# Multiple Agency Fiscal Note Summary

| **Bill Number:** 2642 E S HB | **Title:** Sub. use disorder coverage |
|---|---|

## Estimated Cash Receipts

| Agency Name | 2019-21 | | 2021-23 | | 2023-25 | |
|---|---|---|---|---|---|---|
| | GF- State | Total | GF- State | Total | GF- State | Total |
| Washington State Health Care Authority | 0 | 84,000 | 0 | 98,000 | 0 | 98,000 |
| Washington State Health Care Authority | In addition to the estimate above,there are additional indeterminate costs and/or savings. Please see individual fiscal note. | | | | | |
| **Total $** | **0** | **84,000** | **0** | **98,000** | **0** | **98,000** |

## Estimated Operating Expenditures

| Agency Name | 2019-21 | | | 2021-23 | | | 2023-25 | | |
|---|---|---|---|---|---|---|---|---|---|
| | FTEs | GF-State | Total | FTEs | GF-State | Total | FTEs | GF-State | Total |
| Washington State Health Care Authority | .5 | 126,000 | 210,000 | 1.0 | 146,000 | 244,000 | 1.0 | 146,000 | 244,000 |
| Washington State Health Care Authority | In addition to the estimate above,there are additional indeterminate costs and/or savings. Please see individual fiscal note. | | | | | | | | |
| Office of Insurance Commissioner | .3 | 0 | 74,718 | .3 | 0 | 67,860 | .3 | 0 | 67,860 |
| Department of Social and Health Services | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| Department of Health | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| **Total $** | **0.8** | **126,000** | **284,718** | **1.3** | **146,000** | **311,860** | **1.3** | **146,000** | **311,860** |

## Estimated Capital Budget Expenditures

| Agency Name | 2019-21 | | | 2021-23 | | | 2023-25 | | |
|---|---|---|---|---|---|---|---|---|---|
| | FTEs | Bonds | Total | FTEs | Bonds | Total | FTEs | Bonds | Total |
| Washington State Health Care Authority | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| Office of Insurance Commissioner | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| Department of Social and Health Services | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| Department of Health | .0 | 0 | 0 | .0 | 0 | 0 | .0 | 0 | 0 |
| **Total $** | **0.0** | **0** | **0** | **0.0** | **0** | **0** | **0.0** | **0** | **0** |

## Estimated Capital Budget Breakout

| Prepared by: Jason Brown, OFM | Phone: (360) 902-0539 | Date Published: Final 2/28/2020 |
|---|---|---|

# Individual State Agency Fiscal Note

| Bill Number: 2642 E S HB | Title: Sub. use disorder coverage | Agency: 107-Washington State Health Care Authority |
|---|---|---|

## Part I: Estimates

☐ **No Fiscal Impact**

**Estimated Cash Receipts to:**

| ACCOUNT | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|
| General Fund-Federal 001-2 | | 84,000 | 84,000 | 98,000 | 98,000 |
| **Total $** | | 84,000 | 84,000 | 98,000 | 98,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

**Estimated Operating Expenditures from:**

| | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|
| FTE Staff Years | 0.0 | 1.0 | 0.5 | 1.0 | 1.0 |
| **Account** | | | | | |
| General Fund-State 001-1 | 0 | 126,000 | 126,000 | 146,000 | 146,000 |
| General Fund-Federal 001-2 | 0 | 84,000 | 84,000 | 98,000 | 98,000 |
| **Total $** | 0 | 210,000 | 210,000 | 244,000 | 244,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. 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: | Kevin Black | Phone: (360) 786-7747 | Date: 02/20/2020 |
| Agency Preparation: | Cari Tikka | Phone: 360-725-1181 | Date: 02/26/2020 |
| Agency Approval: | Catrina Lucero | Phone: 360-725-7192 | Date: 02/26/2020 |
| OFM Review: | Jason Brown | Phone: (360) 902-0539 | Date: 02/28/2020 |

# 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 - Operating Budget Expenditures**

| Account | Account Title | Type | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|---|---|
| 001-1 | General Fund | State | 0 | 126,000 | 126,000 | 146,000 | 146,000 |
| 001-2 | General Fund | Federal | 0 | 84,000 | 84,000 | 98,000 | 98,000 |
| | | **Total $** | 0 | 210,000 | 210,000 | 244,000 | 244,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

**III. B - Expenditures by Object Or Purpose**

| | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|
| FTE Staff Years | | 1.0 | 0.5 | 1.0 | 1.0 |
| A-Salaries and Wages | | 80,000 | 80,000 | 160,000 | 160,000 |
| B-Employee Benefits | | 29,000 | 29,000 | 58,000 | 58,000 |
| C-Professional Service Contracts | | 53,000 | 53,000 | | |
| E-Goods and Other Services | | 37,000 | 37,000 | 24,000 | 24,000 |
| G-Travel | | 1,000 | 1,000 | 2,000 | 2,000 |
| J-Capital Outlays | | 10,000 | 10,000 | | |
| M-Inter Agency/Fund Transfers | | | | | |
| N-Grants, Benefits & Client Services | | | | | |
| P-Debt Service | | | | | |
| S-Interagency Reimbursements | | | | | |
| T-Intra-Agency Reimbursements | | | | | |
| 9- | | | | | |
| **Total $** | 0 | 210,000 | 210,000 | 244,000 | 244,000 |

In addition to the estimates above, there are additional indeterminate costs and/or savings. Please see discussion.

**III. C - Operating FTE 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 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|---|
| Medical Assistance Program Specialist 3 | 77,952 | | 1.0 | 0.5 | 1.0 | 1.0 |
| **Total FTEs** | | | 1.0 | 0.5 | 1.0 | 1.0 |

**III. D - Expenditures By Program (optional)**

NONE

# Part IV: Capital Budget Impact

**IV. A - Capital Budget Expenditures**

NONE

**IV. B - Expenditures by Object Or Purpose**

NONE

**IV. C - Capital Budget Breakout**

*Identify acquisition and construction costs not reflected elsewhere on the fiscal note and describe potential financing methods*

NONE

None

# Part V: New Rule Making Required

Bill Number: 2642 ES HB HCA Request #: 20-163

## Part II: Narrative Explanation

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

This bill removes barriers and delay to accessing substance use disorder treatment.

This version of the bill differs from the previous version in the following ways:

- Language has been added detailing the requirement for a treating provider to document to the health plan the member's need for continued care, based on the provider's assessment of medical necessity.
- Language has been added which allows the health plan to deny coverage based on insurance fraud.
- The Office of the Insurance Commissioner (OIC) has been added to the list of agencies required to participate in the action plan development, detailed in Section 5 of the bill.
- Language regarding the required action plan is added to Section 5 which adds consideration of an equivalent reimbursement mechanism for commercial plans in addition to exploring options for allowing Medicaid managed care organizations (MCOs) an administrative rate.

Section 1 creates a new section describing the Legislature's intent to remove barriers for treatment of substance use disorders (SUD) created by current prior authorization and premature utilization management review requirements.

Section 2 and Section 3 add new sections to RCW 41.05 (State Health Care Authority) and RCW 48.43 (Insurance Reform) for private insurance carriers to require expanded coverage of SUD in residential treatment facilities. These expanded coverage requirements apply to health plans offered to public employees and their enrolled dependents via the state's self-insured and fully insured health plan offerings, as of January 1, 2021. The bill requires health plans:

- Provide coverage of SUD treatment without necessitating a prior authorization, for at least two business days including an extension for weekends and holidays, in a state-licensed residential treatment facility (RTF). The health plan is not able to conduct a utilization management review to determine medical necessity during this initial coverage period. Furthermore, the RTF must notify the health plan of their intent to treat the member within twenty four hours of a member's admission to the facility. The health plan then has twenty four hours to determine if continued treatment is medically necessary. If treatment is not determined to be clinically appropriate by the health plan, the health plan is not required to continue to cover services provided in excess of the initial coverage period.
- Provide coverage of withdrawal management services without necessitating a prior authorization, for at least three days, in state licensed withdrawal management program (WMP). The WMP must notify the health plan of a member's admission to the facility within twenty four hours; the health plan then has 24 hours to determine if treatment beyond the initial coverage period is medically necessary. If treatment is not determined to be clinically appropriate by the health plan, the health plan is not required to continue coverage of services in excess of the initial coverage period.
- Only after the initial coverage period may the health plan terminate coverage for treatment of SUDs or withdrawal management services, if determined by the health plan that coverage for these services is not medically necessary.
- Nothing in this bill prevents a health plan from denying coverage based on insurance fraud.
- If a health plan covers out-of-network services, and a member has been admitted to an out-of-network facility within Washington State, the health plan is required to cover the costs

associated with transportation of the member to an in-network facility. Health plans are not required to reimburse out-of-network facilities at a greater rate than would be provided at an in-network facility.

- A health plan is required to coordinate with RTFs and WMPs when transfer of a member to a different treatment facility is deemed necessary by the treating practitioner. The health plan is required to cover the cost of care at the current facility, regardless of the facility's network status, until a "seamless" transfer is complete, or alternative treatment arrangements are made.

Section 4 adds a new section to chapter 71.24 RCW impacting HCA's Medicaid managed care organizations (MCO). The language is the same as in Section 2 except to be specific to MCOs and requires this section to begin January 1, 2021.

Section 5 adds a new section that directs the HCA to develop an action plan to support improved transitions of care throughout American society for those experiencing addiction in both adults and adolescents. This action plan is to be presented to substance use disorder providers by December 1, 2020 and will require collaboration with the OIC, MCOs, commercial health plans, providers of substance use disorder services and Indian health care providers.

### II. B - Cash Receipts Impact

Indeterminate.

HCA assumes that the requirements of this bill that relate to Medicaid services would be eligible for a 39.8 percent Federal Medical Assistance Percentage (FMAP).

| Cash Receipts | | | FY 2020 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2025 |
|---|---|---|---|---|---|---|---|---|
| 001 | GF-Federal MeC | | - | 84,000 | 49,000 | 49,000 | 49,000 | 49,000 |
| **Total** | | | **-** | **84,000** | **49,000** | **49,000** | **49,000** | **49,000** |
| **Biennial total** | | | | **84,000** | | **98,000** | | **98,000** |

### II. C - Expenditures

This bill revises 41.05 RCW that impacts the fully insured plans for state and school employee benefits, and 71.24 RCW impacts both fee-for-service (FFS) and managed care Medicaid programs.

**Fiscal Impact:**

**Employee and Retiree Benefits (ERB) program**

Indeterminate fiscal impact.

Prior authorization for inpatient treatment of SUD and withdrawal treatment services is currently required via all health plans offered through the Public Employee Benefits Board (PEBB) and the School Employee Benefits Board (SEBB). Implementation of this bill would require PEBB and SEBB health plans to cover these services for at least the initial coverage period, without a prior authorization or utilization management review; in some instances, this may require health plans to provide coverage for members at out-of-network facilities. While the health plan is not required to reimburse out-of-network facilities at a greater rate than what would be paid to an in-network facility, health plans are only given 24 hours to review for medical necessity once notified by a facility of a member's admission; coupled with necessitating coverage prior to health plan review, this requirement would provide some limits to a health plan's ability to guard against clinical concerns and costs that could arise with member

treatment non-contracted facilities. This version of the bill allows a health plan to deny coverage based on insurance fraud.

Furthermore, PEBB and SEBB health plans do not currently cover the costs associated with transportation of members to in-network facilities from out-of-network facilities. Requiring coverage of these costs would result in an additional cost to the health plans, as well as an administrative burden due to procurement of new contracts with transportation services. The associated impact of this additional cost to the PEBB and SEBB fully insured health plans, as well as claims and administrative fees for the self-insured Uniform Medical Plan (UMP) is indeterminate.

This bill improves access to care for those seeking treatment of SUDs; however, the potential costs associated with coverage at out-of-network facilities, increased utilization of services, and costs associated with transportation of members to in-network facilities will have a downstream financial impact of unknown magnitude.

Therefore, implementation of this bill will result in increased premiums for the fully-insured plans, which may impact the state medical benefit contribution and employee contributions for health benefits, as well as increased utilization and claims costs in the Uniform Medical Plan (UMP).

## Medicaid Fiscal Impact

Indeterminate.

### Section 5, Action Plan costs for Medicaid:

HCA requests $210,000 ($126,000 of General Fund-State) funding for 1.0 Full Time Equivalent (FTE) in the 2019-21 Biennium for the action plan required in Section 5 of the bill.

HCA's Expenditures by Fund:

| Expenditures | | | FY 2020 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2025 |
|---|---|---|---|---|---|---|---|---|
| 001 | GF-State | 1 | - | 126,000 | 73,000 | 73,000 | 73,000 | 73,000 |
| 001 | GF-Federal Me | C | - | 84,000 | 49,000 | 49,000 | 49,000 | 49,000 |
| **Total** | | | **-** | **210,000** | **122,000** | **122,000** | **122,000** | **122,000** |
| **Biennial Total** | | | | **210,000** | | **244,000** | | **244,000** |

HCA's Expenditures by Object:

| Objects | | FY 2020 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2025 |
|---|---|---|---|---|---|---|---|
| A | Salaries & Wages | - | 80,000 | 80,000 | 80,000 | 80,000 | 80,000 |
| B | Employee Benefits | - | 29,000 | 29,000 | 29,000 | 29,000 | 29,000 |
| C | Personal Serv Contr | - | 53,000 | - | - | - | - |
| E | Goods and Services | - | 37,000 | 12,000 | 12,000 | 12,000 | 12,000 |
| G | Travel | - | 1,000 | 1,000 | 1,000 | 1,000 | 1,000 |
| J | Capital Outlays | - | 10,000 | - | - | - | - |
| **Total** | | **-** | **210,000** | **122,000** | **122,000** | **122,000** | **122,000** |

HCA's Expenditures by FTE:

| Job title | Salary | FY 2020 | FY 2021 | FY 2022 | FY 2023 | FY 2024 | FY 2025 |
|---|---|---|---|---|---|---|---|
| MEDICAL ASSISTANCE PRO | 77,952 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |
| - | - | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| **Total** | 77,952 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.0 |

By December 1, 2020, HCA would be required to develop an action plan to support improved transitions of care throughout American society for those experiencing addiction in both adults and adolescents. This action plan is to be presented to substance use disorder providers by December 1, 2020 and will require collaboration with Medicaid managed care organizations, commercial health plans, providers of substance use disorder services and Indian health care providers.

This analysis was based on existing expenditures and FMAP and included both Medicaid and non-Medicaid clients. The non-Medicaid expenditures are those that are provided to non-Medicaid eligible clients and those that are not "medically necessary" and therefore are not eligible for federal matching funds.

HCA assumes there will be costs for meetings, attendees' travel, printed materials, meeting venues, 1.0 FTE Medical Assistant Program Specialist 3 program manager for the considerable amount of staff time required to:

- Develop an action plan to support improved transitions of care throughout American society;
- Facilitate meetings with stakeholders to present the action plan;
- Write, negotiate, and execute contracts to implement proposed changes;
- And, ongoing contract monitoring.

HCA's expenditure analysis on both Medicaid and non-Medicaid eligible client services assumes a 65.4 percent FMAP. The non-Medicaid eligible expenditures are those that are provided to non-Medicaid eligible clients and those that are not "medically necessary" and therefore are not eligible for federal matching funds.

**Section 4, medical necessity and transportation related impacts for Medicaid:**

HCA also assumes indeterminate costs associated with Section 4 of the bill regarding changing Medicaid medical necessity requirements that would both impact the fee-for-service (FFS) and the managed care programs. This bill would represent a departure from how HCA Medicaid FFS and managed care plans currently utilizes prior authorizations and utilization management for substance use disorder treatment.

Federal law (SEC. 1902(a)(30) of the Social Security Act [42 U.S.C. 1396a]) and rules (42 C.F.R § 456), the Medicaid State Plan and current Integrated Managed Care (IMC) contract provisions requires medical necessity in coverage for Medicaid payment. Certain provisions in the bill may result in loss of Medicaid federal funding, thus relying on state-only funding.

The IMC contract, pursuant to U.S.C., C.F.R. and the Medicaid State Plan requires:

"All Enrollees are entitled to an assessment of need for SUD services. The Contractor shall ensure use of ASAM Level of Care Guidelines to make prior authorization and continuing care decisions for all SUD services." The IMC contract also states: "The Contractor shall collect all information necessary to make medical necessity determinations (42 C.F.R § 456). The Contractor shall determine which services are medically necessary, according to the definition of Medically Necessary Services in this Contract." 42 C.F.R. § 456 includes a host of provisions requiring the state Medicaid program to ensure payment of medically necessary services. 42 CFR § 456.3 states: "The Medicaid agency must implement a statewide surveillance and utilization control program that - (a) Safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments; (b) Assesses the quality of those services; (c) Provides for the control of the utilization of all services provided under the

plan in accordance with subpart B of this part; and (d) Provides for the control of the utilization of inpatient services in accordance with subparts C through I of this part."

The fiscal impact is unknown due to HCA not being able to estimate how many individuals would receive potentially non-medically necessary care. Currently the FFS program and MCOs and Medicaid behavioral health Administrative Service Organizations (ASOs) do not require prior authorization for emergent withdrawal management. If the withdrawal is planned or scheduled, prior authorization and concurrent review are required. In addition, use of federal Medicaid match for provisions in this bill such as requiring a minimum benefit coverage of two days for SUD treatment and three days for withdrawal services, and coverage for weekends and holidays may not be authorized by CMS which generally requires HCA to only pay for services deemed medically necessary by HCA (or designee: MCO/ASO). If CMS does not authorize the use of federal Medicaid funds for mandated coverage and payment for services as described above, General Fund-State will be required to cover these expenditures.

- **For illustrative purposes, a 1 percent increase in non-medically necessary SUD services (those services currently requiring medical necessity) is estimated to cost $1,932,000 ($668,000 of General Fund-State) in fiscal year 2021. And a 5 percent increase is estimated to cost $9,649,000 ($3,341,000 General Fund-State) in fiscal year 2021. This analysis was based on existing expenditures and FMAP and included both Medicaid and non-Medicaid clients. The non-Medicaid expenditures are those that are provided to non-Medicaid eligible clients and those that are not "medically necessary" and therefore are not eligible for federal matching funds.**

If a patient is at an addiction stabilization facility and the recommended plan of treatment is for placement in a different facility or lower level of care, the payer's care coordination unit must work with the facility to make arrangements for a *seamless transfer* to an appropriate and available facility as soon as possible. If an in-network alternative provider is not available, the payer must continue to pay the facility unit an alternative arrangement is made. HCA assumes that the *seamless transfer* to an appropriate level of care will most likely include non-Medicaid reimbursable services. Federal match is not available for non-Medicaid services. These costs would need to be funded with General Fund-State. The associated costs for *seamless services* is indeterminate.

Furthermore, MCOs and ASOs do not currently cover the costs associated with transportation of members to in-network facilities from out-of-network facilities. Requiring coverage of these costs would result in an additional cost to the health plans, as well as an administrative burden due to procurement of new contracts with transportation services. The associated impact of this additional cost to the MCOs/ASOs is indeterminate.

HCA assumes that WAC and billing guidelines and policies would need to be developed to provide parameters on extended treatment stays. There are additional staff ***and*** reprogramming costs to carve out these services, ensure appropriate review and pay them through a FFS delivery system with state dollars only. New codes may need to be identified to bill for services that may not meet medical necessity. These changes would also require programing changes. The associated impact of these additional changes is indeterminate.

HCA notes potential mental health parity discrepancies between SUD levels of care, as the bill does not discuss any changes for outpatient levels of care, but only higher cost residential levels of care. This could lead to over utilization of higher cost levels of care, driving up overall assumptions of benefit costs. The associated impact of these additional changes is indeterminate. Some of these costs may be offset with better treatment options, but these offsets also cannot be determined.

## Part IV: Capital Budget Impact
None

## Part V: New Rule Making Required
None

# Individual State Agency Fiscal Note

| Bill Number: 2642 E S HB | Title: Sub. use disorder coverage | Agency: 160-Office of Insurance Commissioner |
|---|---|---|

## Part I: Estimates

☐ **No Fiscal Impact**

**Estimated Cash Receipts to:**

NONE

**Estimated Operating Expenditures from:**

| | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|
| FTE Staff Years | 0.0 | 0.6 | 0.3 | 0.3 | 0.3 |
| **Account** | | | | | |
| Insurance Commissioners Regulatory Account-State 138-1 | 0 | 74,718 | 74,718 | 67,860 | 67,860 |
| **Total $** | 0 | 74,718 | 74,718 | 67,860 | 67,860 |

**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: | Kevin Black | Phone: (360) 786-7747 | Date: 02/20/2020 |
| Agency Preparation: | Jane Beyer | Phone: 360-725-7043 | Date: 02/26/2020 |
| Agency Approval: | Bryon Welch | Phone: 360-725-7037 | Date: 02/26/2020 |
| OFM Review: | Jason Brown | Phone: (360) 902-0539 | Date: 02/28/2020 |

## 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.*

Section 3(1), for health plans issued or renewed on or after January 1, 2021, prohibits prior authorization requirements in all health plans and from provider contracts for substance use disorder (SUD) treatment services if the provider is licensed or certified, treatment is within the provider's scope of practice, and the provider is employed by a residential treatment facility and licensed to provide withdrawal management services or inpatient substance use disorder treatment services.

Section 3(2)(a): Health plans must provide the following benefits in their coverage: no less than 2 days (including extension for weekend days or holidays) in a state-licensed substance use disorder residential treatment facility and no less than 3 days of withdrawal management services (including extension for weekend days or holidays) in a state-licensed withdrawal management program prior to conducting a utilization review.

Section 3(3): requires treating SUD providers to use American Society of Addiction Medicine guidelines to determine the patient's care needs post-stabilization.

Section 3(4): requires health plans that cover out-of-network services to pay an out-of-network provider a rate no greater than the rate that would be paid if the facility had been in-network. The out-of-network provider cannot balance bill the patient.

Section 3(5): requires carriers' care coordination units to work with the SUD treatment provider when a patient is being transferred to another facility or a lower level of care.

Section 5: requires the Health Care Authority (HCA) to develop an action plan to support improved SUD care transitions throughout ASAM levels of care for adults and adolescents. The Engrossed bill adds the Office of Insurance Commissioner to the groups that HCA must partner with in developing the action plan. The action plan must be communicated to SUD providers by December 1, 2020.

**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 3(1), for health plans issued or renewed on or after January 1, 2021, prohibits prior authorization requirements in all health plans and from provider contracts for substance use disorder (SUD) treatment services if the provider is licensed or certified, treatment is within the provider's scope of practice, and the provider is employed by a residential treatment facility and licensed to provide withdrawal management services or inpatient substance use disorder treatment services.

Section 3(2)(a): Health plans must provide the following benefits in their coverage: no less than 2 days (including extension for weekend days or holidays) in a state-licensed substance use disorder residential treatment facility and no less than 3 days of withdrawal management services (including extension for weekend

days or holidays) in a state-licensed withdrawal management program prior to conducting a utilization review.

Section 3(3): requires treating SUD providers to use American Society of Addiction Medicine (ASAM) guidelines to determine the patient's care needs post-stabilization.

Section 3(4): requires health plans that cover out-of-network services to pay an out-of-network provider a rate no greater than the rate that would be paid if the facility had been in-network. The out-of-network provider cannot balance bill the patient.

Section 3(5): requires carriers' care coordination units to work with the SUD treatment provider when a patient is being transferred to another facility or a lower level of care.

Section 3 will require health provider contracts to be updated to address the new admission and medical necessity review processes and timelines; and will also require additional review of the health plan form filings to ensure the removal of any prior authorization requirements. The Office of Insurance Commissioner (OIC) receives approximately 150 SUD provider contracts each year and assumes approximately 2.25 hours per contract to review for the new processes and timelines. The OIC receives approximately 470 health plan form filings each year and assumes approximately 15 minutes per filing to review for the removal of prior authorization requirements. Beginning in FY2021, one-time costs of 15 hours of a Functional Program Analyst 4 (FPA4) to update filing review standards, update checklist documents, and train staff; and ongoing costs of 2.25 hours of review time per SUD provider contract, or a total of 338 hours (2.25 hours per contract x 150 contracts) of a Functional Program Analyst 3 (FPA3) (285 hours) and a FPA4 (53 hours); and 15 minutes of review time per health plan form filing, or a total of 118 hours (15 minutes per filing x 470 filings) of a FPA3 (79 hours) and a FPA4 (39 hours) will be required.

Based on current coverage-related rates of non-compliance, and given the breadth of the new coverage requirements for carriers, it is anticipated that there will be two coverage-related enforcement cases in FY2021 requiring 20 hours (10 hours per case x 2 cases) of an Insurance Enforcement Specialist and 32 hours (16 hours x 2 cases) of a Paralegal 2.

Revisions would be needed to WAC 284-43-2000 related to utilization review, WAC 284-43-2020 re drug utilization review, WAC 284-43-7000 et seq re mental health parity and any reference in chapter 284-43 to the chemical dependency benefit mandate for group health plans. Also, terms used in the statute, such as the reference to "insurance fraud" in section 3(3) and "seamless transfer" in section 3(4) would need clarification in rule. Chapter 48.43B WAC would need to be revised to reflect balance billing prohibition provisions in this legislation, potentially as a new section in that chapter. This would require 'normal' rulemaking in FY2021.

Section 5: requires the Health Care Authority (HCA) to develop an action plan to support improved SUD care transitions throughout ASAM levels of care for adults and adolescents. The Engrossed bill adds OIC to the groups that HCA should partner with in developing the action plan. The action plan must be communicated to SUD providers by December 1, 2020. Partnership with the HCA would involve attending meetings of the group, potential research on current law and rules, and gathering needed information. This work would require approximately 60 hours (10 hours x 6 months)of a Senior Policy Analyst in FY2021.

Ongoing costs:
Salary, benefits and associated costs for .06 Functional Program Analyst 4 and .22 FTE Functional Program Analyst 3.

# Part III: Expenditure Detail

**III. A - Operating Budget Expenditures**

| Account | Account Title | Type | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|---|---|
| 138-1 | Insurance Commissioners Regulatory Account | State | 0 | 74,718 | 74,718 | 67,860 | 67,860 |
| | | **Total $** | 0 | 74,718 | 74,718 | 67,860 | 67,860 |

**III. B - Expenditures by Object Or Purpose**

| | FY 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|
| FTE Staff Years | | 0.6 | 0.3 | 0.3 | 0.3 |
| A-Salaries and Wages | | 44,000 | 44,000 | 39,448 | 39,448 |
| B-Employee Benefits | | 15,774 | 15,774 | 14,840 | 14,840 |
| C-Professional Service Contracts | | | | | |
| E-Goods and Other Services | | 14,944 | 14,944 | 13,572 | 13,572 |
| 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 | 74,718 | 74,718 | 67,860 | 67,860 |

**III. C - Operating FTE 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 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|---|
| Functional Program Analyst 3 | 68,892 | | 0.2 | 0.1 | 0.2 | 0.2 |
| Functional Program Analyst 4 | 76,128 | | 0.1 | 0.1 | 0.1 | 0.1 |
| Insurance Enforcement Specialist | 87,108 | | 0.0 | 0.0 | | |
| Paralegal 2 | 68,892 | | 0.0 | 0.0 | | |
| Senior Policy Analyst | 91,896 | | 0.2 | 0.1 | | |
| **Total FTEs** | | | 0.6 | 0.3 | 0.3 | 0.3 |

**III. D - Expenditures By Program (optional)**

NONE

# Part IV: Capital Budget Impact

**IV. A - Capital Budget Expenditures**

NONE

**IV. B - Expenditures by Object Or Purpose**

NONE

**IV. C - Capital Budget Breakout**

*Identify acquisition and construction costs not reflected elsewhere on the fiscal note and describe potential financing methods*

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.*

Revisions would be needed to WAC 284-43-2000 related to utilization review, WAC 284-43-2020 re drug utilization review, WAC 284-43-7000 et seq re mental health parity and any reference in chapter 284-43 to the chemical dependency benefit mandate for group health plans. Also, terms used in the statute, such as the reference to "insurance fraud" in section 3(3) and "seamless transfer" in section 3(4) would need clarification in rule. Chapter 48.43B WAC would need to be revised to reflect balance billing prohibition provisions in this legislation, potentially as a new section in that chapter. This would require 'normal' rulemaking in FY2021.

# Individual State Agency Fiscal Note

| Bill Number: 2642 E S HB | Title: Sub. use disorder coverage | Agency: 300-Department of Social and Health Services |
|---|---|---|

## Part I: Estimates

[X] **No Fiscal Impact**

**Estimated Cash Receipts to:**

NONE

**Estimated Operating Expenditures from:**
NONE

**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: | Kevin Black | Phone: (360) 786-7747 | Date: 02/20/2020 |
| Agency Preparation: | Sara Corbin | Phone: 360-902-8194 | Date: 02/21/2020 |
| Agency Approval: | Dan Winkley | Phone: 360-902-8236 | Date: 02/21/2020 |
| OFM Review: | Robyn Williams | Phone: (360) 902-0575 | Date: 02/21/2020 |

## 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.*

ESHB 2642 has no fiscal impact to the Department of Social and Health Services (DSHS) as passage of this legislation will not impact workload or client benefits.

**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

**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.*

None

## Part III: Expenditure Detail

**III. A - Operating Budget Expenditures**

NONE

**III. B - Expenditures by Object Or Purpose**

NONE

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

NONE

**III. D - Expenditures By Program (optional)**

NONE

## Part IV: Capital Budget Impact

**IV. A - Capital Budget Expenditures**

NONE

**IV. B - Expenditures by Object Or Purpose**

NONE

**IV. C - Capital Budget Breakout**

*Identify acquisition and construction costs not reflected elsewhere on the fiscal note and describe potential financing methods*

NONE

None

## Part V: New Rule Making Required

# Individual State Agency Fiscal Note

| Bill Number: 2642 E S HB | Title: Sub. use disorder coverage | Agency: 303-Department of Health |
|---|---|---|

## Part I: Estimates

[X] **No Fiscal Impact**

**Estimated Cash Receipts to:**

NONE

**Estimated Operating Expenditures from:**
NONE

**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.

[X] Requires new rule making, complete Part V.

| | | | |
|---|---|---|---|
| Legislative Contact: | Kevin Black | Phone: (360) 786-7747 | Date: 02/20/2020 |
| Agency Preparation: | Donna Compton | Phone: (360) 236-4538 | Date: 02/21/2020 |
| Agency Approval: | Stacy May | Phone: (360) 236-4532 | Date: 02/21/2020 |
| OFM Review: | Bryce Andersen | Phone: (360) 902-0580 | Date: 02/21/2020 |

## 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 fiscal impact to the Department of Health has not changed as a result of this engrossed substitute version.

This bill adds an effective date of January 1, 2021 to Sections 2 and 3, prohibiting a health plan issued or renewed on or after this date from requiring an enrollee to obtain prior authorization for substance use disorder treatment services under the provisions of this bill. The changes in this substitute bill create minimal fiscal impacts to the department.

Section 5: A new section is added requiring the Health Care Authority (HCA) to develop an action plan to support improved transitions throughout American society of addiction medicine levels of care. The barriers and action items to be identified and addressed in the action plan must include systems developed by the HCA and Department of Health (department) to allow higher acuity withdrawal management facilities to bill for appropriate lower levels of care while maintaining financial stability. The HCA must develop options for communicating the action plan to substance use disorder providers by December 1, 2020.

**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

**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 5(4)(a): The department will adopt rules regarding systems to allow withdrawal management facilities to bill for appropriate lower levels of care. The department assumes that licensing rules for behavioral health agencies already allow withdrawal management facilities to provide lower levels of services as long as they are certified to provide that lower level of service. The department will collaborate with the HCA on this subsection of the bill. The estimated work is minimal and can be accomplished by existing staff within their normal workload.

## Part III: Expenditure Detail

**III. A - Operating Budget Expenditures**

NONE

**III. B - Expenditures by Object Or Purpose**

NONE

**III. C - Operating FTE 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 2020 | FY 2021 | 2019-21 | 2021-23 | 2023-25 |
|---|---|---|---|---|---|---|
| Fiscal Analyst 2 | 53,000 | | | | | |
| Health Svcs Conslt 1 | 53,000 | | | | | |
| NURSING CONSULTATION ADVISOR | 138,564 | | | | | |
| **Total FTEs** | | | | | | 0.0 |

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

NONE

**III. D - Expenditures By Program (optional)**

NONE

# Part IV: Capital Budget Impact

**IV. A - Capital Budget Expenditures**

NONE

**IV. B - Expenditures by Object Or Purpose**

NONE

**IV. C - Capital Budget Breakout**

*Identify acquisition and construction costs not reflected elsewhere on the fiscal note and describe potential financing methods*

NONE

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