PROPOSED

S2356 SUB A2

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2016

A N A C T

RELATING TO HEALTH AND SAFETY -- INSURANCE--MENTAL ILLNESS AND SUBSTANCE ABUSE – THE ALEXANDER C. PERRY ACT

Introduced By: Senators Miller, Jabour, Crowley, Goodwin, and Satchell

Date Introduced: February 10, 2016

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

SECTION 1. Section 23-17.26-3 of the General Laws in Chapter 23-17.26 entitled "The Alexander C. Perry Act " is hereby amended to read as follows:

23-17.26-3. Comprehensive discharge planning. -- (a) On or before ~~July~~ September 1, ~~2015~~ 2016, each hospital and freestanding emergency care facility operating in the State of Rhode Island shall submit to the director:

(1) With patient consent, each patient presenting to a hospital or freestanding emergency care facility with indication of a substance use disorder, opioid overdose, or chronic addiction shall receive a substance abuse evaluation, in accordance with the standards in subsection (a)(5)(ii) of this section, before discharge. Prior to the dissemination of the standards in subsection (a)(5)(ii) of this section, with patient consent, each patient presenting to a hospital or freestanding emergency care facility with indication of a substance use disorder, opioid overdose, or chronic addiction shall receive a substance abuse evaluation, in accordance with best practices standards, before discharge.

~~(1)~~ (2) Evidence of participation in a high-quality comprehensive discharge planning and transitions improvement project operated by a nonprofit organization in this state; or

~~(2)~~ (3) A plan for the provision of comprehensive discharge planning and information to be

shared with patients transitioning from the ~~hospitals~~ hospital's or freestanding emergency care facility's care. Such plan shall contain the adoption of evidence-based practices including, but not limited to:

(i) Providing ~~in-hospital~~ education in the hospital or freestanding emergency care facility prior to discharge;

(ii) Ensuring patient involvement such that, at discharge, patients and caregivers understand the patient's conditions and medications and have a point of contact for follow-up questions;

(iii) With patient consent, ~~A~~attempting to notify the person(s) listed as patients' emergency contacts and recovery coach before discharge. If the patient refuses to consent to the notification of emergency contacts, such refusal shall be noted in the patient's medical record;

~~(iii)~~ (iv) Attempting to identify patients' primary care providers and assisting with scheduling post-~~hospital~~ discharge follow-up appointments prior to patient discharge;

~~(iv)~~ (v) Expanding the transmission of the department of health's continuity of care form, or successor program, to include primary care providers' receipt of information at patient discharge when the primary care provider is identified by the patient; and

~~(v)~~ (vi) Coordinating and improving communication with outpatient providers.

~~(3)~~ (4) The discharge plan and transition process shall ~~also be made~~ include recovery planning tools for patients with ~~opioid and other substance use disorders~~ substance use disorders, opioid overdoses, and chronic addiction which plan and transition process shall include the elements contained in subsections (a)(~~1)~~(2) or (a)(~~2)~~(3) of this section, as applicable. In addition, such discharge plan and transition process shall also include:

~~(i) Assistance, with patient consent, in securing at least one follow-up appointment for the patient within seven (7) days of discharge, as clinically appropriate:~~

~~(A) With a facility licensed by the department of behavioral healthcare, developmental disabilities and hospitals to provide treatment of substance use disorders,~~

~~(B) With a certified recovery coach;~~

~~(C) With a licensed clinician with expertise in the treatment of substance use disorders, or~~

~~(D) With a Rhode Island licensed hospital with a designated program for the treatment of substance use disorders, The patient shall be informed of said appointment prior to the patient being discharged from the hospital;~~

~~(ii) In the absence of a scheduled follow-up appointment pursuant to subsection (a)(3)(i),~~

every reasonable effort shall be made to contact the patient within thirty (30) days post-discharge to provide the patient with a referral and other such assistance as the patient needs to obtain a follow-up appointment; and

(iii) That the patient receives information about the real-time availability of appropriate in-patient and out-patient services in Rhode Island.

(iv) That the patient, or non-patient, presenting to hospitals, health care clinics, urgent care centers, and emergency room diversion facilities with indication of a substance use disorder, opioid overdose, or chronic addiction, shall receive information about the real-time availability of clinically appropriate in-patient and out-patient services for the treatment of substance use disorders, opioid overdose, or chronic addiction, including:

(A) Detoxification;

(B) Stabilization;

(C) Medication-assisted treatment or medication-assisted maintenance services, including methadone, buprenorphine, naltrexone or other clinically appropriate medications; and

(D) Recovery coaches.

If the clinically appropriate in-patient and out-patient services for the treatment of substance use disorder, opioid overdose, or chronic addiction are not immediately available, the hospital, health care clinic, urgent care center, and emergency room diversion facility shall provide medically necessary and appropriate services until the appropriate transfer of care is completed.

(4) On or before November 1, 2014 2016, the director of the department of health shall develop and disseminate to all hospitals, health care clinics, urgent care centers, and emergency room diversion facilities a model discharge plan and transition process for patients with opioid and other substance use disorders. This model plan may be used as a guide, but may be amended and modified to meet the specific needs of each hospital, health care clinic, urgent care center and emergency room diversion facility. with the director of the department of behavioral healthcare, developmental disabilities and hospitals shall submit revised regulations for patients presenting to hospitals, health care clinics, urgent care centers, and emergency room diversion facilities with indication of a substance use disorder, opioid overdose, or chronic addiction to ensure prompt

~~access to the clinically appropriate in-patient and out-patient services contained in subsection (a)(3)(iv) of this section. The revised regulations shall include a strategy for the development and maintenance of a database of real-time availability of clinically appropriate in-patient and out-patient services contained in subsection (a)(3)(iv) of this section. The director of the department of health with the director of the department of behavioral healthcare, developmental disabilities and hospitals shall develop and disseminate to all hospitals, health care clinics, urgent care centers, and emergency room diversion facilities model pre-admission, admission and discharge guidelines, a recovery plan and transition process for patients with substance use disorders, opioid overdose, or chronic addiction, presenting information on the real-time availability of appropriate in-patient and out-patient services contained in subsection (a)(3)(iv) of this section. Recommendations from the Rhode Island governor's overdose prevention and intervention task force strategic plan may be incorporated into the model plan as a guide, but may be amended and modified to meet the specific needs of each hospital, health care clinic, urgent care center and emergency room diversion facility.~~

(i) That if, after the completion of a substance abuse evaluation, in accordance with the standards in subsection (a)(5)(ii) of this section, the clinically appropriate inpatient and outpatient services for the treatment of substance use disorders, opioid overdose, or chronic addiction contained in subsection (a)(4)(iii) of this section are not immediately available, the hospital or freestanding emergency care facility shall provide medically necessary and appropriate services until the appropriate transfer of care is completed;

(ii) That with patient consent, pursuant to 21 C.F.R. § 1306.07, a physician in a hospital or freestanding emergency care facility who is not specifically registered to conduct a narcotic treatment program may administer narcotic drugs, including buprenorphine, to a person for the purpose of relieving acute opioid withdrawal symptoms when necessary while arrangements are being made for referral for treatment; not more than one day's medication may be administered to the person or for the person's use at one (1) time; and such emergency treatment may be carried out for not more than three (3) days and may not be renewed or extended;

(iii) That each patient presenting to a hospital or freestanding emergency care facility with indication of a substance use disorder, opioid overdose, or chronic addiction shall receive information, made available to the hospital or freestanding emergency care facility in accordance

with subsection (a)(5)(v) of this section, about availability of clinically appropriate inpatient and outpatient services for the treatment of substance use disorders, opioid overdose, or chronic addiction, including:

(A) Detoxification;

(B) Stabilization;

(C) Medication-assisted treatment or medication-assisted maintenance services, including methadone, buprenorphine, naltrexone or other clinically appropriate medications;

(D) Inpatient and residential treatment;

(E) Licensed clinicians with expertise in the treatment of substance use disorders, opioid overdoses, and chronic addiction;

(F) Certified recovery coaches; and

(iv) That when the real-time patient services database outlined in subsection (a)(5)(vi) of this section becomes available, each patient shall receive real-time information from the hospital or freestanding emergency care facility about the availability of clinically appropriate inpatient and outpatient services.

~~(4)~~ (5) On or before ~~November 1, 2016,~~ January 1, 2017, the director of the department of health ~~Shall develop and disseminate to all hospitals, health care clinics, urgent care centers, and emergency room diversion facilities a model discharge plan and transition process for patients with opioid and other substance use disorders. This model plan may be used as a guide, but may be amended and modified to meet the specific needs of each hospital, health care clinic, urgent care center and emergency room diversion facility.~~ with the director of the department of behavioral healthcare, developmental disabilities and hospitals shall:

(i) Develop and disseminate to all hospitals and freestanding emergency care facilities a regulatory standard for the early introduction of a recovery coach during the pre-admission and/or admission process for patients with substance use disorders, opioid overdose, or chronic addiction;

(ii) Develop and disseminate to all hospitals and freestanding emergency care facilities substance abuse evaluation standards for patients with substance use disorders, opioid overdose, or chronic addiction;

(iii) Develop and disseminate to all hospitals and freestanding emergency care facilities

pre-admission, admission, and discharge regulatory standards, a recovery plan and voluntary transition process for patients with substance use disorders, opioid overdose, or chronic addiction. Recommendations from the 2015 Rhode Island Governor's overdose prevention and intervention task force strategic plan may be incorporated into the standards as a guide, but may be amended and modified to meet the specific needs of each hospital and freestanding emergency care facility;

(iv) Develop and disseminate best practices standards for health care clinics, urgent care centers, and emergency diversion facilities regarding protocols for screening, transfer and referral to clinically appropriate inpatient and outpatient services contained in subsection (a)(4)(iii) of this section;

(v) Submit regulations for patients presenting to hospitals and freestanding emergency care facilities with indication of a substance use disorder, opioid overdose, or chronic addiction to ensure prompt, voluntary access to clinically appropriate inpatient and outpatient services contained in subsection (a)(4)(iii) of this section;

(vi) Submit a strategy to assess, develop, implement and maintain a database of real-time availability of clinically appropriate inpatient and outpatient services contained in subsection (a)(4)(iii) of this section on or before January 1, 2018.

SECTION 2. Section 27-38.2-1 of the General Laws in Chapter 27-38.2 entitled "Insurance Coverage for Mental Illness and Substance Abuse" is hereby amended to read as follows:

27-38.2-1. Coverage for the treatment of mental health and substance use disorders.

(a) A group health plan and an individual or group health insurance plan shall provide coverage

for the treatment of mental health and substance-use disorders under the same terms and conditions as that coverage is provided for other illnesses and diseases.

(b) Coverage for the treatment of mental health and substance-use disorders shall not impose any annual or lifetime dollar limitation.

(c) Financial requirements and quantitative treatment limitations on coverage for the treatment of mental health and substance-use disorders shall be no more restrictive than the predominant financial requirements applied to substantially all coverage for medical conditions in each treatment classification.

(d) Coverage shall not impose non-quantitative treatment limitations for the treatment of

mental health and substance-use disorders unless the processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

(e) The following classifications shall be used to apply the coverage requirements of this chapter: (1) Inpatient, in-network; (2) Inpatient, out-of-network; (3) Outpatient, in-network; (4) Outpatient, out-of-network; (5) Emergency care; and (6) Prescription drugs.

(f) Medication-assisted ~~therapy~~ treatment or medication-assisted maintenance services of substance use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone or other clinically appropriate medications, ~~maintenance services, for the treatment of substance-use disorders, opioid overdoses, and chronic addiction~~ is included within the appropriate classification based on the site of the service.

(g) Payors shall rely upon the criteria of the American Society of Addiction Medicine when developing coverage for levels of care for substance-use disorder treatment.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- INSURANCE--MENTAL ILLNESS AND SUBSTANCE ABUSE

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The ~~act~~ Alexander C. Perry Act would require comprehensive discharge planning for patients

treated for substance use disorders, opioid overdoses, and chronic addiction and would require insurers to cover medication-assisted addiction treatment including methadone, buprenorphine, and naltrexone.

This act would take effect upon passage.