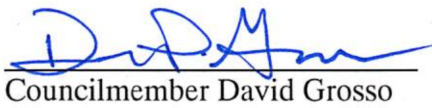
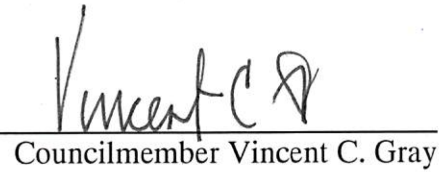
1  
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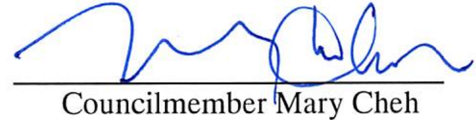
4 
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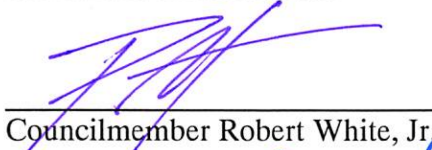
8 
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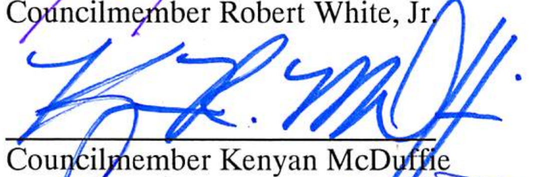
12 
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14 Councilmember Kenyan McDuffie
15 Councilmember Jack Evans
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17 Councilmember Trayon White
18 A BILL
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20 ____________

21 IN THE COUNCIL OF THE DISTRICT OF COLUMBIA

22
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25

26 To improve treatment for substance use disorder by requiring every health plan to transmit upon
27 request a list of all in network providers that treat opiate use disorders along with their
28 contact information; requiring the Department of Health Care Finance to determine the
29 feasibility of expanding opioid use disorder medications offerings in methadone clinics;
30 requiring a study on appropriate reimbursement levels for substance abuse treatment; by
31 requiring that all of currently approved forms of medication assisted therapies prescribed
32 for substance abuse disorder are covered without any utilization control such as a prior
33 authorization or step therapy; requiring high rate opioid prescribers to participate in
34 training; by requiring the Department of Corrections Medical Director to have experience
35 with opioid treatment; by requiring that the Department of Corrections ensure individuals
36 receiving treatment for opioid addiction prior to entering a Department of Corrections
37 facility continue to receive that treatment; by establishing a fatality review team at the
38 Department of Behavioral Health to review all overdose deaths in the District; by
39 requiring health care facilities to make the services of at least one health care provider
40 who is trained authorized under federal law to prescribe opioid addiction treatment
41 medications; by requiring hospital's to establish discharge protocols for individuals
42 identified as having a substance abuse disorder.
43
44 BE IT ENACTED BY THE COUNCIL OF THE DISTRICT OF COLUMBIA, That this

45 act may be cited as the "Opioid Abuse Treatment Act of 2017".

46 Sec. 2. Definitions.

47 For the purposes of this act, the term:

48 (1) "Department" means the Department of Health Care Finance.

49 (2) "Health benefits plan" or "plan" shall have the same meaning as provided in § 31-

50 3131(4)

51 (3) "Local team" means the multidisciplinary and multiagency drug overdose fatality

52 review team established for the District.

53 (4) "Medication Assisted Therapies" means those medications approved by the FDA for

54 the treatment of opioid dependence.

55 (5) "Necessary medications" means those medications as determined by a treating

56 prescriber which if missed may cause serious illness, death or other harmful effects to the

57 patient.

58 (6) " In-network" means providers or health care facilities that are part of a health plan's

59 network of providers available to beneficiaries to receive services.

60 (7) "Opioid addiction treatment medication" means a medication approved by the Federal

61 Food and Drug Administration for the Treatment of opioid use disorders.

62 (8) "Opioid use disorder" means a medical condition that is characterized by the

63 compulsive use of opioids despite adverse consequences from continued use and the

64 development of a withdrawal syndrome when opioid use stops.

65 (9) "Medicaid plan" means any of the managed care plans the District has selected to

66 managed the care of Medicaid beneficiaries.

67 (10) "Prescriber" means an individual with the authority to give directions, either orally
68 or in writing, for the preparation and administration of a remedy to be used in the treatment of
69 any disease.

70 (11) "Prior authorization" means the process of obtaining approval to prescribe a drug
71 from a managed care organization.

72 (12) "Provider" means a supplier of health care in this section meaning but not limited to
73 physicians, physician assistants, nurses, counselors, case workers and other individuals or
74 entities that treat opioid used disorders.

75 (13) "Step therapy" means treatment for a medical condition with the most inexpensive
76 drug therapy before progressing to other more costly or risky therapies only if necessary.

77 Sec. 3. Access to insurance network providers

78 (a) Every plan shall transmit upon request by mail or electronically to any beneficiary or
79 prospective beneficiary a list of all in network providers that treat opiate use disorders along with
80 their appropriate contact information. Prescribers on the list must include a special designation if
81 they have been issued a unique identification number by the Drug Enforcement Agency (DEA)
82 certifying prescribing authority for Buprenorphine agents;

83 (b) The list of providers that treat opioid use disorders shall be updated by the plan no
84 less than on a quarterly basis.

85 (c) Starting on July 1, 2018 and annually thereafter, every plan shall submit a report to
86 the Department, the Department of Behavioral Health and the Chairman of the Council of the
87 District of Columbia that includes the following:

88 (1) A list of all in-network prescribers that prescribe opioid addiction treatment
89 medications and the opioid treatment medication they most prescribe;

90 (2) A delineation of each prescriber by the type of medication assisted therapy
91 option they prescribe;
92 (3) The number of plan beneficiaries that have engaged treatment for opioid use
93 disorder in the previous calendar year and;
94 (4) A description of plan efforts over the past year to ensure an adequate in-
95 network capacity to treat opiate use disorders.
96 (c) The Department shall review these reports to determine each plan's in network
97 sufficiency to treat opiate use disorders for beneficiaries and undertake appropriate actions to
98 ensure appropriate in-network capacity accordingly.
99 Sec. 4. Additional medication offerings in certified Opiate Treatment Programs
100 (a) The Department shall undertake a study on the feasibility of expanding opioid use
101 disorder medication offerings in certified Opiate Treatment Programs by establishing appropriate
102 reimbursement for additional medications being utilized by the program. The report shall
103 include:
104 (1) Overview of the experience in states that have instituted such a policy,
105 including its impact on treatment capacity and programs costs;
106 (2) Potential increase in treatment capacity for the District of Columbia under
107 such a program;
108 (3) Clinical and operational considerations in implementation;
109 (4) Costs related to instituting a sufficient rate to treat opioid use disorders with
110 multiple medications in these settings.
111 (b) This report shall be submitted to the Committee on Health within 180 days of the
112 effective date of this act.

113 Sec. 5. Substance Abuse Reimbursement Rate Study

114 (a) The Department shall undertake a study to determine the current and most appropriate
115 rate to remunerate providers of substance abuse treatment in order to meet the existing treatment
116 gap for substance abuse disorder. The study shall also analyze the costs associated with the lack
117 of treatment under the existing treatment gap.

118 (b) This study shall be submitted the Committee on Health annually beginning no later
119 than 180 days after the effective date of this act.

120 Sec. 6. Open access to treatment options

121 (a) Notwithstanding any other provision in this Section all currently approved forms of
122 medication assisted therapies prescribed for the treatment of substance abuse disorder shall be
123 covered for persons who are otherwise eligible for medical assistance under a Medicaid plan and
124 shall not be subject to any:

125 (1) Utilization control, other than those established under the American Society of
126 Addiction Medicine patient placement criteria;

127 (2) "Prior authorization" or "step therapy"

128 (3) Lifetime restriction limit.

129 Sec. 7. Training of Physicians

130 (a) Every prescriber as specified in section (c) of this section, shall complete on a one-
131 time basis not less than eight hours of coursework or training relating to the treatment and
132 management of substance use disorder patients that is provided by ASAM, the American
133 Academy of Addiction psychiatry, the American Medical Association, the American Osteopathic
134 Association, the American Psychiatric Association, or any other organization that the Director
135 determines appropriate for the purposes of this section. Such coursework or training may be

136 completed in a class room setting, through internet-based instruction, or otherwise as approved
137 by the Director. Each prescriber shall document to the Department at the time of registration or
138 re-registration that the prescriber has completed coursework or training in accordance with this
139 section.

140 (b) The Department shall provide an exemption from the requirements of this section to
141 any prescriber who requests such an exemption and who shows, to the Department's satisfaction
142 that such prescriber is not subject to the requirements of this section.

143 (c) This section shall apply to any prescriber that:

144 (1) Has five or more patients currently on one or more opioid for which the
145 prescriber has undertaken chronic opioid therapy for 90 days of consecutive use, or;

146 (2) Has at least two patients being treated for chronic pain for which the
147 prescriber has prescribed a daily dose of at least 90mg of morphine or its equivalent.

148 Sec. 8. Department of Corrections Medical Director

149 (a) Within 180 days of receiving an appointment as the medical director for the
150 Department of Corrections, such employee(s) shall be trained and certified in addiction medicine
151 in such a way that meets one or more of the following condition:

152 (1) The medical director or medical officer holds a subspecialty board
153 certification in addiction psychiatry from the American Board of Medical specialties or;

154 (2) Potential increase in treatment capacity for the District of Colombia under
155 such a program;

156 (3) The medical director or medical officer holds a subspecialty board
157 certification in addiction medicine from the American Osteopathic Association; or

158 (4) The medical director or medical officer has completed not less than eight

159 hours of coursework or training relating to the treatment and management of opiate-dependent
160 patients that is provided by the American Society of Addiction Medicine, the American
161 Academy of Addiction psychiatry, the American Medical Association, The American
162 Osteopathic Association, The American Psychiatric Association, or any other organization that
163 the Director determines appropriate for the purposes of this section. Such coursework or training
164 may be completed in a class room setting, through internet-based instruction. Each prescriber
165 shall document to the Department of Correction that the prescriber has completed coursework or
166 training in accordance with this section.
167 Sec. 9. Ongoing treatment in the Department of Corrections
168 (a) The Department of Corrections shall ensure that all medications prescribed by duly
169 authorized prescribers to treat chronic conditions to detainees prior to being placed in custody are
170 continued during admittance to a detention facility as defined by this Chapter. Such medications
171 shall be continued to be administered as prescribed to the detained individual for no less than 30
172 days from the date such person is committed to the custody of the Department.
173 (b) The Department of Corrections in consultation with the Department of Health shall
174 establish a system to ensure that all necessary medications are continued to detained persons in
175 the manner that it was prescribed. This shall include promulgating appropriate rules and
176 regulation to effectuate the intent of this section.
177 (c) Such a system shall include, but shall not be limited to the following:
178 (1) Method for determining which medication are deemed necessary;
179 (2) Method for contracting the prescribing physician;
180 (3) Method for validating the prescription; and
181 (4) Method for providing necessary medications to a detained person who has

182 been taken into custody without a supply of such medication.

183 Sec. 10. Fatality review team

184 (a) There is established a fatality review team at the Department of Behavioral Health to

185 prevent drug overdose deaths by:

186 (1) Promoting cooperation and coordination among agencies involved in

187 investigations of drug overdose deaths or in providing services to surviving family members;

188 (2) Developing an understanding of the causes and incidence of drug overdose

189 deaths in the county;

190 (3) Developing plans for and recommending changes within the agencies

191 represented on the local team to prevent drug overdose deaths; and

192 (4) Advising the Department on changes to law, policy, or practice, including the

193 use of devices that are programmed to dispense medications on a schedule or similar technology,

194 to prevent drug overdose deaths.

195 (b) To achieve its purpose, the team shall:

196 (1) In consultation with the Department, establish and implement a protocol for

197 the fatality review team;

198 (2) Set as its goal the investigation of drug overdose deaths in accordance with

199 national standards;

200 (3) Meet at least quarterly to review the status of drug overdose death cases and

201 information on non-fatal overdoses, recommend actions to improve coordination of services and

202 investigations among member agencies, and recommend actions within the member agencies to

203 prevent drug overdose deaths;

204 (4) Collect and maintain data as required by the Department; and

205 (5) Provide requested reports to the Department, including:

206 (A) Discussion of individual cases;

207 (B) Steps taken to improve coordination of services and investigations;

208 (C) Steps taken to implement changes recommended by the local team

209 within member agencies; and

210 (D) Recommendations on needed changes to laws, policies, or practices to

211 prevent drug overdoses deaths.

212 (c) In addition to the duties specified in subsection (b) of this section, a fatality review

213 team may investigate the information and records of an individual convicted of a crime or

214 adjudicated as having committed a delinquent act that caused a death or near fatality described in

215 Section 10 of this act.

216 Sec. 11. Fatality review team access to information

217 (a) On a request of the chair of the team and as necessary to carry out the purpose and

218 duties of the team, the team shall be immediately provided with:

219 (1) Access to information and records, including information about physical

220 health, mental health, and treatment for substance abuse, maintained by a health care provider

221 for:

222 (A) An individual whose death or near fatality is being reviewed by the

223 local team; or

224 (B) An individual convicted of a crime or adjudicated as having

225 committed a delinquent act that caused a death or near fatality

226 (2) Access to information and records including death certificates, law

227 enforcement investigative information, medical examiner investigative information, parole and

228 probation information and records, and information and records of a social services agency, if the
229 agency provided services to:
230 (A) An individual whose death or near fatality is being reviewed by the
231 fatality review team; or
232 (B) An individual convicted of a crime or adjudicated as having
233 committed a delinquent act that caused a death or near fatality; or
234 (C) The family of an individual described in items (B) and (C) of this
235 subparagraph.
236 (b) Substance abuse treatment records requested or provided under this section are
237 subject to any additional limitations on disclosure or re-disclosure of a medical record developed
238 in connection with the provision of substance abuse treatment services under District or 42
239 U.S.C. § 290DD-2 and 42 C.F.R. Part 2.
240 Sec. 12. Meetings of fatality review team
241 (a) Fatality review team shall conduct periodic meetings.
242 (1) Meetings of the fatality review team shall be closed to the public when the
243 team is discussing individual cases of overdose or drug overdose deaths.
244 (2) Except as provided in subparagraph 3 of this section, meetings of local teams
245 shall be open to the public when the local team is not discussing individual cases of overdose or
246 drug overdose deaths.
247 (3)(A) During a public meeting, information may not be disclosed that identifies:
248 (B) A deceased individual;
249 (C) An individual who has experienced an overdose;
250 (D) A family member, guardian, or caretaker of a deceased individual or

251 of an individual who has experienced an overdose; or

252 (E) An individual convicted of a crime or adjudicated as having

253 committed a delinquent act that caused a death or near fatality.

254 (4) This section does not prohibit a fatality review team from requesting the

255 attendance at a team meeting of a person who has information relevant to the team's exercise of

256 its purpose and duties.

257 Sec. 13. Availability of Substance Use Disorder Treatment Prescribers.

258 (a) Each health care facility that is not part of a health care system and each health care

259 system shall make available to patients the services of at least one health care provider who is

260 trained and authorized under federal law to prescribe opioid addiction treatment medications,

261 including buprenorphine-containing formulations.

262 (b) To comply with subsection (a) of this section, a health care facility or a health care

263 system may:

264 (1) Directly employ, or contract with a health care provider who is trained and

265 authorized under federal law to prescribe opioid addiction treatment medications, including

266 buprenorphine-containing formulations; or

267 (2) Deliver the services in person or through telehealth.

268 Sec. 14. Hospital discharge protocols

269 (a) On or before October 1, 2018, each hospital shall have a protocol for discharging a

270 patient who was treated by the hospital for a drug overdose or was identified as having a

271 substance use disorder.

272 (b) The protocol may include:

273 (1) Coordination with peer recovery counselors who can conduct a screening, a

274 brief intervention, and referral to treatment and connection of the patient with community

275 services; and

276 (2) Prescribing naloxone for the patient.

277 (c)(1) Beginning in 2019, a hospital shall include in its annual community benefit report

278 the hospital's protocol for discharging a patient who was treated by the hospital for a drug

279 overdose or was identified as having a substance use disorder.

280 (2) On or before December 1, 2018, each hospital in the District shall submit a

281 report to the Department of Health on each hospital's discharge protocol.

282 (D)(1) The hospital's report shall:

283 (A) Identify opportunities to support a comprehensive treatment

284 continuum for individuals with substance use disorders in hospitals in the District, including

285 withdrawal management; and

286 (B) Includes an assessment of the barriers to providing an effective and

287 efficient continuum of care.

288 (2) On or before October 1, 2018, the Department of Health shall submit a

289 compilation of the hospital reports required under paragraph (2) of this subsection.

290 Sec. 15. Rulemaking

291 The Mayor, pursuant to Title 1 of the District of Columbia Administrative Procedure Act,

292 approved October 21, 1968 (82 Stat. 1204; D.C. Official Code § 2-501 et seq.), may issue rules

293 to implement the provisions of this act.

294 Sec. 16. Fiscal impact statement.

295 The council adopts the fiscal impact statement in the committee report as the fiscal

296 impact a statement required by section 4a of the General Legislative Procedures Act of 1975,

297 approved October 16,2006 (120 Stat. 2038; D.C. official Code Section 1-201.47.

298 Sec. 17. Effective date.

299 This act shall take effect following approval by the Mayor (or in the event of veto by the

300 Mayor, action by the Council to override the veto), a 30-day period of congressional review as

301 provided in section 602(c)(1) of the District of Columbia Home Rule Act, approved December

302 24, 1973 (87 Stat. 813; D.C. Official Code § 1-206.02(c)(1)), and publication in the District of

303 Columbia Register.