STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

6/29/2016 PUBLIC NOTICE OF PROPOSED AMENDMENT TO RHODE ISLAND MEDICAID STATE PLAN

In accordance Rhode Island General Laws 42-35, notice is hereby given that the Executive Office of Health and Human Services (EOHHS) proposes to make the following amendment to the Rhode Island State Plan under Title XIX of the Social Security Act:

Opioid Treatment Programs Health Home

EOHHS, in coordination with Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, is providing public notice of our intent to amend the Medicaid State Plan with regard to Opioid Treatment Programs (OTP) Health Home (HH) services. This amendment proposes the following changes, effective July 1, 2016:

- Bring OTP HH services into Managed Care
- Increase OTP HH rates for Rite Care members from 52.52/week to $53.50/week
- Decrease OTP HH rates for non-Rite Care members from $87.52/week to $53.50/week
- Create Centers of Excellence at OTP HHs

OTP HH services are currently available to eligible Medicaid members through Fee-for-Service. Our proposal seeks to bring OTP HH services into Managed Care in order to foster improved coordination of care, to increase efforts in identifying individuals who would benefit from this service, and foster collaboration between providers and the Managed Care Organizations. This proposal also seeks to set one rate for OTP HH services, regardless of the member's line of business. The proposed rate accounts for only OTP HH services, does not include the cost of medications and is based on the past utilization of OTP HH services across all lines of business.

A key strategy in the Governor's Overdose Strategic Plan is the development of Centers of Excellence (COEs). This is a strategic plan whose goal is to complement existing overdose prevention efforts to achieve the most immediate impact on addiction and overdose. Although methadone availability is widespread in Rhode Island, buprenorphine is not. The COE is an opportunity to dramatically increase buprenorphine prescribing, in addition to continuing to expand methadone and injectable-naltrexone availability. OTP HHs will have the opportunity to apply to become COEs. COEs will provide comprehensive evaluation, including mental health evaluation and treatment or referral, induction and stabilization services, as well as support to providers in the community. It is envisioned that COEs would refer stabilized patients to other providers and receive back patients if they destabilize and require more intensive services. These changes are projected to result in an increase in annual expenditure of approximately $1.9 million.

This proposed amendment is accessible on the EOHHS website (www.eohhs.ri.gov) or available in hard copy upon request (401-462-6348 or RI Relay, dial 711). Interested persons should submit data, views, or written comments by July 29, 2016 to Melody Lawrence, Executive

Office of Health and Human Services, 74 West Rd, Cranston, RI, 02920, or melody.lawrence@ohhs.ri.gov.

In accordance with the Rhode Island General Laws 42-35-3, an oral hearing will be granted on the proposed State Plan Amendment if requested by twenty-five (25) persons, an agency, or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within thirty (30) days of this notice.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief, or handicap in acceptance for or provision of services or employment in its programs or activities.

Opioid Treatment Program Health Home

Summary Description Including Goals and Objectives

The Opioid Treatment Programs (OTP) Health Homes provide resources to opioid dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment through Managed Care as well as Fee-for Service. Data shows most patients are between the ages of 31-64, 86% smoke and all either have or are at risk for: COPD, Cardiac disease, Obesity, Diabetes, Hepatitis C, Viral illnesses.

OTPs provide the opportunity for daily contact with Medical and Clinical professionals who have on-going therapeutic relationships with patients. This enables providers to use existing and enhanced resources to improve the health of patients and decrease inadequate/ineffective medical care. Provision of this service positively impacts the health and welfare of patients, and reduce overall healthcare costs by: Focusing on relationships with primary and specialty care vs. emergency care; Wellness promotion; Routine health monitoring; Pain management; Care management to develop recovery supports that promote self-care.

Each patient is assigned to a team which may be specialized to their specific healthcare needs. Patients have an assigned nurse and case manager to: Monitor healthcare needs; Assist with referral, scheduling, and transportation to medical and other appointments; Develop a health plan; Provide health promotion and wellness activities; Facilitate transitions between levels of care; Support recovery needs; Identify and provide resources that support wellness and recovery.

This Health Home model provides the mechanism to support stronger, formalized relationships between OTPs and community healthcare providers. By bringing OTP HH into Managed Care, providers will receive additional support for reporting and additional assistance in identifying eligible members in need of OTP HH services. OTP HH offers a comprehensive, holistic approach including diagnosis, treatment, support, education, and coordination, improving quality of life, stability, management of chronic conditions, and decreased healthcare costs.

Rhode Island is seeking to augment services offered through the OTP Health Home, through the creation of Centers of Excellence (COE). The COE are intended to expand and enhance the statewide capacity for Medication Assisted Treatment (MAT), increasing accessibility, not only in COEs, but through community providers, improving the quality of care and patient satisfaction. COEs will provide assessments and treatment for opioid dependence, will offer expedited access to care, and serve as a resource to community based providers. The goal of the COE is to provide intensive services to individuals needing to stabilize on medication and begin the recovery process. Once stable, patients will be referred to community-based providers, but still have the opportunity to maintain connections to clinical or recovery support services offered by the COE. Once referred to the community, patients who need more intensive services, perhaps due to relapse or crisis, will have the opportunity for immediate readmission to the COE. The COEs will also have the ability to provide on-site training for physicians and other professionals. Center of Excellence Certification Standards have been developed; in order to serve as a COE, the OTP Health Home will need to apply and will be assessed according to the COE Certification Standards. Certified COEs will be authorized to provide a set of enhanced treatment services to Medicaid beneficiaries

who require MAT using methadone, buprenorphine, or injectable naltrexone for opioid use disorders.

The COE will achieve the following goals: 1) increase the number of admissions into MAT, 2) increase in the number of clients receiving integrated care and treatment, 3) decrease use of illicit opioid, 4) decrease in use of prescription opioids in a non-prescribed manner (i.e.: misuse or abuse of prescription opioids).

Dependency Description

Description of any dependencies between this submission package and any other submission package undergoing review
N/A

Disaster-Related Submission

This submission is related to a disaster*

○ Yes ◉ No

Federal Budget Impact
First **$248,125.00**

Second **$992,500.00**

Federal Statute / Regulation Citation*
Section 1945 SSA

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used*
The Opioid Treatment Programs (OTP) Health Homes provide resources to opioid dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment through Managed Care as well as Fee-for Service. Data shows most patients are between the ages of 31-64, 86% smoke and all either have or are at risk for: COPD, Cardiac disease, Obesity, Diabetes, Hepatitis C, Viral illnesses.

OTPs provide the opportunity for daily contact with Medical and Clinical professionals who have on-going therapeutic relationships with patients. This enables providers to use existing and enhanced resources to improve the health of patients and decrease inadequate/ineffective medical care. Provision of this service positively impacts the health and welfare of patients, and reduce overall healthcare costs by: Focusing on relationships with primary and specialty care vs.

emergency care; Wellness promotion; Routine health monitoring; Pain management; Care management to develop recovery supports that promote self-care.

Each patient is assigned to a team which may be specialized to their specific healthcare needs. Patients have an assigned nurse and case manager to: Monitor healthcare needs; Assist with referral, scheduling, and transportation to medical and other appointments; Develop a health plan; Provide health promotion and wellness activities; Facilitate transitions between levels of care; Support recovery needs; Identify and provide resources that support wellness and recovery.

This Health Home model will provide the mechanism to support stronger, formalized relationships between OTPs and community healthcare providers. By bringing OTP HH into Managed Care, providers will receive additional support for reporting and additional assistance in identifying eligible members in need of OTP HH services. OTP HH offers a comprehensive, holistic approach including diagnosis, treatment, support, education, and coordination, improving quality of life, stability, management of chronic conditions, and decreased healthcare costs.

The State seeks to allow OTP HHs to apply to become COE according to COE Certification Standards. Certified COEs will be authorized to provide a set of enhanced treatment services to Medicaid beneficiaries who require MAT using buprenorphine or injectable naltrexone for opioid use disorders. The COE will expand and enhance the services of the OTP Health Homes to achieve the following goals: 1) increase the number of admissions into MAT, 2) increase in the number of clients receiving integrated care and treatment, 3) decrease use of illicit opioid, 4) decrease in use of prescription opioids in a non-prescribed manner (i.e.: misuse or abuse of prescription opioids).

In order to become a COE, an OTP HH must become certified by the State. COE applications will be assessed according to certification standards that have been developed by the State. The certification standards include requirements that will expand MAT into mainstream primary care settings by providing technical assistance and training to physicians, as well as, expedited referrals to treatment and access to ongoing treatment, recovery and relapse supports for primary care providers and their patients. CEOs will be certified at two levels to ensure timely access to MAT services. Level 1 providers are those that have the ability to meet the requirement of admitting all individuals within twenty-four (24) hours of referral. Level 2 providers are those that have the ability to meet the requirement to admit all patients within forty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday. Level 1 providers will receive an enhanced rate for induction to support the requirement of having physician availability seven (7) days per week.

A multi-disciplinary staff, including peer professionals, will work together to provide patient-centered care that addresses all of an individual's treatment needs. Since the effective treatment of opioid use disorders includes the use of FDA-approved medications (methadone, buprenorphine products and naltrexone), COEs will be able to provide medication services onsite. The COEs will use qualified physicians familiar with the use of these medications and who are waivered to prescribe buprenorphine.

Individualized care will include a range of treatment options. COEs should also make patient-focused programs and services available. These ancillary services which assist patients in recovery include individual and group therapy, help with obtaining other needed health services, social services, and recovery/remission supports such as peer professionals. Peer professionals are peer recovery specialists who have lived with mental illness and/or substance use disorders and have completed formal training to provide one-on-one strength-based support to individuals in recovery.

Other features of COEs will include comprehensive patient and family education programs; quality metrics to examine patient outcomes and to improve services; timely access to care with minimal waiting lists and support resources for patients who have been referred into the community. The goal of the COE is to provide intensive services to individuals needing to stabilize on medication and begin the recovery process. Once stable, patients will be referred to community based providers, but still have the opportunity to maintain connections to clinical or recovery support services offered by the COE. Once referred to the community, patients who need more intensive services, perhaps due to relapse or crisis, will have the opportunity for immediate readmission to the COE. The COEs will also have the ability to provide on-site training for physicians and other professionals.

Referrals to COEs can be made by anyone from the community to a certified provider. It is anticipated that a majority of referrals will be made by Emergency Departments throughout the state treating opioid overdose survivors. All certified COEs will be required to establish clear referral pathways to ensure smooth transitions of care.

The service delivery models used for OTP HH services will be FFS as well as managed care. COE services are FFS only for at least the first year of implementation. However, all Medicaid members have access to the COE services regardless of if they are in managed care or FFS. Medicaid MCOs will be expected to communicate these available carved out services to members and to assist members in getting appropriate referrals to COE services.

Categories of Individuals and Populations Provided Health Homes Services

The state will make Health Homes services available to the following categories of Medicaid participants

☑ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☑ Medically Needy Children Age 18 through 20

☑ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☑ Medically Needy Aged, Blind or Disabled

☑ Medically Needy Blind or Disabled Individuals Eligible in 1973

Population Criteria: The state elects to offer Health Homes services to individuals with

☐ Two or more chronic conditions

☑ One chronic condition and the risk of developing another

Specify the conditions included

☐ Mental Health Condition

☑ Substance Use Disorder

☐ Asthma

☐ Diabetes

☐ Heart Disease

☐ BMI over 25

☐ Other (specify)

Specify the criteria for at risk of developing another chronic condition*

Patients will be assessed for the risk of developing another chronic condition using a uniform checklist at each provider site. This form will address high risk behaviors and other risk factors for chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current abuse of substances other than opioids; family health history. These forms will be completed at assessment for new patients, at admission to Health Home programs for current patients and annually at each physical appointment.

☐ One serious and persistent mental health condition

Enrollment of Participants: Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home*

○ Opt-In to Health Homes provider ◉ Referral and assignment to Health Homes provider with opt-out ○ Other (describe)

Describe the process used*

Health Home participants receiving MAT for opioid dependence and COE participants will be identified via provider or community partner referrals, such as the judicial system or emergency departments, and outreach to prior patients who were discharged due to no contact. Physicians, other providers, managed care organizations, treatment centers, and criminal justice system professionals will be made aware of the integrated MAT system and referral process through a variety of means, including websites and other notices, Grand Rounds, community meetings, and provider agreements.

All eligible patients currently enrolled in Opioid Treatment Programs will be provided a letter explaining Health Home/COE Services and automatic enrollment with information on how to opt-out. Patients will be given the opportunity to meet with Health Home/COEteam representatives to discuss their options. All new patients will be given information on Health Homes Services upon admission and the opportunity to opt-out at that time. Opportunities for opting-out will be provided initially and then annually.

COE participants will not be automatically disenrolled from COE unless discharged.

Patients who initially accept OTP HH services, but who do not consistently participate in any given 90 day period, may be disenrolled by the provider after demonstrated engagement and outreach efforts. Re-enrollment options are always available for initial or subsequent patients who decline health homes. Beneficiaries will be able to agree or decline to receive specific Health Home services during their participation in developing the individualized Plan of Care. Declining Health Home services will have no effect on their regular Medicaid benefits. The Health Home will notify other treatment providers about the goals and types of available Health Home services and involve them in Health Home activities for shared patients. Individuals receiving services in a hospital ED or as an inpatient who may be eligible for Health Home services will be notified about their availability and referred based on patient choice.

Geographic Limitations

◉ Health Homes services will be available statewide ○ Health Homes services will be limited to the following geographic areas ○ Health Homes services will be provided in a geographic phased-in approach

Service Definitions: Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition:

Comprehensive care management is provided for patients, families and supports, to develop and implement a whole-person care plan and monitor the patient's success in achieving goals.

A bio-psychosocial assessment of physical, behavioral, psychological status and social functioning, along with a physical exam, is conducted for each person admitted to an OTP. This determines the appropriate level of care; need for specialized medical/psychological evaluations; need for family participation or other supports; and the staff and/or program to provide the care.

Based on the assessment a goal-oriented, person centered care plan is developed and implemented by a multi-disciplinary team, which includes the patient served.

The healthcare liaison, whose primary function is to establish and maintain primary/specialty care provider relationships, provides a process for outreach, planning, and communication. These relationships promote multidisciplinary treatment recommendations and planning by fostering consistent access and communication.

Communication of patient preferences is incorporated throughout the Health Home process. Consumer driven care plans focus on the desired goals of the patient. Communication with providers will reference patient preference and choice. Case management can teach patients self advocacy to communicate preferences.

Most of the team composition is experienced in the provision of services to OTP patients. Programs will focus on role expansion and training to incorporate the holistic healthcare perspective. Case managers will be recruited and trained in a Health Home model of care.

Recovering individuals are central to a recovery oriented system of care. Rhode Island has two established recovery support centers able train medication assisted advocates and has a cadre of Certified Recovery Coaches accessible to OTP patients. Upon patient request, Recovery Coaches will participate in planning and implementation of Health Home services.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum*

All six of the current OTP providers have electronic health records. Three of these providers use software that is certified for meaningful use - representing more than half of the OTP population. Providers have adopted a standardized assessment tool that can

be updated to reflect outcomes. OTP HHs received training on utilizing an ASAM PPC assessment tool that provides standardized outcome measures.

OTPs are required to submit patient specific data to the RI Behavioral Health Online Data (RIBHOLD) system at admission, discharge and relevant changes in condition. OTPs will receive training from BHDDH on extraction and meaningful use of the data in RIBHOLD. RIBHOLD data is used to provide outcomes to SAMHSA to reflect changes in abstinence rates, housing, employment, social connections, criminal justice involvement, and retention in treatment (NOMs). The information collected extends beyond these basic measures to include relevant comorbid conditions. Health Homes would provide OTPs with additional training and incentive to use updated data submissions to identify and document the effectiveness of the Health Home model on multiple outcomes, including health condition.

Care plans established at the OTPs can be shared with multiple providers using the State's HIE – CurrentCare with the client's consent. The HIT coordinator position will assist programs in becoming data sharing partners and/or participants in the CurrentCare Direct Messaging feature. This participation will facilitate the sharing of care plans and reduce duplication of effort. Current Care representatives have been and will continue to be participants in the OTP Health Home planning process.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

> Qualified Behavioral Health Specialists will conduct initial bio-psychosocial assessments and work with patients and other team members to develop care plans. Case managers will be responsible for ensuring adherence to the plan, engaging family members and other supports, and monitoring outcomes.
>
> Case managers will assist patients in accessing other specialized care, encouraging patients to keep appointments and follow through with care recommendations.

Nurses

> Nurses will assist physicians in the admission and annual physicals. They will assist in the development of the care plan. Nurses will regularly coordinate with other healthcare providers and establish routine communications. Nurses will continue to assess patients throughout treatment and monitor progress in achieving health care plan goals.

Physicians

> Physicians review the bio-psychosocial assessments and conduct initial and annual physicals of all OTP patients. Physicians are central to the creation of the

care plan and lead teams to identify need for specialized care. Physicians monitor medication stabilization and are available to consult with all other providers.

Pharmacists

Pharmacists are available for consultation to the Health Home team to review patient medications and make recommendations to the care plan based on this assessment.

Care Coordination

Definition:

Care coordination involves implementing an individualized care plan to attain goals and improve chronic conditions. Care managers are responsible for conducting these activities across all settings. This service provides case management necessary to access medical, social, vocational, educational, and other services, including, but not limited to: Assistance in accessing health care and follow-up care; Assessing housing needs - providing assistance to access and maintain safe/affordable housing; Conducting outreach to family members and others to support connections to services, and expand social networks; Assisting in locating community services in medical, social, legal and behavioral healthcare areas and ensuring that all services are coordinated; Coordinating with other providers to monitor health status, medical conditions, medications/side effects; Coordinating with other entities such as the member's Managed Care Organization, the criminal justice system, Child and Family Court and DCYF.

Currently OTPs have established relationships with some primary care and medical specialty providers in their regions. Regular contact occurs with hospitals regarding medication verification and continuity of care. OTPs also have relationships with private psychiatrists and community mental health organizations. These linkages can be strengthened and formalized as OTPs become Health Home providers.

Memorandums of understanding are used consistently by OTPs as standard practice when working with community providers. Formal agreements are less prevalent with recovery support services. Health Homes can provide the impetus to expand the recovery support network.

As 42 CFR Part II programs, OTPs are aware of the need for compliant consent forms. The state has established a standardized process to share Part II information with the statewide Health Information Exchange (CurrentCare). Patients are fully apprised of consent choice and confidentiality regulations as they pertain to substance abuse treatment.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum*

OTPs will be able to link electronic health records to the State Health Information Exchange - CurrentCare. Behavioral Healthcare Organizations (including OTPs) are required by regulation to offer enrollment in the CurrentCare system. Regulations provide access to an approved authorization to release information form that provides compliant data exchange with 42 CFR Part II protected information. OTPs understand

and meet the requirements of HIPAA relevant to information sharing. Three of these OTPs - representing more than half of the OTP patients in the state, use certified EHR software. Currently the State receives regular data from the Department of Corrections on OTP patients that become incarcerated in an effort to provide continuity of care. This information is shared with the identified provider. MCOs have developed a process to notify CMHO Health Homes of any hospitalization within 24 hours in an effort to coordinate care. This process will be established for OTP Health Homes as well. MCOs have provided CMHOs with routine utilization reports and will do the same with OTPs so they are able to see where patients are - and are not - accessing care.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

The position with primary responsibility for this service will be case managers. Case managers will seek input from other team members, but will be the primary contact for care plan implementation. Case managers will assist patients in accessing other services by appointment reminding, attending appointments, identifying need and associated resources. Case managers will most often be the team member with the most patient contact and outreach to patients and their supports to maintain engagement in services. Case managers will most frequently interact with providers of other services and note compliance with care recommendations. Case managers will report back to other team members on care plan implementation - success and challenges and seek input from others to enhance outcome and goal attainment.

Health Promotion

Definition:

Health promotion services encourage and support healthy ideas and concepts to motivate individuals to adopt healthy behaviors. The services also enable individuals to self-manage their health. Health promotion services may be provided by any member of the OTP Health Home team.

Health promotion activities place a strong emphasis on self-direction and skills development for monitoring and management of chronic health conditions. Health promotion assists individuals to take a self-directed approach to health through the provision of health education. Specific health promotion services may include, but are not limited to, providing or coordinating assistance with:

o Promoting individual's health and ensuring that all personal health goals are included in person centered care plans;

o Promotion of mental health treatment, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity;

o Providing health education to individuals and family members (where appropriate) about chronic conditions;

o Providing prevention education to individuals and family members (where appropriate) about health screening and immunizations;

o Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and

o Promoting self-direction and skill development in the area of independent administering of medication.

o Linking the member to disease management and health education programs offered by his/her managed care organization.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum*

Information will be collected on a periodic basis on individual participation in both external and internal health promotion activities. For those activities included in the EHR, this information can be shared with other providers using the CurrentCare HIE. Individuals accessing health promotion activities through the Department of Health's Chronic Disease Self-Management Program will also be tracked by the Department of Health for follow-through, participation and completion. OTP staff have been encouraged to become providers for the DOH programs and train in the Stanford Model along with offering RNs and pharmacists the opportunity to become certified diabetes outpatient coordinators and certified cardiac outpatient coordinators.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Master's level team leaders will be responsible for the oversight of this service. Care managers may assist in the provision of health promotion activities.

Nurses

Health Home team RNs will have primary responsibility for the provision of health promotion activities. Nurses will create and facilitate groups targeting health promotion (i.e.nutrition, smoking cessation, exercise) as well as meet with participants individually to monitor and encourage health promotion activities. Nurses will provide educational materials to individuals and be available as primary consultants for any questions related to health promotion activities.

Physicians

Physicians will have routine contact with Health Home patients and will encourage participation in health promotion activities.

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition:

Comprehensive transitional care services focus on the transition of patients from any long-term care facility or other out-of-home setting into the community. Health Home team members work closely with the patient to transition smoothly back to the community and share information with discharging organizations to prevent gaps in care that could result in re-admission.

To facilitate timely and effective transitions, all OTPs will maintain collaborative relationships with emergency departments, local hospitals, long-term care and residential facilities and other applicable settings. OTPs will utilize healthcare liaisons to assist in discharge planning - existing OTP patients and new referrals - from inpatient settings to OTPs. Care coordination will also assist in transitioning incarcerated individuals.

Healthcare liaisons, care coordinators and other team members will provide transitional care services. The team will collaborate with physicians, nurses, social workers, discharge planners and pharmacists within the hospital or residential setting to ensure a care plan has been developed and work with family members (where appropriate) and community providers to ensure that the plan is communicated, adhered to and modified as indicated.

When an OTP patient is admitted to a hospital, there is dialogue with medical staff for medication verification. Education is provided to hospitals regarding OTP Health Home services and this dialogue can be expanded beyond dosing information to continuity of care and discharge planning.

Managed Care Organizations and Medicaid have created mechanisms for periodic utilization reports provided to OTP HHs.In fact, MCOs have developed next day notification procedures to Health Homes on all hospital admissions.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum*

Health information technology is crucial in establishing effective, comprehensive transitional care. Currently, all OTPs have electronic medical records, though may not be able to share health record information easily. Providers are encouraged to participate in Direct Messaging available through the State's Health Information Exchange - CurrentCare. Direct Messaging allows providers to share information securely and efficiently.

Data that is submitted through RIBHOLD is currently accessed online by the providers to prevent dual enrollment. If a client is currently active in one program, another will not be able to admit until that client is "cleared" for admission by being discharged. OTP providers are very accustomed to using this form of HIT to coordinate care amongst themselves. Easy access to enrollment data allows providers to request prior treatment information that will assist them in development of a comprehensive treatment approach.

BHDDH also receives daily census data from the Department of Corrections in order to alert providers that an active OTP patient has been incarcerated and to provide continuity of care during at least the initial period of incarceration.

Through a collaborative process with MCOs, OTPs will be provided with quarterly utilization reports for their clients, enabling them to address need for coordination and transition. OTPs will also receive next day notification by MCOs on any Health Home patient that is hospitalized. These standard reports will be submitted to OTPs on a regular basis and assist in the effective provision of transitional care services.

OTPs have relationships with providers of long term care services including nursing facilities and substance abuse residential treatment. These providers may also participate in Direct Messaging enabling OTPs to provide and receive information enhancing their ability to meet client needs in transitioning.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

The Master's Level team leader will need to assess the consistency of the care plan(s) established in relation to the clinical treatment plan. This person will interact with other providers in addressing the patient's treatment and health needs while in another setting and work with the team to establish a transitional plan.

The case manager will be responsible for the application of services in a transitional care plan. The care manager will be responsible for assuring the patient is able to follow through with transition plans and is assisted in doing so.

The hospital liaison will work closely with the hospital staff, especially discharge planners, to assess the suitability of transition plans. Hospital liaisons will work with other long term facilities to plan for coordination of care during and after a residential stay.

Nurses

The registered nurse will likely be the primary provider/monitor of transitional care activities. Nurses have the most day-to-day interaction with other physical health care providers. Nurses are responsible for the oversight of medication delivery and administration. The RN will be the party responsible to develop the transitional care plan and accommodate any of the needs of individuals, such as transportation, ambulation, and risk of infection, etc.

Physicians

The team physician will be responsible for the review of other treatment received and re-integration in the outpatient setting. Physicians will need to coordinate with other physicians to ensure continuity of care. Physicians will guide other team members in the establishment of a transitional care plan.

Pharmacists

Patients transitioning from long term programs or hospitalizatons may have the need for a medication review by the pharmacist to ensure that medications prescribed during or post these stays will not adversly interact with methadone.

Individual and Family Support (which includes authorized representatives)

Definition:

Patient Support Services provide quality care that allows clients to maintain independence and improve the quality of their lives. This support may involve families, communities, professionals and any other entity identified by the patient as integral to their recovery process. Individual support services, including family where appropriate, are provided by the care coordinator and other members of the health team to reduce barriers to individuals' care coordination, increase skills, engagement and improve health outcomes. These services may include, but are not limited to:

- Providing assistance in accessing needed self-help and peer support services;
- Advocacy for individuals and families;
- Assisting individuals to identify and develop social support networks;
- Assistance with medication and treatment management and adherence;
- Identifying resources that will help individuals and their families reduce barriers to promote the highest level of health and success;
- Connection to peer advocacy groups, wellness centers, Rhode Island Coalition for Addiction and Recovery Efforts (RICares), Faces and Voices of Recovery (FaVoR) and psycho-educational programs; and
- Individual and family support (where appropriate) services that may be provided by any member of the OTP Health Home team.

OTP Health Homes provide support, education and resources to any family member as defined by the patient.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum*

With appropriate consents to release information, family and other supports of Health Home participants may have access to relevant information contained in the electronic health record. Such information may be useful to supports for developing appropriate recovery plans and engaging patients in open discussions around needs and follow through. Families may also provide helpful collateral information that may guide the assessment and care planning for the individual.

Families may have need to access information through HIT in the event of emergency or potentially for legal issues. Family members can be made aware of provider's

participation in Direct Messaging and in the event of an emergency can let responders know that there is information to be accessed in that manner.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

All members of the Health Home teams may be involved in the provision of individual and family support services. While care managers may have primary responsibility, it is reasonable to assume that all of a Health Home client's supports may have access to all team members.

Nurses

Nurses may involve family in instructions for following care plans and discussions around medication adherence.

Physicians

Doctors may include family members or patient advocates in their meetings with patients.

Pharmacists

Pharmacists may provide information to family and other supports on potential medication interactions and signs and symptoms of medication overdose.

Referral to Community and Social Support Services

Definition:

Referral to community and social support services, including programs offered by the member's managed care organization, provides patients with a wide array of support services to help overcome barriers, increase self-management skills and achieve overall health. Appropriate referrals are driven by the assessment process and are noted on the patient's care plan in consultation with and agreement from the patient. The State assures appropriate referrals are made by monitoring the assessment, planning and care provided by OTPs.

Referral to community and social support involves facilitating access to assistance for individuals to address medical, behavioral, educational, and social and community issues that may impact overall health. Such referrals are made through telephone or in person consultation and may include electronic transmission of requested data. Follow through on referrals will be the role of the healthcare liaison or the case manager, depending upon the type of referral. The types of community and social support services to which individuals will be referred may include, but are not limited to:

- Primary care providers and specialists;

- Wellness programs, including smoking cessation, fitness, weight loss programs or yoga;

- Specialized support groups (i.e. cancer or diabetes support groups);

- Recovery support services such as support groups, recovery coaches, 12 step groups;

- Housing, including recovery housing;

- Social integration opportunities including Recovery Centers;

- Benefit attainment assistance;

- State Nutrition Assistance Program (SNAP);

- Office of Rehabilitation Services;

- Social integration and social skill building programs;

- Faith based organizations;

- Community Mental Health Organizations;

- Higher levels of care for addiction treatment, including IOP, PHP, residential or detox that can be accessed with assistance from the member's managed care organization 24 hours per day, seven days per week.;

- Appropriate cultural support centers;

- Social Case managers, outreach workers, disease management programs and other resources offered by the member's managed care organization.

Referral to community and social support services may be provided by any member of the OTP health home team

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum*

Referrals to community and social support services can be made through Direct Messaging with any participating practices. It is important to note that for many of these programs, clinical detail in health records may not be needed or appropriate.

OTPs making referrals to the Rhode Island Department of Health's Chronic Condition Self-Management Programs can use the established referral process. Releases are signed and a referral form is completed and then emailed to the DOH. DOH tracks the referrals and assists the patient in making and keeping appointments. Peers follow up on all referrals at least three times to insure that the patient is connecting to the service. These services include but are not limited to: arthritis exercise programs; arthritis walking with ease programs; certified diabetes and certified cardiovascular disease outpatient educators; Living Well Rhode Island; Diabetes Self-Management; Health Smart Behaviors; Draw a Breath Asthma Program; Livestrong at the YMCA; Chronic Pain self-management workshops; QuitWorks RI; YMCA's Healthy Lifestyles Behavior Change Program.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Case managers will most likely make the bulk of referrals that are not specific to medical appointments, though would not be restricted from doing so when appropriate. Case managers are the primary link to resources of recovery support in the community. Working with the Master's Level Team Leader, case managers will be responsible for maintaining updated lists of resources with contact information. Case managers will ensure follow through on referrals and assist patients, when needed, in getting to appointments or ensuring connection.

Nurses

Nurses will likely be the primary source of referral for medical appointments, ensuring that patients are properly referred and that essential information is provided and received.

Physicians

Physicians may make referrals for HH patients on a regular basis. It would be expected that in referrals to specialty care for individuals with specific complications, a physician referral would be most appropriate. For the Certified Diabetes Outpatient Educator and the Certified Cardiovascular Disease Outpatient Educator Programs, the referral must come from a physician.

Health Homes Patient Flow: Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter*

The attached RI flow chart depicts the Health Home process for "Alice" the opioid dependent HH client described in our previously submitted narrative. This chart identifies the process for individuals who may present in local hospital emergency departments. Through the HH process, it is expected that OTPs will work to increase their coordination of care with local hospitals and educate them on Health Home services. For an opioid dependent patient who presents in an ED, an assessment will be made as to whether that patient is currently enrolled in an OTP. If yes, they will be educated as to benefit of HH services, if no, outreach will be made to OTP hospital liaison who will offer OTP/HH services and coordinate appointment for assessment/intake. Assuming client is appropriate for treatment and decides to enroll in Health Homes, they would then be assigned to a Health Home team that may be focused on their primary chronic condition and meet with members of that team to create a recovery care plan. The patient would have access to the team nurse for any concerns, care needs and routine screenings. The patient would work with the team to have care coordinated with other health care providers which would include appointment scheduling, information sharing, medication reviews, and follow-up. Case management would assist the client getting to appointments, connecting with other recovery support services, addressing needs and family engagement (if appropriate). If the primary chronic condition focus changes, the patient may transfer to a different team that addresses that

particular condition if they choose to. As the client progresses in attaining recovery care goals, the focus of the team will be to continue care coordination, provide resource to the patient, and meet any arising needs. For members in managed care, the OTP HH team will also engage with the member's managed care organization for assistance in accessing other primary care, specialty care, and acute services.

For patients that are self-referring, enrolled in Managed Care or are already engaged in OTP services, opportunity to participate in HH services will be offered and patients will progress through services as described above.

Types of Health Homes Providers

☑ Designated Providers

Indicate the Health Homes Designated Providers the state includes in its program and the provider qualifications and standards

- ☐ Physicians
- ☐ Clinical Practices or Clinical Group Practices
- ☐ Rural Health Clinics
- ☐ Community Health Centers
- ☐ Community Mental Health Centers
- ☐ Home Health Agencies
- ☐ Case Management Agencies
- ☑ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards*

All Health Home designated providers are Opioid Treatment Programs licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals as Behavioral Healthcare Organizations. Licensed status indicates that all programs are required to abide by the Rules and Regulations for Behavioral Healthcare Organizations. All OTP Health Home providers are accredited by independent accrediting bodies and certified by SAMHSA.

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. Effective MAT programs also provide services such as physical and mental health care, case management, life skills training, employment support, integrated family support, and recovery support services. Health Home services build on existing MAT resources and infrastructure. Methadone treatment is highly regulated and can only be provided through specialty Opioid Treatment Programs (OTPs), which have provided

comprehensive addictions services but with limited integration into the broader health care or mental health treatment systems.

The OTP Health Home is a Designated Provider as described in Section 1945(h)(5). The OTP Health Home builds upon the existing treatment system by developing into specialty treatment centers that provide the six (6) Health Home services in addition to the traditional comprehensive methadone addictions treatment.

If an OTP HH provider would like to be authorized to receive reimbursement for COE services, the OTP HH provider must submit an application to the State. The State will assess each COE application according to the Certification Standards for Centers of Excellence. The Certification Standards detail the requirements that the COEs are held to, including, but not limited to the staffing requirements, person-centered approach to care, care coordination activities, use of HIT, quality monitoring and reporting, as well as the scope of COE services which include complete biopsychosocial assessments and physical exams; observed medication inductions; individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis. The Certification Standards for Centers of Excellence are available on EOHHS' website at the following link: http://testweb.bhddh.ri.gov/quick_links/excellence.php

- ☐ Federally Qualified Health Centers (FQHC)
- ☐ Other (Specify)

☐ Teams of Health Care Professionals

☐ Health Teams

Provider Infrastructure: Describe the infrastructure of provider arrangements for Health Home Services*

Opioid treatment programs are uniquely suited to provide health home services to opioid dependent patients receiving medication assisted treatment. Compliant with both federal and state statutes, OTPs are staffed by medical and clinical staff and have daily to biweekly contact with clients in a clinical setting. OTPs providing Health Home services are required to be licensed by the Department of BHDDH and demonstrate compliance with Rules and Regulations as determined through routine monitoring and audits. OTPs are also required to receive certification through SAMHSA and maintain independent accreditation.

To provide Health Home services, OTPs are required to maintain a specific staffing pattern dedicated solely to the implementation of the six service domains identified by CMS. Staffing is based on a ratio of a 125 patients per team. Teams are organized by primary co-morbid condition if numbers allow (i.e. a Hepatitis C specific Health Home team, a COPD focused Health Home team), otherwise, patients will be organized on teams with many comorbid conditions or risk factors present. These teams are led by staff trained and knowledgeable in the primary health concern of the patient. Presence in particular teams may be fluid based upon changes in the patient's presentation and primary concerns.

The COE staffing requirements, as described in the COE Certification Standards, include Drug Abuse Treatment Act (DATA)-waivered physicians, nurses (RN or LPN), Master's Level Clinician (clinician to patient ratio not to exceed 1:100), pharmacist, and a combination of licensed chemical dependency professionals, case managers and or peer recovery coaches.

The following is a description of each core OTP Health Home team member and their roles:

SUPERVISING MD: The OTP physician has primary responsibility for the overall treatment of the patient.

Care Management:

- Coordinate and review health assessment that identifies medical and wellness needs.
- Provide consultative support to provider Case managers to help identify the physical health needs of individuals and work with relevant organizations to develop a services plan and arrange for the delivery of physical health services as needed.
- Ensure individuals with complex, co-occurring physical health disorders are well understood or being served by primary care providers, as needed through regular phone contact, correspondence, to their medical and health promotion providers.
- Ensure that the individual's plan of care developed by the Health Home team integrates the continuum of medical, behavioral health services and identifies the primary care physician/nurse practitioner, specialist(s) and other providers directly involved in the individual's care.
- Ensure that the individual's plan of care developed by the Health Home team clearly identifies goals and timeframes for improving the patient's health and health care status and the interventions that will produce this effect.
- Attend organizational staff meetings as needed to assess medical status and progress, coordinate medical and health promotion activities, and develop solutions to problems other staff are experiencing.
- Collaborate with nurses in assessment of client's physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordination medical treatment.

Care Coordination and Health Promotion

- Ensure that individual plans of care clearly identify primary, specialty, behavioral health and community networks and supports that address identified needs.

- Ensure OTP clients have meaningful engagement with internal and community wellness and prevention resources for smoking cessation, diabetes, asthma, hypertension, etc., based on individual needs and preferences.

Individual and Family Supports

- Ensure the care plans reflects patient and family or caregiver preferences, education and support for self-management, self help recovery, and other resources as appropriate.

- Communicate/share information with individuals and their families and other caregivers as appropriate.

- With other team members, provide support and education to family members of clients to help them become knowledgeable about opioid dependence, collaborate in the treatment process, and assist in their family member's progress.

Referral to Community/Social Supports

- Participate in the development of agencies' policies, procedures and accountabilities (contractual agreements) to support effective collaborations between primary care, specialist and team, including follow-up and consultations that clearly define roles and responsibilities.

Continuous Quality Improvement

- Participate in agency continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management.

- Clinical supervision, education and training of the team pertaining to medical issues, as needed.

RN SUPERVISOR: This team member has primary responsibility for the implementation of health homes services and specific care plans. Nurses assist the physician in the monitoring of routine health screens, they conduct regular face-to-face assessments of clients, screen BMI and blood pressure, make referrals, monitor medications and assist in the coordination with outside providers, including hospitals. The RN supervisor is involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.

The following is a detailed list of RN Health Home responsibilities:

- In collaboration with the team physician, coordinate, schedule and administer agency's assessment of clients' health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate substance abuse treatment with medical treatment. (comprehensive care management),

- Provide ongoing health assessments (identify health issues, behaviors, needs, barriers) and all other assessments, which are appropriate for the nursing scope of practice. (comprehensive care management)

- Build relationships with medical providers in the community, which will provide the team with a network of physical health resources. (comprehensive transitional care)

- Collaborate and regularly liaises with pharmacies, labs and community agencies based on consumer's health and wellness needs. (comprehensive transitional care)

- Refer clients to other health providers and other resources within the community when appropriate. (referral to community and social support services)

- Accompany consumers to medical appointments; facilitate medical follow up, when appropriate. (comprehensive care management)

- Provide supportive case management to families by ensuring they receive assistance with patient advocacy, information regarding program, team, or community health and educational resources, and referrals to appropriate community services and/or agencies. (care coordination)

- Support client access to services such as medical appointments, hospitals, transportation, housing services and social programs by methods such as providing health care information and contacting relevant programs/services. (care coordination)

- Act as an advocate for clients. (care coordination)

- Under the direction of the team physician, the nurse will develop, revise, and maintain medication protocols, policies and procedures. (care coordination)

- Provide support and education to family members of clients to help them become knowledgeable about substance use disorders, collaborate in the treatment process, and assist their family member in making progress. (family supports)

- Manage pharmaceuticals and medical supplies. (family supports)

- Facilitate wellness promotion activities such as smoking cessation, chronic condition self management, and nutrition. (wellness promotion)

MASTER'S LEVEL TEAM LEADER/PROGRAM DIRECTOR: A licensed clinician involved with identifying potential OTP patients, conducting outreach, assessing preliminary service needs, establishing a comprehensive care plan, developing an individualized Plan of Care with goals set in conjunction with the patient, assigning Health Home team roles and responsibilities, developing treatment guidelines and protocols, monitoring health status and treatment progress,

and developing QI activities to improve care. These individuals are the bridge between clinical and Health Home services. Team leaders supervise case managers, facilitate team meetings and provide the necessary outreach and patient engagement strategies. Team leaders, in conjunction with the RNs, act as the healthcare liaison with community and institutional providers. Team leaders will participate in transitional care meetings and establish working relationships with primary and specialty care practices, along with other specialty behavioral healthcare providers (CMHCs, residential treatment providers, etc.). They are involved in providing all aspects of Health Home services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.

- Lead on development of health services plans at the treatment plan meetings; monitor each client's status and response to health coordination and prevention activities; and provide feedback regarding staff performance, and give direction to staff regarding individual cases and supervise members of health home team in the development of wellness and prevention initiatives; health education groups. Oversee primary functions of HH Team, including but not limited to:

a. Provide on-going training to case managers in the recognition and management of chronic medical conditions. (health promotion)

b. Coordinate and integrate disease self-management activities (improve integration within general health promotion practices practice). (care coordination)

c. Provide effective discharge planning implementation/ continuity of care. (care coordination, comprehensive transitional care)

d. Ensure quality communication with CMHOs, federally qualified health centers, hospitals, other providers, etc. (troubleshoot when necessary on issues). (care coordination)

e. Develop and maintain working relationships with primary and specialty care providers, including inpatient facilities. (comprehensive care management)

f. Consult with community agencies and families to maintain coordination of the treatment process.(referral to community and social support services, individual and family support services)

g. Assure that team is meeting overall Health Homes goals. (comprehensive care management)

h. Educate community health referral sources, perform clinical screens and participating, organizing and executing care-coordination and prevention. (health promotion)

i. Design and develop prevention and wellness initiatives. (health promotion)

j. Monitor Health Home performance and leads improvement efforts. (care coordination)

CASE MANAGER/HOSPITAL LIAISON: Encourage client towards self-management (i.e. if possible, encourage direct communication between the consumer-patient/caregiver and primary

care provider; meet patients at their level in order to prepare them to self-manage their acute and chronic conditions). Enhance communication and collaboration between clients, professionals across sites of care, potentially reducing medical errors, missed appointments, and dissatisfaction with care. Advocate, make phone calls and facilitate connections when critical need emerges, and coordinate communication with key medical and social services involved with the patient's care upon discharge, when necessary.

1. Maintain good working relationship with medical and psychiatric units (know how to function in variety of medical inpatient cultures). (comprehensive transitional care)

2. Engage with the patient upon admission to the hospital. (comprehensive transitional care)

3. Communicate any noteworthy information back to the inpatient staff. (comprehensive transitional care)

4. Engage consumer and family in their discharge plan by providing them with resources and tools that enable them to participate in the formulation of the transition plan. (individual and family support services)

5. Collaborate with inpatient staff regarding discharge planning (determine the level of improvement and resources necessary for discharge). (comprehensive transitional care)

6. Upon hospital discharge (phone calls or home visit):

- Assist client to identify key questions or concerns.
- Ensure Client:
  - Understands Medications and knows how to take as prescribed
  - Has access to a nurse and physician to discuss any potential side-effects;
  - Is knowledgeable about indications if their condition is worsening and how to respond;
  - Knows how to prevent health problem from becoming worse;
  - Has knowledge of and transportation to all follow-up appointments.
- Prepare client for what to expect if another level of care site is required (i.e. how to seek immediate care in the setting to which they have transitioned).
- Review with Health Home team transition care goals, relevant transfer information (i.e., all scheduled follow-up appointments; any barriers preventing making appointments); function as resource to team members – to clarify all outstanding questions. (comprehensive transitional care)

7. Establish a plan of return to hospital, if clinically appropriate, or if the community transition plan is not working. (comprehensive transitional care)

8. Coordinate transportation to drive client home and to ensure they are properly settled i.e. has appropriate food, etc. (comprehensive care management)

9. Provide advocacy in getting appointment, if necessary, or if to obtain answers needed to manage condition as necessary upon discharge. (comprehensive transitional care)

CASE MANAGER: The case manager is responsible for the implementation of the care plan. They provide direct support to the client in and out of the treatment setting. They are responsible for the following:

- In collaboration with the team physician and nurse, coordinate and schedule medical assessment of client physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate medical treatment. (care coordination)

- Provide practical help and support, advocacy, coordination, side-by-side individualized support problem solving, direct assistance, helping clients to obtain medical and dental health care. (individual and family support services)

- Provide nutritional, education and assistance with grocery shopping and food preparation as it relates to an identified medical issue (e.g., diabetes, etc.). (individual and family support services)

- Provide health education, counseling and symptom management challenges to enable client to be knowledgeable in the prevention and management of chronic medical illness, as advised by the client's primary/specialty medical team. (comprehensive care management)

- Collaborate in the treatment process with primary and specialty care providers as required. (care coordination)

- Support the client to consistently adhere to their medication regimens (e.g., phone prompting, MI), especially for clients who are unable to engage. (comprehensive care management)

- Accompany clients to and assist them at pharmacies to obtain medications. . Accompany clients to medical appointments, facilitate medical follow up. (comprehensive care management)

- Provide education about prescribed medications (e.g. consistently discussing the purpose of medications, educating through written materials; enlist the help of other clients, etc.). (health promotion)

- Work with inpatient medical services to complete admission and discharge preparation when necessary; utilize personal health record to help patient self-manage; provide coaching/role playing for person's follow-up appointments. (comprehensive transitional care)

- Provide direct assistance to obtain the necessities of daily life, e.g., legal advocacy for consumers involved in the criminal justice system; benefits counseling (e.g., food stamps, home energy assistance, income tax, transportation, etc.). (comprehensive care management)

PHARMACISTS: Healthcare professionals who focus on safe and effective medication use. They are an integrated member of the health care team directly involved in patient care. Professional interpretation and communication of this specialized knowledge to patients, physicians, and other health care providers are functions which pharmacists provide, and are

central to the provision of safe and effective drug therapy. Pharmacists are responsible for ordering, receiving, storing, and providing nursing staff with medication to be administered. They may review patient medication lists for safety and potential interactions.

There are three collaborative positions shared across Health Home sites/agencies. These vital roles ensure consistency in implementation at each site and fidelity to the Health Home model.

The first of these positions is an Administrative Level Coordinator. This person oversees the implementation of Health Home services at all agencies and acts as the liaison to the State agencies supporting Health Homes. This Coordinator participates in team meetings and works with staff to achieve fidelity to this proposed model. The coordinator strategizes with teams to encourage client participation, develop wellness programs, identify potential community partners and assist in outcome evaluation.

The second shared position is the Health Information Technology Coordinator. The responsibility of the HIT coordinator is to assist programs in the enhancement of their EHRs to effectively monitor program outcomes and to connect with the State HIE, or find other means to share meaningful data. Based on experience from the CMHO Health Home, RI recognizes the need to establish, with each EHR, a mechanism for tracking Health Home service events.

Finally, the State created the position of Health Home Training Coordinator. Provision of Health Homes services in an OTP represents a significant culture shift that will require specific ongoing training to identify and inform current resources and best-practices in Health Home delivery systems. A centralized training coordinator not only makes practical sense, but also promotes consistency. This person ensures that programs have equal understanding of the goals and implementation of a successful Health Home program. The coordination of training will consider all disciplines involved in the effective delivery of Health Home services.

State oversight of the OTP Health Home program will be the responsibility of the State Opioid Treatment Authority housed at the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and a representative of the State Medicaid Authority. These individuals will work closely with the shared coordinators, and leadership of each OTP site to ensure that programs are monitored for process fidelity and outcomes.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services**
2. **Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders**
4. **Coordinate and provide access to mental health and substance abuse services**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up**

from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care

6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services**
8. **Coordinate and provide access to long-term care supports and services**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level**

Description*

To facilitate the capacity to use health information technology, BHDDH will actively work with Health Home providers to become viewers and data sharing partners in the State's HIE - Current Care. BHDDH will capitalize on the progress made by our CMHO Health Homes in connecting to the HIE with provisions for compliance with 42 CFR Part II. A requirement to offer patients enrollment in the HIE along with an approved authorization to release is contained in State regulation for OTPs. All of our OTPs have EHRs. The State will coordinate information from the MCOs and Medicaid as has been done with the CMHO Health Homes. MCOs will provide quarterly utilization reports to OTPs along with next day notification of hospitalization. The MCOs will use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes.

BHDDH will coordinate efforts with OTPs and the Department of Health's Chronic Disease Self-Management program and other DOH related programs that will inform the strategies of the initiatives. These relationships were established during the planning process to ensure a holistic approach.

BHDDH will use our Client Information database (RIBHOLD) to provide outcome/trend data to providers and prevent dual enrollment with other Health Homes and duplication of services.

OTPs will be supported in transforming into Health Homes through participation in statewide learning activities, monitoring and technical assistance. BHDDH will modify its monitoring/evaluation instrument created for CMHO Health Homes for OTPs. This instrument was well received by providers and HH reviewers as it incorporates self-assessment with a departmental review of process and individual cases. Use of evidence based practice and provision of culturally appropriate, quality driven and cost effective services will continue to be a requirement of both licensing and contracts.

BHDDH will provide links to Health Home and Center of Excellence information on its website as a means of communication with providers and others.

Other Health Homes Provider Standards: The state's requirements and expectations for Health Homes providers are as follows*

All OTPs will be required to apply for Health Home Accreditation in their next scheduled Accreditation cycle. If an OTP HH provider would like to be authorized to receive reimbursement for COE services, the OTP HH provider must submit an application to the State. The State will assess each COE application according to the Certification Standards for Centers of Excellence. The Certification Standards detail the requirements that the COEs are held to, including, but not limited to the staffing requirements, person-centered approach to care, care coordination activities, use of HIT, quality monitoring and reporting, as well as the scope of COE services which include complete biopsychosocial assessments and physical exams; observed medication inductions; individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis. The Certification Standards for Centers of Excellence are available at the following link:
http://testweb.bhddh.ri.gov/quick_links/excellence.php

All OTPs will be required to sign the following:

Health Homes Certification Agreement

I- Introduction/Mission Statement:

A Health Home is the fixed point of responsibility to provide person centered care; providing timely post discharge follow-up, and improving consumer health outcomes by addressing primary medical, specialist and behavioral health care through direct provision, or through contractual or collaborative arrangements with appropriate service providers, of comprehensive, integrated services. Emphasis is placed on the monitoring of chronic conditions, provision of preventative and education services around self care and wellness. This program is accountable for reducing avoidable health care costs, specifically preventable hospital admissions/readmissions and avoidable emergency room visits.

The OTP agrees to fulfill and maintain the following requirements necessary for Certification as a Health Home Provider:

II. Admission

A. Admission Criteria: Clients with opioid dependence that meet state and federal criteria for Methadone Maintenance Treatment and are currently receiving financial support through the entitlement program of Medicaid.

B. Discharge Criteria: Adhere to all Rules and Regulations for the licensing of Behavioral Healthcare Orgainizations in Section 28.0

III. Provider Standards:

- Provide quality-driven, cost effective, culturally appropriate, and person- and family-centered Health Home services;

- The HH team shall maintain staff compliant with competencies, professional qualifications and experience as described throughout the RI Rules and Regulations for the Licensing of Behavioral Health Organizations;

- Have a physician(s) assigned for the purpose of Health Home team participation to each individual receiving OTP Health Home services;

- Conduct wellness interventions as indicated based on individuals' level of risk and willingness to participate;

- Agree to participate in any statewide learning collaborative that may be implemented for Health Home providers;

- Within three months of Health Home service implementation, have executed a contract or Memorandum of Understanding (MOU) with regional hospital(s) or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions of Health Home participants, as well as maintain a mutual awareness and collaboration to identify individuals seeking Emergency Department services that might benefit from a connection with an OTP Health Home provider;

- Agree to a establish a contract(s) or MOU(s) with Federal Qualified Healthcare Centers (FQHCs) and/or primary care centers in the OTP area;

- Establish a process for receiving and accepting relevant information to coordinate care for Health Home participants among the OTP and primary and specialty care providers, including mental health treatment providers. This may include development of data sharing system that includes Electronic Medical Record (EMR)expansion, use of Direct Messaging through the State's Health Information Exchange to help safeguard privacy of this information and assure compliance with all related state and federal confidentiality regulations;

- Demonstrate a capacity to use health information technology to link services, facilitate communication among team members, and between the health team and individual and family caregivers, and providing feedback to practices, as feasible and appropriate;

- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease-management on

individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level;

- Develop treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;

- Monitor individual and population health status and service use to determine adherence to or variance from treatment guidelines;

- Develop and disseminate reports that indicate progress toward meeting outcomes for client satisfaction, health status, service delivery and costs;

- Agree to convene regular, ongoing and documented internal health home team meetings with all relevant providers to plan and implement goals and objectives of practice transformation;

- Agree to participate in CMS and state-required evaluation activities;

- Agree to develop required reports describing OTP Health Home activities, efforts and progress in implementing Health Home services (e.g., monthly clinical quality indicators reports);

- Ensure capacity to provide multiple contacts as needed for a team of 125 clients. Contacts can include phone contact, such as coordinating care with other providers and support systems, as well as direct contact with the individual;

- Agree to participate in annual chart reviews by the Department to assure compliance with standards, measures, outcomes and quality care from each team;

- Any compliance concerns regarding program standards, team composition, measures, outcomes or reporting will be reviewed by the Department for certification status.

Health Home Care Coordination Team:

- Develop and maintain a Health Home team that, at a minimum, is comprised of the following: a case manager, who will serve as the central coordinator for Health Home services, a case manager/hospital liaison, a physician, a registered nurse, a master's level team leader, and a pharmacist;

- Agree to work with centralized members of Health Home Implementation team including Health Information Technology Coordinator, Administrative Level Coordinator, and Health Home Training Coordinator;

- Other Health Home team members may include, but are not limited to: primary care physicians, peer wellness specialists, mental health specialists, employment specialists and community integration specialists;

- Team members shall meet all of the qualifications in the BHDDH "Rules and Regulations for the Licensing of Behavioral Healthcare Organizations;"

- The Health Home Team Staff Composition required to provide services based on a one hundred twenty-five person team is outlined below.* Any deviation from that staffing pattern will require a written proposal to the Department for approval.

Qualifications:	Health Home FTE
Master's Level Team Leader	1.00
Physician	0.25
Registered Nurse	1.00
Case Manager-Hospital Liaison	1.00
Case Manager	1.00
Pharmacist	0.10
Total Personnel	4.35

- Monthly census of team composition will be submitted to the Department for review and compliance with the standard.

- Programs will share the following collaborative positions:

Administrative Level Coordinator	1.00
HIT Coordinator	0.50
Training Coordinator	0.50

IV. Care Coordination Responsibilities:

- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and other substance use disorders;

- Coordinate and provide access to mental health and other substance abuse services;

- Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings;

- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families, and referrals through the Department of Health's Chronic Disease Self Management Programs;

- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
- Coordinate and provide access to long-term care supports and services;
- Develop and implement a person-centered care plan that is flexible and integrates all clinical and non-clinical healthcare related needs and services. Plan is compliant with sections 25 and 26 of the Rules and Regulations for the Licensing of Behavioral Healthcare Organizations;
- Ensure that all services, including mental health treatment, are coordinated across provider settings;
- Behavioral Health Care Organizations, in review of their Policies and Procedures, are to update all relevant Policies and Procedures to reflect Health Homes;
- Changes in any aspect of an individual's health must be noted, shared with the team, and used to change the care plan, as necessary. All relevant information is to be obtained and reviewed by the team;
- Facilitate timely and effective transitions from inpatient and long-term care settings to the community, as appropriate;
- Health Home providers will identify hospital liaisons to assist in the discharge planning of individuals, existing OTP clients and new referrals, from inpatient settings to OTPs and mental health treatment, if indicated;
- Care coordination may also occur when transitioning an individual from a jail/prison setting into the community;
- A member of the team of health professionals provides care coordination services between hospitals and community services;
- Team members collaborate with physicians, nurses, social workers, discharge planners and pharmacists as needed to ensure that a person-centered care plan has been developed, and work with family members and community providers to ensure that the plan is communicated, adhered to and modified as appropriate;
- Provide assistance to individuals to identify and develop social support networks;
- Provide assistance with medication and treatment management and adherence, to include referrals for mental health vocational and counseling services.
- Connection to peer advocacy groups, wellness centers, NAMI, RICARES, Family Psychoeducational programs, etc.;
- Provide Individual and family support services to assist individuals to access services that will reduce barriers to treatment and improve health outcomes. Support services may include advocacy, information, navigation of the treatment system, and the development of self-management skills;

- Referral to primary and or specialty care as requested by physician.

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

☑ Fee for Service

☑ PCCM

The PCCMs will be a Designated Provider or part of a Team of Health Care Professionals

*

○ Yes ◉ No

☑ The State provides assurance that it will not duplicate payment between its Health Home payments and PCCM payments.

☑ Risk Based Managed Care

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

*

◉ Yes ○ No

Provide a summary of the contract language that you will impose on the Health Plans in order to deliver the Health Homes services*

COE services are not an in-plan benefit in managed care. COE services are available to all Medicaid members, but will be paid for through FFS.

For OTP HH, the language included in the contract between EOHHS and the MCOs addresses the goals of the program, patient eligibility, provider eligibility, descriptions of core functions and responsibilities of OTP HH providers, assessment and reporting requirements, OTP HH team composition and staffing levels, descriptions of services provided by OTP HHs, and MCO responsibilities. MCO responsibilities include contracting with OTP HH to serve their members, coordinating care with the member's use of other MCO covered services, referring other MCO members who meet the enrollment criteria to OTP Health Homes, providing OTP HH with reporting to facilitate the coordination of medical and behavioral health care, use utilization data (inpatient admissions, readmissions, ER visits, and Pharmacy reports) along with predictive models to identify members with new health risks to share with OTP Health Homes, oversight to ensure contract requirements are being met, assist the OTP HHs with identifying necessary components of metric reporting, adhere to the reporting date requirements based on a reporting calendar, adhere to continuity of care requirements, including maintenance of relationships between members and treating providers (including beneficiaries transitioning into the managed care organization), holding the member

harmless, and ensure that the OTP HH are submitting HIPAA compliant claims data for services delivered under the OTP HH and ACT bundles.

For MCO enrollees active with OTP Health Homes, the MCO will leverage the care management provided at the Health Home and will not duplicate services. The MCO will work collaboratively with Health Homes to ensure all the member's needs are met.

For clients enrolled in OTP Health Homes, the OTP is the lead provider for all care coordination/care management services. To facilitate collaboration, both the OTP and the MCO will be provided with necessary data from the Department.

On a quarterly basis, the Department will provide the MCO with a list of their enrolled members in OTP Health Homes. The format for this file will be agreed upon between the MCO and EOHHS. MCOs store this information in a central database that can be accessed by all relevant staff. On an interim basis, OTP Health Homes will inform the MCO directly of any new HH enrollees/disenrollees.

Weekly, the MCO will send the OTP Health Home a health utilization profile for the most recent twelve-month period, for every new member of the OTP Health Home Program. The format and transmission method for this health utilization profile will be mutually agreed upon by the OTP Health Home and the MCO. The elements of the health utilization profile will include, but will not be limited to, physician office visits (primary care and specialty), prescriptions, emergency room (ER) visits, and inpatient stays.

The OTP Health Home will provide the MCO with a high-level summary of the care plan, in a format agreed upon by the Health Home and the MCO.

The MCO will inform the OTP Health Home of all inpatient admissions prior to discharge, and will engage the OTP in a collaborative discharge planning process, whenever possible. Upon discharge, the OTP Health Home will contact the member to ensure all appropriate services and supports are in place to prevent future hospitalization. The OTP will coordinate with the MCO to obtain any necessary authorizations for in-plan services, as appropriate.

The State intends to include the Health Home payments in the Health Plan capitation rate*

(•) Yes ( ) No

☐ Other Service Delivery System

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☑ Fee for Service

☑ Individual Rates Per Service

☑ Fee for Service Rates based on

☐ Severity of each individual's chronic conditions

☐ Capabilities of the team of health care professionals, designated provider, or health team

☑ Other

Describe below

☐ Per Member, Per Month Rates

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

There are no variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided.

☐ PCCM (description included in Service Delivery section)

☑ Risk Based Managed Care (description included in Service Delivery section)

☑ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

*

☐ Tiered Rates based on

Provide a comprehensive description of the policies the state will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Effective July 1, 2013, the Rhode Island State Medicaid Plan paid $87.52 for all OTP HH enrollees, except for Rite Care members which were reimbursed at a rate of $52.52. The varying rates were due to the fact that methadone was only an In-Plan benefit in Rite Care. The OTP HH rate for Rite Care members was reduced to account for this. The methodology to develop costs for the Health Home service is based on the cost to employ key health professionals (salary and fringe benefits) who will provide the Health Home services. The staffing enhancements are based on a model of 4.55 FTEs for every 125

OTP patients served. The Health Home payment is a weekly, bundled rate per patient. The OTP provider initiates a claim for the weekly rate, using a new procedure code for Health Home services. The provider may make a weekly claim using the Health Home code for a patient who receives an average of one encounter per week in one month. Encounters will be recorded in fifteen minute increments and providers will be required to submit monthly encounter data to BHDDH.

Effective July 1, 2016, OTP HH services and the related methadone treatment costs will be an In-Plan benefit for all product lines and the OTP HH weekly rate will be $53.50. This rate does not include the cost of methadone treatment and is based on the utilization of OTP HH services across all lines of business.

Effective July 1, 2106, any OTP HH provider which is certified as a COE will be able to bill for two new procedure codes; a one-time procedure code for induction activities at the time of initial enrollment/assessment and thereafter, a procedure code for COE services to be billed weekly until date of discharge to community, but no longer than six months. The rates are as follows:

- Level 1 COE: $600.00 One-Time Induction; $125.00 Weekly COE services
- Level 2 COE: $400.00 One-Time Induction; $125.00 Weekly COE services

The Induction payment reimburses for the initial assessment process (complete biopsychosocial assessments, physical examination, observed medication induction, and initial individualized treatment planning). The weekly bundled rate accounts for all COE services (continued individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis). COE rates do not include the cost of the medications. Providers will need to bill for medications separately.

Agency Rates

○ FFS Rates included in plan ◉ Comprehensive methodology included in plan ○ The agency rates are set as of the following date and are effective for services provided on or after that date

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. **In the SPA please provide the cost data and assumptions that were used to develop each of the rates**
2. **Please identify the reimbursable unit(s) of service**
3. **Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit**

4. **Please describe the state's standards and process required for service documentation, and**
5. **Please describe in the SPA the procedures for reviewing and rebasing the rates, including**
    1. **the frequency with which the state will review the rates, and**
    2. **the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.**

Providers may bill weekly, bi-weekly, or monthly as long as there is an accompanying level of care coordination activity that is no less than 30 minutes per billing period. Encounters will be recorded in fifteen minute increments and providers will be required to submit monthly encounter data to BHDDH. As previously mentioned, the OTP HH requires at east 30 minutes of HH activity per month. This activity can be face-to-face care management, telephonic contact with the client or collateral contacts, or face-to-face meetings with collateral providers. The State requires documentation using one of two codes; face-to-face care management or indirect and collateral contact.

Effective July 1, 2013, the Rhode Island State Medicaid Plan paid $87.52 for all OTP HH enrollees, except for Rite Care members which were reimbursed at a rate of $52.52. The varying rates were due to the fact that methadone was only an In-Plan benefit in Rite Care. The OTP HH rate for Rite Care members was reduced to account for this. The methodology to develop costs for the Health Home service is based on the cost to employ key health professionals (salary and fringe benefits) who will provide the Health Home services, according to the following assumptions:

Medical Director .25 FTE $94,640

HH Coordinator 1 FTE $81,120

Registered Nurse 1 FTE $81,120

Case Manager 2 FTE $108,160

Pharmacist .1 FTE $18,928

Administrative Level Coordinator (shared position across HH sites) .1 FTE $10,816

Staff Training (shared half time position across HH sites) .05 FTE $5,408

Technology/IT (shared half time position across HH sites) .05 FTE $8,112

Effective July 1, 2016, OTP HH services and the related methadone treatment costs will be an In-Plan benefit for all product lines and the weekly rate for OTP HH will be $53.50. This rate does not include the cost of medication and is based on the utilization of OTP HH services from 2013-2015 across all lines of business.

The State reviewed demographic and encounter data submitted by the providers along with the staffing patterns among providers to ensure that the current model was being applied. The State also reviewed expenditures from onset of the program in SFY 2014 to SFY 2016 year-to-date under the existing rate structure to develop a blended rate for FFS and Managed Care. The historical data was also trended for utilization and MCO enrollment going forward as more members enroll in managed care and fewer members remain out of plan. Based on this analysis, EOHHS has rebased the rate to reflect past expenditures and anticipates minimal impact on provider stability, quality and financial security.

Effective July 1, 2106, any OTP HH provider which is certified as a COE will be able to bill for two new procedure codes; a one-time procedure code for induction activities at the time of initial enrollment/assessment and thereafter, a procedure code for COE services to be billed weekly until date of discharge to community, but no longer than six months. The rates are as follows:

- Level 1 COE: $600.00 One-Time Induction; $125.00 Weekly COE services
- Level 2 COE: $400.00 One-Time Induction; $125.00 Weekly COE services

The Induction payment reimburses for the initial assessment process (complete biopsychosocial assessments, physical examination, observed medication induction, and initial individualized treatment planning). Level 1 providers receive an enhanced rate for induction to support the requirement of having physician availability seven (7) days per week and to incent OTP HHs to develop the capacity to admit patients within 24 hours of referral. The weekly bundled rate accounts for all COE services (continued individualized treatment planning; individual and group counseling; randomized toxicology; coordination of care with other treatment providers; referral for services not provided at the COE or to higher levels of care; case management to address other support service needs; wellness promotion activities; continued provision of outpatient clinical and recovery support services to individuals successfully transferred to the community; consultation and support to community buprenorphine physicians; discharge planning; readmission and re-stabilization of individuals who have relapsed or are experiencing crisis). COE rates do not include the cost of the medications. Providers will need to bill for medications separately.

On a go-forward basis, EOHHS will review the encounter data for OTP HH and COE services in conjunction with MCO monitoring and BHDDH oversight as the substance abuse authority. EOHHS and BHDDH will also collect program cost data and rebase the rate for the SFY 2019 and annually thereafter.

Assurances

☑ The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved*

There are no 1915(c) waivers in RI - everything is under 1115 demonstration waiver authority.

EOHHS and BHDDH will identify clients who receive targeted care management through Ryan White funding and also receiving OTP Health Home services and coordinate on a case-by-case basis to eliminate duplication of services.

EOHHS has included contract language in the OTP provider responsibilities section that OTP HHs are to coordinate with the Integrated Health Home and Assertive Community Treatment program to avoid duplication of services. Members can only be enrolled in one specialized program at a time and cannot be simultaneously enrolled in ACT, OTP HH and OTP Health Home.

☑ The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

Rhode Island will annually assess cost savings using a pre/post-period comparison. The assessment will include total Medicaid savings for the intervention group. The data source will be Medicaid claims and the measure will be PMPM Medicaid expenditures. RI has current Medicaid data on all clients who received OTP HH services. RI also distributed a survey to OTP patients which included questions that assess their use of primary care physicians, specialty care, and Emergency rooms. This survey will be distributed again for a pre/post evaluation.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum

(including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)*

BHDDH will actively work with Health Home providers, and specifically with the HIT coordinator, to increase use of the State's HIE - CurrentCare. BHDDH will capitalize on the progress made by our CMHO Health Homes in connecting to the HIE with provisions for compliance with 42 CFR Part II. Participation in the HIE means that programs will have ready access to health care information from other sources such as PCPs, hospitals, pharmacies and labs. While OTPs are required to access information through the State's Prescription Monitoring Program, not all prescription information is contained there (only certain schedules). Participation also means that OTPs can share information (with client consent) so that other providers are aware of a client's participation in an OTP along with other relevant treatment information.

Information from MCOs and Medicaid will be provided to OTPs in routine reporting. MCOs will provide quarterly utilization reports along with next day notification of hospitalization. This will help OTPs effectively transition their patients and provide seamless care.

BHDDH will coordinate efforts with OTPs and the Department of Health's Chronic Disease Self Management program. Clients can be referred to these programs through email and tracked for follow through by DOH, with a report back to the referring provider.

BHDDH will use the RIBHOLD system to provide outcome/trend data to providers and prevent dual enrollment with other Health Homes.

OTPs will be supported in transforming into Health Homes through participation in statewide learning activities, monitoring and technical assistance. Physicians will have the opportunity to participate in DOH's Grand Rounds.

BHDDH will provide links to Health Home information on its website as a means of communication with providers and others.

OTPs will work with the HIT coordinator to develop systems for effective communication with patients such as texting, use of social media, twitter, and email alerts.

Quality Measurement and Evaluation

☑ The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state

☑ The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals

☑ The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS

☑ The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

OTP Health Home Opt-out Form

Attestation Statement

For use by OTP Health Home eligible Medicaid client

□ I have met with the case manager for _____
Name of OTP Health Home

who has explained the program to me and the case management services I can receive. I have decided not to join/discontinue my enrollment at this time.

For use by case manager
□ I have discussed _____
Name of OTP Health Home

program with _____. The benefits of membership
Name of Medicaid Member

were explained; however the Medicaid client has decided not to join/un-enroll at this time.

Reason for Opting Out

Signatures

I understand that I will not get a case manager or Health Home services, but I will still continue to get my substance abuse treatment services.

I also understand that should I decide at a later date that I would like to receive Health Home services, I <u>will not</u> be eligible to receive services for 12 months beginning on the date documented below.

_____ _____ _____
Name of Member or Client's Legal Representative (print) Original Signature Date

_____ _____ _____
Name of OTP Health Home Case Manger (print) Original Signature Date

OTP Health Home Flow Chart

Patient Background:

- 49 y/o Hispanic Female
- Opioid Dependence
- Suicidal ideation/major depressive disorder
- Hep C +
- Dental Problems
- No Primary Care Physician
- Presented to ED w/ suicidal ideation & Opioid WD