HOUSE BILL No. 1153

DIGEST OF INTRODUCED BILL

Citations Affected: IC 5-10-8-9; IC 12-15; IC 12-21-8; IC 12-23-18; IC 16-21-8.5; IC 27-8-5-15.8; IC 27-13-7-14.2.

Synopsis: Mental health and addiction matters. Specifies that an individual's incarceration, hospitalization, or other temporary cessation in substance or chemical use may not be used as a factor in determining the individual's eligibility for coverage in: (1) a state employee health care plan; (2) Medicaid; (3) the healthy Indiana plan; (4) a policy of accident and sickness insurance; or (5) a health maintenance health care contract. Requires an opioid treatment program to: (1) provide a patient of the facility referral for continuing care before releasing the patient from care by the facility; and (2) counsel female patients concerning the effects of the program treatment if the female is or becomes pregnant and provide to the patient birth control if requested by the patient. Requires the division of mental health and addiction to annually perform an audit of 20% of an opioid treatment program facility's patient plans to ensure compliance with federal and state laws and regulations. Requires the division of mental health and addiction to establish a mental health and addiction program to reduce the stigma of mental illness and addiction. Requires hospitals to establish emergency room treatment protocols concerning treatment of a patient who is overdosing, has been provided an overdose intervention drug, or is otherwise identified as having a substance use disorder.

Effective: July 1, 2021.

Shackleford

January 7, 2021, read first time and referred to Committee on Public Health.

Introduced

First Regular Session of the 122nd General Assembly (2021)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2020 Regular Session of the General Assembly.

HOUSE BILL No. 1153

A BILL FOR AN ACT to amend the Indiana Code concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-10-8-9 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 9. (a) This section does not apply if the application of this section would increase the premiums of the health services policy or plan, as certified under IC 27-8-5-15.7, by more than four percent (4%) as a result of complying with subsection (c).

(b) As used in this section, "coverage of services for mental illness" includes benefits with respect to mental health services as defined by the contract, policy, or plan for health services. The term includes services for the treatment of substance abuse and chemical dependency when the services are required in the treatment of a mental illness.

(c) If the state enters into a contract for health services through prepaid health care delivery plans, medical self-insurance, or group health insurance for state employees, the contract may not permit treatment limitations or financial requirements on the coverage of services for mental illness if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical

conditions.

(d) This ~~section~~ **subsection** applies to a contract for health services through prepaid health care delivery plans, medical self-insurance, or group medical coverage for state employees that is issued, entered into, or renewed after ~~June 30, 1997.~~ **June 30, 2021. If the state enters into a contract for health services through prepaid health care delivery plans, medical self-insurance, or group health insurance for state employees, the contract may not allow an individual's incarceration, hospitalization, or other temporary cessation in substance or chemical use to factor into a determination of an individual's eligibility for coverage of the treatment of substance abuse or chemical dependency.**

(e) This section does not require the contract for health services to offer mental health benefits.

SECTION 2. IC 12-15-5-13, AS AMENDED BY P.L.179-2019, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 13. (a) The office shall provide coverage for treatment of opioid or alcohol dependence that includes the following:

(1) Counseling services that address the psychological and behavioral aspects of addiction.

(2) When medically indicated, drug treatment involving agents approved by the federal Food and Drug Administration for the:

(A) treatment of opioid or alcohol dependence; or

(B) prevention of relapse to opioids or alcohol after detoxification.

(3) When determined by the treatment plan to be medically necessary, inpatient detoxification in accordance with the most current edition of the American Society of Addiction Medicine Patient Placement Criteria.

(4) In determining eligibility for substance abuse treatment for a recipient, the office or a managed care organization may not consider an individual's incarceration, hospitalization, or other temporary cessation in substance or chemical use as a factor to deny eligibility.

(b) The office shall:

(1) develop quality measures to ensure; and

(2) require a managed care organization to report;

compliance with the coverage required under subsection (a).

(c) The office may implement quality capitation withholding of reimbursement to ensure that a managed care organization has provided the coverage required under subsection (a).

(d) The office shall report the clinical use of the medications

covered under this section to the mental health Medicaid quality advisory committee established by IC 12-15-35-51. The mental health Medicaid quality advisory committee may make recommendations to the office concerning this section.

SECTION 3. IC 12-15-44.5-3.5, AS ADDED BY P.L.30-2016, SECTION 28, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 3.5. (a) The plan must include the following in a manner and to the extent determined by the office:

(1) Mental health care services.

(2) Inpatient hospital services.

(3) Prescription drug coverage, including coverage of a long acting, nonaddictive medication assistance treatment drug if the drug is being prescribed for the treatment of substance abuse.

(4) Emergency room services.

(5) Physician office services.

(6) Diagnostic services.

(7) Outpatient services, including therapy services.

(8) Comprehensive disease management.

(9) Home health services, including case management.

(10) Urgent care center services.

(11) Preventative care services.

(12) Family planning services:

(A) including contraceptives and sexually transmitted disease testing, as described in federal Medicaid law (42 U.S.C. 1396 et seq.); and

(B) not including abortion or abortifacients.

(13) Hospice services.

(14) Substance abuse services.

(15) Pregnancy services.

(16) A service determined by the secretary to be required by federal law as a benchmark service under the federal Patient Protection and Affordable Care Act.

(b) The plan may not permit **the following:**

(1) Treatment limitations or financial requirements on the coverage of mental health care services or substance abuse services if similar limitations or requirements are not imposed on the coverage of services for other medical or surgical conditions.

(2) In determining coverage for substance abuse treatment, the plan may not factor in an individual's incarceration, hospitalization, or other temporary cessation in substance or chemical use when determining the individual's eligibility for the treatment.

(c) The plan may provide vision services and dental services only to individuals who regularly make the required monthly contributions for the plan as set forth in section 4.7(c) of this chapter.

(d) The benefit package offered in the plan:

(1) must be benchmarked to a commercial health plan described in 45 CFR 155.100(a)(1) or 45 CFR 155.100(a)(4); and

(2) may not include a benefit that is not present in at least one (1) of these commercial benchmark options.

(e) The office shall provide to an individual who participates in the plan a list of health care services that qualify as preventative care services for the age, gender, and preexisting conditions of the individual. The office shall consult with the federal Centers for Disease Control and Prevention for a list of recommended preventative care services.

(f) The plan shall, at no cost to the individual, provide payment of preventative care services described in 42 U.S.C. 300gg-13 for an individual who participates in the plan.

(g) The plan shall, at no cost to the individual, provide payments of not more than five hundred dollars ($500) per year for preventative care services not described in subsection (f). Any additional preventative care services covered under the plan and received by the individual during the year are subject to the deductible and payment requirements of the plan.

SECTION 4. IC 12-21-8 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 8. Mental Health Education Program

Sec. 1. The division shall establish and administer a statewide program to reduce the stigma of mental illness and addiction in Indiana.

Sec. 2. The program must include the following:

(1) Awareness raising interventions, including signs or symptoms that an individual may be suffering from a mental illness or addiction.

(2) Literacy programs to improve knowledge of mental illnesses and addiction.

(3) Dissemination of lists of resources available on a regional basis to individuals who believe they are suffering from a mental illness or addiction.

(4) The benefits for an individual to obtain services to treat a mental illness or addiction.

(5) Dissemination of educational materials targeted to

different ages and populations.

SECTION 5. IC 12-23-18-0.5, AS AMENDED BY P.L.8-2016, SECTION 2, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 0.5. (a) An opioid treatment program shall not operate in Indiana unless the opioid treatment program meets the following conditions:

(1) Is specifically approved and the opioid treatment facility is certified by the division.

(2) Is in compliance with state and federal law.

(3) Provides treatment for opioid addiction using a drug approved by the federal Food and Drug Administration for the treatment of opioid addiction, including:

(A) opioid maintenance;

(B) detoxification;

(C) overdose reversal;

(D) relapse prevention; and

(E) long acting, nonaddictive medication assisted treatment medications.

(4) Beginning July 1, 2017, is:

(A) enrolled:

(i) as a Medicaid provider under IC 12-15; and

(ii) as a healthy Indiana plan provider under IC 12-15-44.2; or

(B) enrolled as an ordering, prescribing, or referring provider in accordance with Section 6401 of the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) and maintains a memorandum of understanding with a community mental health center for the purpose of ordering, prescribing, or referring treatments covered by Medicaid and the healthy Indiana plan.

(5) Provides to a patient of the opioid treatment facility who is being released from the program referrals to appropriate providers to continue the care that:

(A) the facility deems appropriate for the patient; or

(B) the patient requests;

before the patient's release from care of the facility.

(b) Separate specific approval and certification under this chapter is required for each location at which an opioid treatment program is operated. If an opioid treatment program moves the opioid treatment program's facility to another location, the opioid treatment program's

certification does not apply to the new location and certification for the new location under this chapter is required.

(c) Each opioid treatment program that is enrolled as an ordering, prescribing, or referring provider shall report to the office on an annual basis the services provided to Indiana Medicaid patients. The report must include the following:

(1) The number of Medicaid patients seen by the ordering, prescribing, or referring provider.

(2) The services received by the provider's Medicaid patients, including any drugs prescribed.

(3) The number of Medicaid patients referred to other providers.

(4) Any other provider types to which the Medicaid patients were referred.

SECTION 6. IC 12-23-18-5, AS AMENDED BY P.L.8-2016, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 5. (a) The division shall adopt rules under IC 4-22-2 to establish the following:

(1) Standards for operation of an opioid treatment program in Indiana, including the following requirements:

(A) An opioid treatment program shall obtain prior authorization from the division for any patient receiving more than seven (7) days of opioid maintenance treatment medications at one (1) time and the division may approve the authorization only under the following circumstances:

(i) A physician licensed under IC 25-22.5 has issued an order for the opioid treatment medication.

(ii) The patient has not tested positive under a drug test for a drug for which the patient does not have a prescription for a period of time set forth by the division.

(iii) The opioid treatment program has determined that the benefit to the patient in receiving the take home opioid treatment medication outweighs the potential risk of diversion of the take home opioid treatment medication.

(B) Minimum requirements for a licensed physician's regular:

(i) physical presence in the opioid treatment facility; and

(ii) physical evaluation and progress evaluation of each opioid treatment program patient.

(C) Minimum staffing requirements by licensed and unlicensed personnel.

(D) Clinical standards for the appropriate tapering of a patient on and off of an opioid treatment medication.

(E) The provision of counseling to female patients upon

admission and periodically through the patient's treatment by the facility concerning the effects of the program treatment if the female is or becomes pregnant and the provision to the patient of birth control if requested by the patient.

(2) A requirement that, not later than February 28 of each year, a current diversion control plan that meets the requirements of 21 CFR Part 290 and 42 CFR Part 8 be submitted for each opioid treatment facility.

(3) Fees to be paid by an opioid treatment program for deposit in the fund for annual certification under this chapter as described in section 3 of this chapter.

The fees established under this subsection must be sufficient to pay the cost of implementing this chapter.

(b) The division shall conduct an annual onsite visit of each opioid treatment program facility to assess compliance with this chapter. **As part of an annual onsite visit, the division shall audit at least twenty percent (20%) of the opioid treatment program facility's patient plans to determine whether the facility is complying with federal and state rules and regulations, including the following:**

(1) Meeting tapering standards established by the division under subsection (a)(1)(D).

(2) Complying with the goal of providing a patient with the minimal clinically necessary medication dose with the goal of opioid abstinence as set forth in section 5.3 of this chapter.

(3) Performing and complying with the drug testing requirements for patients set forth in section 2.5 of this chapter.

(4) Racial demographics of the patients.

Any personally identifying information and medical information of a patient obtained through the audit are confidential.

(c) Not later than April 1 of each year, the division shall report to the general assembly in electronic format under IC 5-14-6 the number of prior authorizations that were approved under subsection (a)(1)(A) in the previous year and the time frame for each approval.

SECTION 7. IC 16-21-8.5 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]:

Chapter 8.5. Emergency Room Treatment of Patients with Substance Use Disorders

Sec. 1. Not later than January 1, 2022, a hospital licensed under this article shall have established protocols on the emergency room

treatment of a patient who:

(1) is overdosing on a substance;

(2) has been provided an overdose intervention drug immediately prior to being transported to the hospital; or

(3) is otherwise identified as having a substance use disorder.

Sec. 2. The protocols required in section 1 of this chapter must include the following:

(1) An assessment of the patient before discharge by a provider whose scope of practice includes providing treatment for an individual with a substance use disorder, including:

(A) a physician licensed under IC 25-22.5;

(B) a psychologist licensed under IC 25-33;

(C) an addiction counselor or a clinical addiction counselor licensed under IC 25-23.6-10.5; or

(D) a person described in IC 25-23.6-10.1-2.

(2) Treatment, assistance in obtaining treatment, or a referral to treatment to a provider described in subdivision (1).

Sec. 3. The hospital shall provide training on the protocols to any staff or contractor providing services in the emergency department of the hospital.

SECTION 8. IC 27-8-5-15.8, AS ADDED BY P.L.103-2020, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 15.8. (a) As used in this section, "treatment of a mental illness or substance abuse" means:

(1) treatment for a mental illness, as defined in IC 12-7-2-130(1); and

(2) treatment for drug abuse or alcohol abuse.

(b) As used in this section, "act" refers to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 and any amendments thereto, plus any federal guidance or regulations relevant to that act, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

(c) As used in this section, "nonquantitative treatment limitations" refers to those limitations described in 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(d) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for treatment of a mental illness or substance abuse shall submit a report to the department not later than December 31 of each year that contains the following information:

(1) A description of the processes:

(A) used to develop or select the medical necessity criteria for coverage of services for treatment of a mental illness or substance abuse; and

(B) used to develop or select the medical necessity criteria for coverage of services for treatment of other medical or surgical conditions.

(2) Identification of all nonquantitative treatment limitations that are applied to:

(A) coverage of services for treatment of a mental illness or substance abuse; and

(B) coverage of services for treatment of other medical or surgical conditions;

within each classification of benefits.

(e) **Coverage of treatment of a mental illness or substance abuse must meet the following:**

(1) There may be no separate nonquantitative treatment limitations that apply to coverage of services for treatment of a mental illness or substance abuse that do not apply to coverage of services for treatment of other medical or surgical conditions within any classification of benefits.

(2) An individual's incarceration, hospitalization, or other temporary cessation in substance or chemical use may not factor into a determination of the individual's eligibility for coverage of the treatment of mental illness or substance abuse.

(f) An insurer that issues a policy of accident and sickness insurance that provides coverage of services for treatment of a mental illness or substance abuse shall also submit an analysis showing the insurer's compliance with this section and the act to the department not later than December 31 of each year. The analysis must do the following:

(1) Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected.

(2) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation.

(3) Provide the comparative analyses, including the results of the analyses, performed to determine the following:

(A) That the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the

processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of other medical or surgical conditions.

(B) That the processes and strategies used to apply each nonquantitative treatment limitation for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative limitation for treatment of other medical or surgical conditions.

(g) The department shall adopt rules to ensure compliance with this section and the applicable provisions of the act.

SECTION 9. IC 27-13-7-14.2, AS ADDED BY P.L.103-2020, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2021]: Sec. 14.2. (a) As used in this section, "treatment of a mental illness or substance abuse" means:

(1) treatment for a mental illness, as defined in IC 12-7-2-130(1); and

(2) treatment for drug abuse or alcohol abuse.

(b) As used in this section, "act" refers to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Act of 2008 and any amendments thereto, plus any federal guidance or regulations relevant to that act, including 45 CFR 146.136, 45 CFR 147.136, 45 CFR 147.160, and 45 CFR 156.115(a)(3).

(c) As used in this section, "nonquantitative treatment limitations" refers to those limitations described in 26 CFR 54.9812-1, 29 CFR 2590.712, and 45 CFR 146.136.

(d) An individual contract or a group contract that provides coverage of services for treatment of a mental illness or substance abuse shall submit a report to the department not later than December 31 of each year that contains the following information:

(1) A description of the processes:

(A) used to develop or select the medical necessity criteria for coverage of services for treatment of a mental illness or substance abuse; and

(B) used to develop or select the medical necessity criteria for coverage of services for treatment of other medical or surgical conditions.

(2) Identification of all nonquantitative treatment limitations that are applied to:

(A) coverage of services for treatment of a mental illness or substance abuse; and

(B) coverage of services for treatment of other medical or

surgical conditions;

within each classification of benefits.

(e) **Coverage of treatment of a mental illness or substance abuse must meet the following:**

(1) There may be no separate nonquantitative treatment limitations that apply to coverage of services for treatment of a mental illness or substance abuse that do not apply to coverage of services for treatment of other medical or surgical conditions within any classification of benefits.

(2) An individual's incarceration, hospitalization, or other temporary cessation in substance or chemical use may not factor into a determination of the individual's eligibility for coverage of the treatment of mental illness or substance abuse.

(f) An individual contract or a group contract that provides coverage of services for treatment of a mental illness or substance abuse shall also submit an analysis showing the insurer's compliance with this section and the act to the department not later than December 31 of each year. The analysis must do the following:

(1) Identify the factors used to determine that a nonquantitative treatment limitation will apply to a benefit, including factors that were considered but rejected.

(2) Identify and define the specific evidentiary standards used to define the factors and any other evidence relied upon in designing each nonquantitative treatment limitation.

(3) Provide the comparative analyses, including the results of the analyses, performed to determine the following:

(A) That the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to design each nonquantitative treatment limitation for coverage of services for treatment of other medical or surgical conditions.

(B) That the processes and strategies used to apply each nonquantitative treatment limitation for treatment of a mental illness or substance abuse are comparable to, and applied no more stringently than, the processes and strategies used to apply each nonquantitative limitation for treatment of other medical or surgical conditions.

(g) The department shall adopt rules to ensure compliance with this section and the applicable provisions of the act.