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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2024

A N A C T

RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING

Introduced By: Representatives Donovan, Tanzi, Boylan, Morales, Caldwell, Carson, Speakman, Cotter, Potter, and McGaw
Date Introduced: March 04, 2024

Referred To: House Finance

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 "Comprehensive Discharge Planning" is hereby amended to read as follows:

23-17.26-3. Comprehensive discharge planning.

(a) On or before January 1, 2017, each hospital and freestanding emergency-care facility operating in the state of Rhode Island shall submit to the director a comprehensive discharge plan that includes:

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

(2) A plan for the provision of comprehensive discharge planning and information to be shared with patients transitioning from the 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 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) Encouraging notification of the person(s) listed as the patient's emergency contacts and certified peer recovery specialist to the extent permitted by lawful patient consent or applicable law, including, but not limited to, the Federal Health Insurance Portability and Accountability Act

of 1996, as amended, and 42 C.F.R. Part 2, as amended. The policy shall also require all attempts at notification to be noted in the patient's medical record;

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

(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

(vi) Coordinating and improving communication with outpatient providers.

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

(i) That, 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 use evaluation, in accordance with the standards in subsection (a)(4)(ii), before discharge. Prior to the dissemination of the standards in subsection (a)(4)(ii), 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 use evaluation, in accordance with best practices standards, before discharge;

(ii) That if, after the completion of a substance use evaluation, in accordance with the standards in subsection (a)(4)(ii), the clinically appropriate inpatient and outpatient services for the treatment of substance use disorders, opioid overdose, or chronic addiction contained in subsection (a)(3)(iv) are not immediately available, the hospital or freestanding emergency-care facility shall provide medically necessary and appropriate services with patient consent, until the appropriate transfer of care is completed;

(iii) 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 time. Such emergency treatment may be carried out for not more than three (3) days and may not be renewed or extended;

(iv) 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)(4)(v), about the availability of clinically appropriate inpatient and outpatient services for the treatment of mental health disorders, including 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~~ Outpatient, inpatient and residential treatment;

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

(F) Certified peer recovery specialists~~; and~~.

(v) That, when the real-time patient-services database outlined in subsection (a)(4)(vi) 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) On or before January 1, 2017, the director of the department of health, 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 certified peer recovery specialist 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 use 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 healthcare clinics, urgent-care centers, and emergency-diversion facilities regarding protocols for patient screening, transfer, and referral to clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv);

(v) Develop 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)(3)(iv);

(vi) Develop a strategy to assess, create, implement, and maintain a database of real-time availability of clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv) of this section on or before January 1, 2018.

(b) Nothing contained in this chapter shall be construed to limit the permitted disclosure of confidential healthcare information and communications permitted in § 5-37.3-4(b)(4)(i) of the confidentiality of health care communications act.

(c) On or before September 1, 2017, each hospital and freestanding emergency-care facility operating in the state of Rhode Island shall submit to the director a discharge plan and transition process that shall include provisions for patients with a primary diagnosis of a mental health disorder without a co-occurring substance use disorder.

(d) On or before January 1, 2018, the director of the department of health, with the director of the department of behavioral healthcare, developmental disabilities and hospitals, shall develop and disseminate mental health best practices standards for healthcare clinics, urgent care centers, and emergency diversion facilities regarding protocols for patient screening, transfer, and referral to clinically appropriate inpatient and outpatient services. The best practice standards shall include information and strategies to facilitate clinically appropriate prompt transfers and referrals from hospitals and freestanding emergency-care facilities to less intensive settings.

(e) The director of the department of health, with the director of the department of behavioral healthcare, developmental disabilities and hospitals, shall utilize the real-time database created under § 23-17.26-3(a)(4)(vi), and develop and implement a plan to ensure that patients with mental health disorders, including substance use disorders, who are in need of, and agree to, clinically appropriate and medically necessary residential, inpatient, or outpatient services are discharged from hospitals and freestanding emergency-care facilities into such settings as expeditiously as possible.

(f) On or before March l, 2028, the senate and house committees on health and human services and/or any other committee deemed appropriate by the president of the senate and the speaker of the house of representatives shall conduct a hearing on the impact of subsection (e) of this section to include presentations from payors and providers, and other stakeholders at the discretion of the committee chairs.

SECTION 2. Chapter 23-17.26 of the General Laws entitled "Comprehensive Discharge

Planning" is hereby amended by adding thereto the following section:

23-17.26-5. Comprehensive patient consent form.

Each hospital and freestanding emergency-care facility shall incorporate patient consent for certified peer recovery specialist services into a comprehensive patient consent form. Consent for certified peer recovery services shall be contained in its own discrete section of the comprehensive patient consent form. This section shall be implemented no later than January 1, 2025.

SECTION 3. Section 27-38.2-1 of the General Laws in Chapter 27-38.2 entitled "Insurance Coverage for Mental Illness and Substance Use Disorders" is hereby amended to read as follows:

27-38.2-1. ~~Coverage for treatment of mental health and substance use disorders~~ Coverage for treatment of mental health disorders, including substance use disorders.

(a) A group health plan and an individual or group health insurance plan, and any contract between the Rhode Island Medicaid program and any health insurance carrier, as defined under chapters 18, 19, 20, and 41 of title 27, 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~~ disorders, including 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~~ disorders, including 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~~ be subject to non-quantitative treatment limitations for the treatment of mental health ~~and~~ disorders, including 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 treatment or medication-assisted maintenance services of substance use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine, naltrexone, or other clinically appropriate medications, 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 and determining placements for substance use disorder treatment.

(h) Patients with substance use disorders shall have access to evidence-based, non-opioid treatment for pain, therefore coverage shall apply to medically necessary chiropractic care and osteopathic manipulative treatment performed by an individual licensed under § 5-37-2.

(i) Parity of cost-sharing requirements. Regardless of the professional license of the provider of care, if that care is consistent with the provider's scope of practice and the health plan's credentialing and contracting provisions, cost sharing for behavioral health counseling visits and medication maintenance visits shall be consistent with the cost sharing applied to primary care office visits.

(j) Consistent with coverage for medical and surgical services, a health plan as defined in subsection (a) of this section shall cover clinically appropriate and medically necessary residential or inpatient services, including detoxification and stabilization services, for the treatment of mental health disorders, including substance use disorders, in accordance with this subsection.

(1) The health plan shall provide coverage for clinically appropriate and medically necessary residential or inpatient services, including American Society of Addiction Medicine levels of care for residential and inpatient services, and shall not require preauthorization prior to a patient obtaining such services, provided that the facility shall provide the health plan notification of admission, proof that an assessment was conducted based upon the criteria of the American Society of Addiction Medicine or after an appropriate psychiatric assessment for mental health disorders, that residential or inpatient services is the most appropriate and least restrictive level of care necessary, the initial treatment plan, and estimated length of stay within forty-eight hours (48) of admission.

(2) Notwithstanding § 27-38.2-3, coverage provided under this subsection shall not be subject to concurrent utilization review during the first twenty-eight (28) days of the residential or inpatient admission provided that the facility notifies the health plan as provided in subsection (j)(1) of this section. The facility shall perform daily clinical review of the patient, including consultation with the health plan at, or just prior to, the fourteenth day of treatment to ensure that the facility determined that the residential or inpatient treatment was clinically appropriate and medically necessary for the patient using an assessment based upon the criteria of the American Society of Addiction Medicine or after an appropriate psychiatric assessment for mental health disorders.

(3) Prior to discharge from residential or inpatient services, the facility shall provide the

patient and the health plan with a written discharge plan which shall describe arrangements for additional services needed following discharge from the residential or inpatient facility as determined using an assessment based upon the criteria of the American Society of Addiction Medicine or after an appropriate psychiatric assessment for mental health disorders. Prior to discharge, the facility shall indicate to the health plan whether services included in the discharge plan are secured or determined to be reasonably available. The health plan may conduct utilization review procedures, in consultation with the patient's treating clinician, regarding the discharge plan and continuation of care.

(4) Any utilization review of treatment provided under this subsection may include a review of all services provided during such residential or inpatient treatment, including all services provided during the first twenty-eight (28) days of such residential or inpatient treatment. Provided, however, the health plan shall only deny coverage for any portion of the initial twenty-eight (28) days of residential or inpatient treatment on the basis that such treatment was not medically necessary if such residential or inpatient treatment was contrary to the assessment based upon the criteria of the American Society of Addiction Medicine or after an appropriate psychiatric assessment for mental health disorders. A patient shall not have any financial obligation to the facility for any treatment under this subsection other than any copayment, coinsurance, or deductible otherwise required under the policy.

(5) This subsection shall apply only to covered services delivered within the health plan's provider network.

(6) Nothing herein prohibits the health plan from conducting quality of care reviews.

(k) No health plan as defined in subsection (a) of this section shall refuse to cover treatment for mental health disorders, including substance use disorders, regardless of the level of care, that such health plan is required to cover pursuant to this section solely because such treatment is ordered by a court of competent jurisdiction or by a government operated diversion program.

(l) On or before March l, 2028, the senate and house committees on health and human services and/or any other committee deemed appropriate by the president of the senate and the speaker of the house of representatives shall conduct a hearing on the impact of subsections (j) and (k) of this section to include presentations from payors and providers, and other stakeholders at the discretion of the committee chairs.

SECTION 4. This act shall take effect on January 1, 2025.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

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RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING

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This act would require a health plan to cover clinically appropriate and medically necessary residential or inpatient services, including detoxification and stabilization services, for the treatment of mental health disorders, including substance use disorders. A health plan shall not require preauthorization prior to a patient obtaining such services provided certain notifications are provided to the health plan within forty-eight hours (48) of admission. This act would also provide that such coverage shall not be subject to concurrent utilization review during the first twenty-eight (28) days of the residential or inpatient admission.

This act would take effect on January 1, 2025.

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