a new language to chapter 70.225 RCW requiring certain facilities, entities, and provider groups to demonstrate that its electronic health records system can use the state health information exchange fully integrate data to and from the prescription drug monitoring program by January 1, 2019 or by January 1, 2020, if their federally certified electronic health records system vendor is not able to comply with subsection (1) of this section by December 1, 2018.

Section 20(2): Amends RCW 70.168.090, Statewide Trauma Care System, requiring the Department of Health (department) to establish a statewide electronic emergency medical services data system and adopt rules requiring every licensed ambulance and aid service report and furnish patient encounter data to the electronic emergency medical data system by July 1, 2019. This subsection also requires specific data elements for the data system and secure transport method, such as the state health information exchange, be defined by rule and must include data on fatal and nonfatal overdoses or drug poisoning.

Section 23: Adds a new section to chapter 69.50 RCW, Controlled Substances Act, requiring health care practitioners prescribing an opioid for the first time for outpatient use to discuss with the patient the risks of opioids and pain management alternatives. This section does not apply to practitioners licensed under chapter 18.92 RCW, Veterinary Medicine, Surgery and Dentistry.

Section 24: Requires the department to create a warning statement of the risks of opioids and information about the safe disposal of opioids on the department's website.

Section 25: Adds a new section to chapter 18.22 RCW, Podiatric Medicine and Surgery, requiring the podiatiric physicians to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following intital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 26: Adds a new section to chapter 18.32 RCW, Dentistry, requiring dentists to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following intital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 27: Adds new section to chapter 18.57 RCW, Osteopathy - Osteopathic Medicine and Surgery, requiring osteopathic physicians to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following intital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 28: Adds new section to chapter 18.57A RCW, Osteopathic Physicians Assistant, requiring the osteophathic physicians assistants to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following intital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 29: Adds new section to chapter 18.71 RCW, Physicians, requiring physicians to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following inital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 30: Adds new section to chapter 18.71A RCW, Physicians Assistant, requiring physicians assistants to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following intital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 31: Adds new section to chapter 18.79 RCW, Nursing Care, requiring advanced registered nurse practitioners to: 1) complete a one-time continuing education regarding best practices in the prescribing of opioids and; 2) to register for the PMP following intital licensure or at the time of renewal; a) provide proof of registration and; b) sign an attestation that the provider has reviewed the prescribing rules in order to prescribe opioids beginning January 1, 2019.

Section 32: Adds new section to chapter 43.70 RCW stating the Secretary of Health shall be responsible for coordinating the state-wide response to the opioid epidemic.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

Current law RCW 43.70.250 requires that the health professions account administered by the department be fully self-supporting and that sufficient revenue be collected through fees to fund expenditures in the Health Professions Account. The department does not foresee the need to adjust fees as a result of this bill. The department will monitor the fund and will adjust fees over a 5 year period to ensure that the fees are sufficient to cover all expenditures.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

The Department of Health (department) assumes State General-Fund will be provided to complete some of the tasks associated with this bill.

Section 2(8) & 10(8): The department believes it could potentially identify people who overdose through our Rapid Health Information Network (RHINO) and/or Emergency Medical Services (EMS) data in near real time. Currently the department has no authority to share patient names with DSHS for follow up unless opioid overdoses became a statewide notifiable condition.

Section 9(5)(b): Currently, affected boards and commissions are conducting rules workshops to address patient education requirements in ESHB 1427 Opioid Treatment Programs passed during the 2017 legislative session.

Section 24: The department would create warning language about the risks of opiate use, opiate abuse and information about safe disposal of opioids. The warning language and safe disposal information will be available on the department's website for providers with prescribing authority to print and provide to patients during the in-person consult. The department anticipates costs to be minimal and will be accomplished by existing staff within their normal workload.

Section 32: The department is currently coordinating the state-wide response to the opioid epidemic.
Rulemaking

The department believes that two sets of rulemaking are required to implement this bill, one for the Prescription Monitoring Program (PMP) and one for the EMS.

Sections 14 & 17: One-time rulemaking will be required to (15) add new definitions for prescriber and requester and (17) require identified facilities, entities and provider groups to integrate PMP data via the Health Information Exchange (HIE) into their Emergency Health Records (EHR) system. Rulemaking will consist of two stakeholder meetings and one formal rules hearing. Rulemaking costs will include staff-time, Office of the Attorney General support in the amount of $1,000 and related costs. Costs in FY2019 will total 0.1 FTE and $11,000 (GFS).

Section 20(2): One-time rulemaking will be required to define specific data elements of the statewide EMS data system and the secure transport method. Rulemaking will consist of two stakeholder meetings and one formal rules hearing. Rulemaking costs will include staff-time, Office of the Attorney General support in the amount of $1,000 and related costs. Costs in FY2019 will total 0.1 FTE and $11,000 (GFS).

WaTech Registration Fee

The department has recently been notified that WaTech will begin billing for Identity Verification (IDV) services, also known as Knowledge Based Authentication (KBA), offered to customers of SecureAccess Washington (SAW) at $0.99 fee per transaction. Currently there are 59,000 licensed prescribers and roughly 30% are using the PMP. On average the department is seeing a delegate for every three registered prescriber and therefore anticipate roughly 55,000 additional registrations. Impacted prescribers have a combined annual growth rate of 3.7%.

The department has also been notified that the fee will be assessed to every attempt and not just successful registration. WaTech has indicated that the department has a 39% failure rate. Based on this failure rate the department assumes an additional 21,000 registration attempts that will result in failure in the first year and an additional 3.7% annually based on growth rate.

Based on this information the department estimates total costs to be 0.2 FTE and $96,000 (GFS) in FY2019. Starting in FY2020, ongoing costs will be $3,000 (GFS).

The department believes that if PMP usage becomes mandated the department will see three to four delegates to every prescriber.

Disease Control Health Statistics (DCHS)

Section 2(9): Requires the department to develop a data collection implementation plan and submit recommendation report by December 31, 2018. The department assumes that the report will need to capture the cost and feasibility of adding a data element(s) to the hospital patient discharge data collection system,Comprehensive Hospital Abstract Reporting (CHARS), our Electronic Death Registration System (EDRS), and the Washington Health Life Events System (WHALES) to capture non-English speaking patients who were hospitalized or died of an overdose.

The department anticipates one-time costs for staff to research options for collection of data, defining system requirements, and vendor consulation to determine system modification costs. Work would also include staff time to conduct stakeholder meetings to determine the level of effort and feasibility of collecting this information from patients and informants (the person reporting information on the decedent who died of an overdose). One-time costs in FY2019 are 0.2 FTE and $30,000 (GFS).

Continuing Education and Attestation

Section 25-31: Affected boards and commissions anticipate needing additional staff to coordinate the implementation of the continuing education and attestation requirement. The department assumes a four year implementation period for continuing education, as a majority of credential holders are on two-year renewel cycles. The department assumes an ongoing cost for the proof of registration and attestation requirement related work. Work will include educating stakeholders on new requirements, coordinating stakeholder comments and

concerns with board and commission responses and actions. Managing the intake and processing of new complaints as well as verifying continuing education and attestation upon renewal. Currently 31% of affected prescribers renew online allowing for an automated PMP registration verification. For the remaining 69%, the attestation verification will be manually processed each renewal. Additionally, there will be one-time administrative costs for Health Technoloty Staff staff to reconfigure the department's Integrated Licensing and Regulatory System (ILRS) for the collection of attestations. In FY2020-FY2021 there will be reduced costs for maintenance and operations of ILRS. Total costs are 3.9 FTE and $366,000 for FY2019 (02G) and 3.9 FTE and $353,000 (02G) in FY2020-FY2022. Starting in FY2023, ongoing costs are 2.5 FTE and $228,000 (02G).

Office of Community Health Systems

Section 20(2): Requires the department to establish a statewide electronic emergency medical services data system and adopt rules requiring every licensed ambulance and aid service report and furnish patient encounter data to the electronic emergency medical data system by July 1, 2019. The department assumes this would ensure that the department has the ability to track and provide intervention data for overdoses reported by EMS that never make it to an emergency department. Costs would include ongoing support in data quality, analytics, and reporting as well as system enhancements and incentives for all-volunteer EMS agencies to assure reporting compliance. Total costs are 2.3 FTE and $462,000 for FY2019 (GFS). Starting in FY2020, ongoing costs total 2.0 FTE and $407,000 (GFS).

Section 20(2): This subsection also requires specific data elements of the data system and the secure transport method, such as the state health information exchange, be defined in rule and must include data on fatal and nonfatal overdoses or drug poisoning. The department anticipates that an IT Specialist will be needed in FY2019 to identify and analyze required infrastructure and components needed to integrate HIE with EMS. One-time costs in FY2019 are 1.5 FTE and $164,000 (GFS).

Prescription Monitoring Program

Section 12: Requires facilities, entities, and provider groups that receive Medicaid and have a federally-certified EHR to integrate PMP data into their EHR via the HIE to improve clinician access to PMP data. This also requires EHR vendors that sell federally certified systems in Washington to integrate with the PMP using the HIE. The department estimates it will need an onboarding specialist and some administrative support to work with groups looking to integrate and to provide technical assistance via telephonic and electronic consultation. Total costs are 1.6 FTE and $160,000 for FY2019 (GFS). Starting in FY2020, ongoing costs total 1.6 FTE and $154,000 (GFS).

Section 23-29: Requires identified prescribers to be registered with the PMP. Currently there are 59,000 licensed prescribers and roughly 30% are using the PMP. While the bill does not mandate usage, the department anticipates there will be an increase in calls by registering the remaining prescribers. The department assumes that the majority of calls over the first two years will be for registration related assistance and that the majority of calls for the following years will be for usage related assistance. The department receives an average of 40 calls per day (0.26% of registered prescribers) at an average of 18 minutes per call. Based on current call volume, the department estimates an increase of 40 calls per day (0.10% of new prescriber registrations) at an average of 18 minutes per call. Staff would be assisting providers who are trying to register, who have been locked out, and who need help navigating the system. Total costs are 5.6 FTE and $483,000 (GFS) for FY2019. Starting in

FY2020, ongoing costs total 5.8 FTE and $499,000 (GFS).

Total impact for this bill would be 15.8 FTE and $1,417,000 (GFS) and $366,000 (02G) in FY2019. Total costs in FY2020-FY2022 are 13.3 FTE and $1,063,000 (GFS) and $353,000 (02G). Starting in FY2023, ongoing costs would total 12.0 FTE and $1,063,000 (GFS) and $228,000 (02G)

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years		15.8	7.9	13.3	12.7
A-Salaries and Wages		945,000	945,000	1,590,000	1,506,000
B-Employee Benefits		330,000	330,000	554,000	525,000
C-Professional Service Contracts		1,000	1,000		
E-Goods and Other Services		387,000	387,000	526,000	522,000
J-Capital Outlays		31,000	31,000		
T-Intra-Agency Reimbursements		89,000	89,000	162,000	154,000
Total:	$0	$1,783,000	$1,783,000	$2,832,000	$2,707,000

III. B - Detail: *List FTEs by classification and corresponding annual compensation. Totals need to agree with total FTEs in Part I and Part IIIA*

Job Classification	Salary	FY 2018	FY 2019	2017-19	2019-21	2021-23
EPIDEMIOLOGIST 2	86,508		1.0	0.5	1.0	1.0
(NON-MEDICAL) Fiscal Analyst 2	49,020		2.8	1.4	2.2	2.1
HEALTH SERVICES	49,020		3.8	1.9	3.8	3.7
CONSULTANT 1 HEALTH SERVICES	58,284		1.8	0.9	1.8	1.7
CONSULTANT 2 HEALTH SERVICES	72,744		1.7	0.9	1.5	1.3
CONSULTANT 4 Health Svcs Conslt 1	49,020		2.0	1.0	1.3	1.3
IT SPECIALIST 5	84,384		1.1	0.6		
MANAGEMENT ANALYST 4	69,240		1.0	0.5	1.0	1.0
SECRETARY SENIOR	37,476		0.6	0.3	0.7	0.7
Total FTEs			15.8	7.9	13.3	12.7

Part IV: Capital Budget Impact

NONE

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

Sections 15, 17 & 18: The department will adopt rules to implement this bill.

Individual State Agency Fiscal Note

Bill Number:	Title:	Agency:
2489 E S HB AMS WM S5789.1	Opioid use disorder	310-Department of Corrections

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Expenditures from:

Non-zero but indeterminate cost. Please see discussion.

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☒ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☐ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

Legislative Contact:	Travis Sugarman	Phone: 786-7446	Date: 03/01/2018
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Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

Part I Section 1 is a new section that declares that opioid use disorder is a public health crisis. It requires state agencies to: (1) Increase access to evidence-based opioid use disorder treatment services; (2) Promote coordination of services within the substance use disorder treatment and recovery support system; (3) Strengthen partnerships between opioid use disorder treatment providers and their allied community partners; (4) Expand the use of the state prescription drug monitoring program; and (5) Support comprehensive school and community-based substance use prevention services.

Part II Section 2(1) amends RCW 71.24.585 to state medications used in the treatment of opioid use disorder (OUD) are the most effective intervention to reduce deaths from opioid overdose and keep people in treatment. The state recognizes medications approved by the federal food and drug administration as evidence-based for the treatment of OUD and medications with other therapeutic procedures are the treatment of choice for persons with OUD. Providers must inform patients of all treatment options available including both controlled and noncontrolled medications.

Part II Section 2(3) amends the current subsection to state that the goals of treatment of OUD are the cessation of unprescribed opioid use, reduced morbidity, and restoration of the ability to lead a productive and fulfilling life.

Part II Section 2(5) is a new subsection stating the Health Care Authority (HCA) must to partner with the Department of Social and Health Services (DSHS), the Department of Corrections (DOC), the Department of Health (DOH), and any others as appropriate to develop a statewide approach to leveraging Medicaid funding to treat opioid addiction and provide emergency overdose treatment. Potential alternative sources of funding, include seeking a section 1115 demonstration waiver to fund opioid response treatment for persons eligible for Medicaid at or during the time of incarceration and soliciting private funds, grants, and donation from any willing person or entity.

Part II Section 2(8) is a new subsection directing DSHS to partner with DOH and other state agencies to create a program with the goal of connecting certified peer counselors with individuals who have had a nonfatal overdone within 48 hours of the overdose.

Part II Section 2(9) is a new subsection directing state agencies to work together to increase outreach and education about opioid overdoses to non-English speaking communities, including developing a plan to collect data on the number of overdoses for non-English speakers.

Part II Section 4 is a new section added to chapter 71.24 RCW stating DSHS must work with DOH, HCA, the accountable communities of health, and community stakeholders to develop a plan for the coordinated purchasing and distribution of opioid overdose reversal medication across the state.

Part II Section 6 amends RCW 71.24.560 requiring all approved opioid treatment programs that provide services to people who are pregnant to disseminate health education information to all pregnant clients concerning the effects opioid use and opioid replacement therapy may have on their baby, including the development of dependence and subsequent withdrawal. In addition, programs must educate people who become pregnant about the risks to both the mother and their fetus of not treating OUD.

Part II Section 9(1) amends RCW 69.41.095 to indicate a practitioner may prescribe, dispense, distribute, and deliver an opioid overdose reversal medication through a variety of methods including directly to the patient, by prescription, drug therapy agreement, standing order, or family member.

Part II Section 9(3) amends the current subsection to allow any person or entity to lawfully possess, store, deliver, distribute, or administer an opioid overdose reversal medication pursuant to a prescription, collaborative drug therapy agreement, standing order, or protocol issued by a practitioner.

Part II Section 9(6) is a new subsection stating the labeling requirements of RCW 69.41.050 do not apply to opioid overdose reversal medications dispensed in accordance with this section. The individual or entity must ensure directions for use are provided with the medication.

Part III Section 22 is a new section that allows a pharmacist to partially fill a prescription of a schedule II controlled substance, if the partial fill is requested by the patient or prescribing practitioner and the total quantity dispensed does not exceed the quantity prescribed.

Part III Section 23 is a new section added to chapter 69.50 that requires any practitioner who writes the first prescription for an opioid during the course of treatment to any patient to discuss the risks of opioid use, and pain management alternatives. The practitioner must provide a written copy of warning language provided by DOH. The practitioner must document completion of the required discussion. A practitioner may designate the conversation responsibility to any appropriately credentialed individual. This section does not apply to opioid prescriptions issued for terminal diseases or end of life care, if the practitioner determines the health, wellbeing or care of the patient would be compromised from such a discussion or if the prescription is in an inpatient or outpatient treatment setting.

Part III Section 25 is a new section added to chapter 18.22 and requires podiatric physicians to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Part III Section 26 is a new section added to chapter 18.32 and requires dentists to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Part III Section 27 is a new section added to chapter 18.57 and requires osteopathic physicians to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Part III Section 28 is a new section added to chapter 18.57A and requires osteopathic physician assistants to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Part III Section 29 is a new section added to chapter 18.71 and requires physicians to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has

reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Part III Section 30 is a new section added to chapter 18.71A and requires physician assistants specifically authorized to prescribe opioids to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Part III Section 31 is a new section added to chapter 18.79 and requires advanced registered nurse practitioners licensed to prescribe opioids to have one hour of Continuing Education on best practices for opioid prescribing, to register for the prescription monitoring program following licensure or renewal or provide proof of registration, and sign an attestation that the provider has reviewed the prescribing rules, in order to prescribe opioids in Washington state.

Effective date is assumed 90 days after adjournment of session in which this bill is passed.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

None. Our impacts are general fund state.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

At this time DOC has a fiscal impact of indeterminate but over $50,000. As DOC develops its plan to treat OUD and opioid overdose, costs will become clearer. An illustration of potential costs is below.

The bill requires DOC to increase access to OUD treatment services, partner with the HCA to explore cost reduction options, and possess and distribute opioid overdose reversal medication. The bill allows pharmacists to partially fill opioid prescriptions, and requires conversations on risks and alternatives of opioids an OUD treatment with patients and pregnant persons. The bill also requires DOC to work with state agencies to increase outreach and education to non-English speaking communities, collect data on overdoses in this community and directs state agencies to partner to connect peer counselors with individuals who have suffered a nonfatal opioid overdose with 48 hours. To meet these requirements, DOC intends to expand treatment for incarcerated individuals for OUD, provide staff with training, and provide access to opioid overdose reversal medication.

Treatment of OUD:
The DOC has just begun to track OUD prevalence in incarcerated individuals, but based on the high level of incarcerated individuals at DOC with a history of substance abuse, DOC anticipates needing to treat many incarcerated individuals. The DOC intends to develop a plan to track and expand access to medical treatment of OUD for incarcerated individuals.

Initially DOC may begin treating only community supervision violators housed in prisons 30 days prior to release, and estimates treating approximately 208 patients a year. This number is based on an estimated 26% individuals releasing from prison violating their terms of community supervision with a positive opioid test or a dirty urinalysis. Of those violators, an estimated 10% would opt for treatment of OUD.

Average number of individuals released from prison each FY: 8,000
Assumed 26% with a positive opioid test or dirty urinalysis: 2,080 (8,000 X .26)
Assumed 10% of these individuals will volunteer to receive treatment: 208 (2,080 X .1)

The primary medications that will be used by DOC for treatment of OUD will be Buprenorphine film, administered daily, and Vivitrol, a monthly injection. Based on information from other correctional systems across the country DOC assumes most of the population would opt for Buprenorphine medication over Vivitrol.

Of an estimated 208 patients, it is assumed 10% (20.8) would opt for Vivitrol, and the rest (187.2) would receive Buprenorphine. Treatment would begin approximately 30 days prior to release from prison. The total estimated cost for prescription medication per FY for 208 patients is $69,888, and $139,776 per biennium. This is calculated by taking the medication cost per dose and multiplying it by the number of doses required per FY and the estimated number of patients per FY.

Buprenorphine: $8 per day X 30 days X 187.2 patients = $44,928
Vivitrol: $1,200 per month X 1 month X 20.8 patients = $24,960
Total cost of medication per FY = $69,888

Medical Staff Training:
Should DOC begin administrating medical treatment for OUD, it would be crucial to provide health care staff with education and training regarding the usage of medications that will be provided to DOC patients for OUD, including the risks associated with and alternatives to opioids to provide informed and responsible care and fulfill on the various requirements in the bill. In addition, to adequately coordinate with state agencies as directed in the bill, additional travel will be required. An estimated the cost for training and the additional travel per FY is $30,000.

Opioid Overdose Reversal Medication:
The evidence-based treatment for opioid overdose reversal is Naloxone (Narcan). The DOC is committed to ensuring Naloxone (Narcan) intra-nasal toolkits are available throughout DOC facilities and are with community correctional officers. The exact number and location of kits is to be determined.

According to the Drug Enforcement Administration (DEA), it only takes a very small amount of fentanyl or its derivatives – either inhaled or absorbed through the skin – to result in severe adverse reactions. Not only are users exposed to danger, but others who encounter fentanyl including first responders and law enforcement may also experience health issues from coming into contact with the drug. Depending on the severity of the overdose, as many as three (3) doses of Naloxone (Narcan) may be necessary to reverse the overdose.

Should DOC place Narcan toolkits throughout each facility and with community corrections officers, DOC may need up to 1,610 Narcan toolkits, with a usage of 25% each year that need to be replaced. In addition, all kits need to be replaced every two years. Naloxone has a shelf life of approximately 18-24 months and is required to have an expiration date at least 12 months out from the date of the prescription. Expired naloxone should be replaced with a new kit. At a cost of $75 per kit, for 1,610 kits the cost is $120,750 in the FY the kits are first bought (1,610 X 75 = 120,750), and $30,188 in the second FY (1,610 X .25 = 402.5 X 75 = $38,188). Costs of $120,750 and $38,188 in alternating FY's are assumed to be ongoing.

To treat an estimated 208 patients, provide training and travel to staff and provide access to opioid overdose reversal medication, DOC would require $215,638 the first FY, $125,076 in the second FY and ongoing costs of $215,638 and $125,076 in alternating FY's. A breakdown of costs is below.

First FY
Prescription Medication: $69,888
Medical Provider Training/Travel: $30,000
Naloxone (Narcan) Treatment Kits: $120,750
Total: $220,638

Second FY
Prescription Medication: $69,888
Medical Provider Training/Travel: $30,000
Naloxone (Narcan) Treatment Kits: $30,188
Total: $130,076

As DOC develops its treatment plans, DOC will it's clarify the fiscal needs. DOC anticipates the number of treatments necessary could rise to above 1,000. To treat an additional 1,000 patients, the cost is $3,209,400 per FY. It is assumed 2.5% (25) of patients will opt for Vivitrol, and the rest (975) will receive Buprenorphine. New patients will likely be a combination of incarcerated individuals preparing to transition back into the community and newly admitted individuals being sentenced to prison time and thus, treatment is expected to be needed throughout the entire FY, 365 days of Buprenorphine or 12 doses of Vivitrol.

Buprenorphine: $8 per day X 365 days X 975 patients = $2,847,000
Vivitrol: $1,208 per month X 12 months X 25 patients = $362,400
Total cost of medication per FY = $3,209,400

In addition, should the patient count rise, DOC would need additional staffing and contract dollars to assist with transition planning and coordination of clinical handoffs to community treatment providers. The DOC estimates it would need two (2) Registered Nurse 2's (RN2) to serve as Discharge & Coordination Nurses, at an annual cost of $159,207 ($318,414 total) the first year of hire and $153,841 each ($307,682 total) ongoing. The DOC would also need $750,000 per FY to reimburse or compensate community treatment providers to begin working with DOC incarcerated patients for a period of time prior to their expected release date. Research shows the first few weeks after release from a correctional facility are the highest risk for relapse and overdose deaths. Having community treatment providers begin the interaction with the patient and assist with transition planning is needed to close the timeline gap of getting accepted into a treatment program after release.

Assumptions:
1. The bill requires DOC to partner with HCA to develop an approach to leverage Medicaid funding to treat opioid addiction and provide emergency overdose treatment. Should DOC receive a section 1115 demonstration waiver to fund opioid response treatment for persons eligible for Medicaid at or during the time of incarceration or other funds, grants, or donations, there is the potential for a significant reduction in the costs of prescription medication, community transition planning and overdose treatment kits.

Part III: Expenditure Detail

Part IV: Capital Budget Impact

None.

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.

Individual State Agency Fiscal Note

Bill Number:	Title:	Agency:
2489 E S HB AMS WM S5789.1	Opioid use disorder	360-University of Washington

Part I: Estimates

☐ **No Fiscal Impact**

Estimated Cash Receipts to:

NONE

Estimated Expenditures from:

	FY 2018	FY 2019	2017-19	2019-21	2021-23
Account					
General Fund-State 001-1	0	41,150	41,150	0	0
Total $	0	41,150	41,150	0	0

Estimated Capital Budget Impact:

NONE

The cash receipts and expenditure estimates on this page represent the most likely fiscal impact. Factors impacting the precision of these estimates, and alternate ranges (if appropriate), are explained in Part II.

Check applicable boxes and follow corresponding instructions:

☐ If fiscal impact is greater than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete entire fiscal note form Parts I-V.

☒ If fiscal impact is less than $50,000 per fiscal year in the current biennium or in subsequent biennia, complete this page only (Part I).

☐ Capital budget impact, complete Part IV.

☐ Requires new rule making, complete Part V.

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Part II: Narrative Explanation

II. A - Brief Description Of What The Measure Does That Has Fiscal Impact

Briefly describe by section number, the significant provisions of the bill, and any related workload or policy assumptions, that have revenue or expenditure impact on the responding agency.

The direct fiscal impact on the University of Washington (UW) for 2489 ES HB AMS WM S5789.1 would come from Section 17(1) and 17(2). This section requires vendors that sell federally certified electronic health records systems to integrate with and make available the Prescription Monitoring Program (PMP). The UW assumes that vendors that contract with the UW, specifically Epic and Cerner, would pass costs through to UW Medicine through one-time implementation charges.

2489 ES HB AMS WM S5789.1 does not differ from the most recent version of this bill, 2489 ES HB AMS HLTC S5405.1, in a way that would have a fiscal impact on the UW; thus, we are returning the same fiscal note for this version of the bill.

II. B - Cash receipts Impact

Briefly describe and quantify the cash receipts impact of the legislation on the responding agency, identifying the cash receipts provisions by section number and when appropriate the detail of the revenue sources. Briefly describe the factual basis of the assumptions and the method by which the cash receipts impact is derived. Explain how workload assumptions translate into estimates. Distinguish between one time and ongoing functions.

II. C - Expenditures

Briefly describe the agency expenditures necessary to implement this legislation (or savings resulting from this legislation), identifying by section number the provisions of the legislation that result in the expenditures (or savings). Briefly describe the factual basis of the assumptions and the method by which the expenditure impact is derived. Explain how workload assumptions translate into cost estimates. Distinguish between one time and ongoing functions.

SECTION 4 and SECTION 12
These sections state that the plan for the coordinated purchasing and distribution of opioid overdose reversal medication across Washington state shall be developed in consultation with the University of Washington's Alcohol and Drug Addiction Institute (ADAI) and community agencies. Sections 4 and 12 will not result in a fiscal impact for ADAI or the UW as a whole, as the consultative work being suggested is within the scope of the already funded work that ADAI research scientists are doing and would not require additional FTE or support. The UW assumes that the intent of this language is simply to tell state agencies to consult with faculty and staff at the UW, not to take on activities that would require FTE or other costs.

SECTION 17
Section 17(1) states that a vendor that sells a federally certified electronic health records system for use in the state of Washington must ensure their system can integrate with the Prescription Monitoring Program (PMP) utilizing the state health information exchange by December 1, 2018. Per Section 17(2), UW Medicine would need to demonstrate that three of four Emergency Health Record (EHR) systems across the UW Medicine system were able to use the state health information exchange to access the PMP by July 1, 2019. The UW assumes that the costs for vendors to make the PMP readily available will be passed through to UW Medicine. If this bill passes, the UW will be required to update electronic medical record software sourced from Epic and Cerner (Millennium, Soarian) so that the PMP is available to providers within the electronic health records workflow (per subsection 1b). Due to the number of UW Medicine sites and legacy software systems, the UW is estimating that vendors will charge $41,150.

UW Medicine has developed a plan for a system wide electronic medical records overhaul that would lead to one unified system that has PMP integration building into it, eliminating access challenges we currently have with in our legacy EMR systems. The process was begun in 2015 (FY16) and is scheduled for completion sometime in 2020. Due to the complexity of the UW Medicine system and high volume of daily data transmission, we

continue to experience connection issues and have spent $139,000 of an estimated $180,000 to date on this project. We will also need to design the system to link to the pharmacy database in the current ordering workflow of the physicians, which has been significant to project implementation.

The earlier implementation date required by Section 17 is a factor in the estimated vendor charge of $41,150 as the PMP integration project will need to be accelerated. The UW is only including additional vendor charges and not internal costs for implementation in this fiscal note. The vendor charge is assumed to be one-time costs for PMP integration and does not include any future technical support that would be needed to ensure the software is functioning properly. The estimate also does not include the EHR provided by Pulsecheck at UW Medicine sites.

Part III: Expenditure Detail

III. A - Expenditures by Object Or Purpose

	FY 2018	FY 2019	2017-19	2019-21	2021-23
FTE Staff Years					
A-Salaries and Wages					
B-Employee Benefits					
C-Professional Service Contracts					
E-Goods and Other Services		41,150	41,150		
G-Travel					
J-Capital Outlays					
M-Inter Agency/Fund Transfers					
N-Grants, Benefits & Client Services					
P-Debt Service					
S-Interagency Reimbursements					
T-Intra-Agency Reimbursements					
9-					
Total:	$0	$41,150	$41,150	$0	$0

Part IV: Capital Budget Impact

Part V: New Rule Making Required

Identify provisions of the measure that require the agency to adopt new administrative rules or repeal/revise existing rules.