

**2022 -- S 2078 SUBSTITUTE A**

LC003766/SUB A

**STATE OF RHODE ISLAND**

**IN GENERAL ASSEMBLY**

**JANUARY SESSION, A.D. 2022**

**A N A C T**

**RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING**

Introduced By: Senators Miller, Valverde, Goodwin, DiPalma, DiMario, Zurier, and  
Seveney

Date Introduced: January 25, 2022

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

1 SECTION 1. Section 23-17.26-3 of the General Laws in Chapter 23-17.26 entitled  
2 "Comprehensive Discharge Planning" is hereby amended to read as follows:

3 **23-17.26-3. Comprehensive discharge planning.**

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

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

9 (2) A plan for the provision of comprehensive discharge planning and information to be  
10 shared with patients transitioning from the hospital's or freestanding emergency-care facility's care.

11 Such plan shall contain the adoption of evidence-based practices including, but not limited to:

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

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

17 (iii) Encouraging notification of the person(s) listed as the patient's emergency contacts  
18 and certified peer recovery specialist to the extent permitted by lawful patient consent or applicable  
19 law, including, but not limited to, the Federal Health Insurance Portability and Accountability Act

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

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

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

8 (vi) Coordinating and improving communication with outpatient providers.

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

12 In addition, such discharge plan and transition process shall also include:

13 (i) That, with patient consent, each patient presenting to a hospital or freestanding  
14 emergency-care facility with indication of a substance use disorder, opioid overdose, or chronic  
15 addiction shall receive a substance use evaluation, in accordance with the standards in subsection  
16 (a)(4)(ii), before discharge. Prior to the dissemination of the standards in subsection (a)(4)(ii), with  
17 patient consent, each patient presenting to a hospital or freestanding emergency-care facility with  
18 indication of a substance use disorder, opioid overdose, or chronic addiction shall receive a  
19 substance use evaluation, in accordance with best practices standards, before discharge;

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

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

33 (iv) That each patient presenting to a hospital or freestanding emergency-care facility with  
34 indication of a substance use disorder, opioid overdose, or chronic addiction, shall receive

1 information, made available to the hospital or freestanding emergency-care facility in accordance  
2 with subsection (a)(4)(v), about the availability of clinically appropriate inpatient and outpatient  
3 services for the treatment of mental health disorders, including substance use disorders, opioid  
4 overdose, or chronic addiction, including:

- 5 (A) Detoxification;
- 6 (B) Stabilization;
- 7 (C) Medication-assisted treatment or medication-assisted maintenance services, including  
8 methadone, buprenorphine, naltrexone, or other clinically appropriate medications;
- 9 (D) Outpatient, ~~Inpatient~~ inpatient and residential treatment;
- 10 (E) Licensed clinicians with expertise in the treatment of substance use disorders, opioid  
11 overdoses, and chronic addiction; and

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

13 (v) That, when the real-time patient-services database outlined in subsection (a)(4)(vi)  
14 becomes available, each patient shall receive real-time information from the hospital or  
15 freestanding emergency-care facility about the availability of clinically appropriate inpatient and  
16 outpatient services.

17 (4) On or before January 1, 2017, the director of the department of health, with the director  
18 of the department of behavioral healthcare, developmental disabilities and hospitals, shall:

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

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

26 (iii) Develop and disseminate, to all hospitals and freestanding emergency-care facilities,  
27 pre-admission, admission, and discharge regulatory standards, a recovery plan, and voluntary  
28 transition process for patients with substance use disorders, opioid overdose, or chronic addiction.  
29 Recommendations from the 2015 Rhode Island governor's overdose prevention and intervention  
30 task force strategic plan may be incorporated into the standards as a guide, but may be amended  
31 and modified to meet the specific needs of each hospital and freestanding emergency-care facility;

32 (iv) Develop and disseminate best practices standards for healthcare clinics, urgent-care  
33 centers, and emergency-diversion facilities regarding protocols for patient screening, transfer, and  
34 referral to clinically appropriate inpatient and outpatient services contained in subsection (a)(3)(iv);

1 (v) Develop regulations for patients presenting to hospitals and freestanding emergency-  
2 care facilities with indication of a substance use disorder, opioid overdose, or chronic addiction to  
3 ensure prompt, voluntary access to clinically appropriate inpatient and outpatient services  
4 contained in subsection (a)(3)(iv);

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

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

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

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

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

29 (f) On or before March 1, 2026, the senate and house committees on health and human  
30 services and/or any other committee deemed appropriate by the president of the senate and the  
31 speaker of the house of representatives shall conduct a hearing on the impact of subsection (e) of  
32 this section to include presentations from payors and providers, and other stakeholders at the  
33 discretion of the committee chairs.

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

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

2 **23-17.26-5. Comprehensive patient consent form.**

3 Each hospital and freestanding emergency-care facility shall incorporate patient consent  
4 for certified peer recovery specialist services into a comprehensive patient consent form. Consent  
5 for certified peer recovery services shall be contained in its own discrete section of the  
6 comprehensive patient consent form. This section shall be implemented no later than January 1,  
7 2023.

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

10 **27-38.2-1. ~~Coverage for treatment of mental health and substance use disorders~~**  
11 **Coverage for treatment of mental health disorders, including substance use disorders.**

12 (a) A group health plan and an individual or group health insurance plan, and any contract  
13 between the Rhode Island Medicaid program and any health insurance carrier, as defined under  
14 chapters 18, 19, 20, and 41 of title 27, shall provide coverage for the treatment of mental health ~~and~~  
15 disorders, including substance use disorders, under the same terms and conditions as that coverage  
16 is provided for other illnesses and diseases.

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

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

23 (d) Coverage shall not ~~impose~~ be subject to non-quantitative treatment limitations for the  
24 treatment of mental health ~~and~~ disorders, including substance use disorders unless the processes,  
25 strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment  
26 limitation, as written and in operation, are comparable to, and are applied no more stringently than,  
27 the processes, strategies, evidentiary standards, or other factors used in applying the limitation with  
28 respect to medical/surgical benefits in the classification.

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

32 (f) Medication-assisted treatment or medication-assisted maintenance services of substance  
33 use disorders, opioid overdoses, and chronic addiction, including methadone, buprenorphine,  
34 naltrexone, or other clinically appropriate medications, is included within the appropriate

1 classification based on the site of the service.

2 (g) Payors shall rely upon the criteria of the American Society of Addiction Medicine when  
3 developing coverage for levels of care and determining placements for substance use disorder  
4 treatment.

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

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

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

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

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

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

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

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

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

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

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

26 (l) On or before March 1, 2026, the senate and house committees on health and human  
27 services and/or any other committee deemed appropriate by the president of the senate and the  
28 speaker of the house of representatives shall conduct a hearing on the impact of subsections (j) and  
29 (k) of this section to include presentations from payors and providers, and other stakeholders at the  
30 discretion of the committee chairs.

31 SECTION 4. This act shall take effect on January 1, 2023.

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LC003766/SUB A  
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EXPLANATION  
BY THE LEGISLATIVE COUNCIL  
OF  
A N A C T  
RELATING TO HEALTH AND SAFETY -- COMPREHENSIVE DISCHARGE PLANNING

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

8           This act would take effect on January 1, 2023.

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