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State/Territory Name: Rhode Island

State Plan Amendment (SPA) #:16-006

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

December 9, 2016

Elizabeth Roberts, Secretary
Executive Office of Health and Human Services
State of Rhode Island and Providence Plantations
57 Howard Avenue, LP Building
Cranston, RI 02920

Dear Secretary Roberts:

We are pleased to inform you of the approval of Rhode Island State Plan Amendment (SPA) No. 16-006, submitted September 29, 2016. Effective July 1, 2016, this SPA grants authority to move Opioid treatment health home services in–network for the Medicaid Managed Care Organizations. It authorizes an increase to reimbursement rates for RItecare members and a decrease to the rates for non-RIteCare members along with creating Centers of Excellence.

Please note that the automated informal notification available in MacPro incorrectly states that enhanced match is available for this SPA. Enhanced match is NOT available for this SPA and the system will be corrected to reflect that in the future.

If you have any questions regarding this matter you may contact Lynn DelVecchio (617) 565-1201 or by e-mail at Lynn.DelVecchio@cms.hhs.gov

Sincerely,

Richard R. McGreal
Associate Regional Administrator

Cc: Darren J. McDonald, Ph.D., Interim Medicaid Director
Melody Lawrence, Interdepartmental Project Manager

MD-S-30-RI

Records / Submission Packages

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Submission - Summary

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

Package ID RI2016MH0004O

Submission Type Official - Review 1

Approval Date 12/9/2016

Superseded SPA ID N/A

SPA ID RI-16-006

Initial Submission Date 9/29/2016

Effective Date N/A

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State Information

+/-

State/Territory Name Rhode Island

Medicaid Agency Name Executive Office of Health and Human Services

Submission Component

+/-

(•) State Plan Amendment

(•) Medicaid
( ) CHIP

Submission Type

+/-

(•) Official Submission Package
( ) Draft Submission Package

Allow this official package to be viewable by other states?

( ) Yes
(•) No

Key Contacts

+/-

Name	Title	Phone Number	Email Address
McDonald, Darren	Deputy Medicaid Director	(401)462-1965	darren.mcdonald@ohhs.ri.gov
Lawrence, Melody	Health Services Manager	(401)462-6348	melody.lawrence@ohhs.ri.gov

SPA ID and Effective Date

TN: RI 16-006 supersedes
TN: RI 13-011

Approved: 12/9/2016

Effective: 7/1/2016

+/-

SPA ID RI-16-006

Reviewable Unit	Proposed Effective Date
Health Homes Intro	7/1/2016
Health Homes Population and Enrollment Criteria	7/1/2016
Health Homes Geographic Limitations	7/1/2016
Health Homes Services	7/1/2016
Health Homes Providers	7/1/2016
Health Homes Service Delivery Systems	7/1/2016
Health Homes Payment Methodologies	7/1/2016
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2016

Executive Summary

+/-

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 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

COE staffing model includes the use of peer support specialists. CMS is currently reviewing RI's Category 2 waiver request for Peer Support Specialists, change number 15-07-CII.

Disaster-Related Submission

+/-

This submission is related to a disaster

- ○ Yes
- ◉ No

Federal Budget Impact and Statute/Regulation Citation

+/-

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2016	$248,125.00
Second	2017	$992,500.00

Federal Statute / Regulation Citation

Section 1945 SSA

Governor's Office Review

+/-

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe This amendment has not been reviewed specifically with the Governor's Office. Under the Rhode Island Medicaid State Plan, the Governor has elected not to review the details of state plan materials. However, in accordance with Rhode Island law and practice, the Governor is kept apprised of major changes in the state plan.

Authorized Submitter

+/-

The following information will be provided by the system once the package is submitted to CMS.

Name of Authorized Submitter Adrienne Delozier

Title None

Phone number 4435271718

Email address adrienne.delozier@cms.hhs.gov

Authorized Submitter's Signature Adrienne Delozier

☑ I hereby certify that I am authorized to submit this package on behalf of the Medicaid Agency.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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RI - Submission Package - RI2016MH0004O - (RI-16-006) Follow

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Submission - Medicaid State Plan

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

Package ID	RI2016MH0004O	**SPA ID**	RI-16-006
Submission Type	Official - Review 1	**Initial Submission Date**	9/29/2016
Approval Date	12/9/2016	**Effective Date**	N/A
Superseded SPA ID	N/A		

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Submission - Medicaid State Plan

The submission includes the following

☑ Benefits

☑ Health Homes Program

◉ Create new Health Homes program
○ Amend existing Health Homes program
○ Terminate existing Health Homes program

◉ Copy from existing Health Homes program
○ Create new program from blank form

Name of Health Homes Program RI Opioid Treatment Program Health Home Services

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Submission - Public Comment

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

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Name of Health Homes Program RI Opioid Treatment Program Health Home Services

Indicate whether public comment was solicited with respect to this submission.

- ○ Public notice was not required and comment was not solicited
- ○ Public notice was not required, but comment was solicited
- ◉ Public notice was required and comment was solicited

Indicate how the public notice was issued and public comment was solicited

☐ Newspaper Announcement

☐ Publication in state's administrative record, in accordance with the administrative procedures requirements

☑ Email to Electronic Mailing List or Similar Mechanism

Date of Email or other electronic notification Jun 29, 2016

Description of mailing list, in particular parties and organizations included, and, if not email, description of similar mechanism used Public notice is electronically emailed to EOHHS' list of interested parties. Such mailing list includes, but is not limited to providers, advocates, and other state agencies.

☑ Website Notice

Select the type of website

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting Jun 29, 2016

Website URL http://www.eohhs.ri.gov/ReferenceCenter/StatePlanAmendmentsand1115WaiverChanges.aspx

☐ Website for State Regulations

☐ Other

☑ Public Hearing or Meeting

Date of meeting	Time of meeting	Location of meeting
8/19/2016	10:00 AM	Arnold Conference Center, Eleanor Slater Hospital John O. Pastore Complex, 111 Howard Avenue Cranston, RI 02920

☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	Type
Interested parties OTP HH	9/17/2016 9:18 PM EDT	
Notice to Public	9/17/2016 9:19 PM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	Type
No items available		

Indicate the key issues raised during the public comment period (optional)

☐ Access

☐ Quality

☐ Cost

☐ Payment methodology

☐ Eligibility

☐ Benefits

☐ Service delivery

☐ Other issue

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Submission - Tribal Input

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Name of Health Homes Program RI Opioid Treatment Program Health Home Services

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state
- (●) Yes
- ( ) No

This state plan is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations
- (●) Yes
- ( ) No

☑ The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any tribal consultation conducted with respect to this submission

Tribal consultation was conducted in the following manner

☑ Indian Health Programs

Name of Program	Date of consultation	Method/Location of consultation
Narragansett Indian Health Center	6/29/2016	Email and letter via US Postal Service

☐ Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation

☐ Indian Tribes

The state must upload copies of documents that support the solicitaion of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizaions, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	Type
TN OTP HH 6.29.16	9/17/2016 9:25 PM EDT	PDF

Name	Date Created	Type

Indicate the key issues raised (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Submission - SAMHSA Consultation

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

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Superseded SPA ID	N/A		

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Name of Health Homes Program RI Opioid Treatment Program Health Home Services

☑ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
10/18/2012

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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Health Homes Intro

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

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Approval Date	12/9/2016	**Effective Date**	7/1/2016
Superseded SPA ID	N/A		

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Program Authority

+/-

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program RI Opioid Treatment Program Health Home Services

Executive Summary

+/-

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 Home proposal seeks to provide patients with resources to navigate an often fragmented service delivery system. The target population for this proposal is opioid dependent Medicaid recipients who are currently receiving or who meet criteria for Medication Assisted Treatment. 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 will enable providers to use existing and enhanced resources to improve the health of patients and decrease inadequate/ineffective medical care. Provision of this service will positively impact 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 would be assigned to a team which may be specialized to their specific healthcare needs. Patients would 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. This 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.

General Assurances

+/-

☑ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.

☑ The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

☑ The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.

☑ The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.

☑ The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.

☑ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Records / Submission Packages

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Health Homes Population and Enrollment Criteria

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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. Providers are required to have clients sign an enrollment form. The provider keeps the enrollment form in the client's medical record. Every 6 months, providers attest to the fact that an enrollment form was signed for all clients enrolled in the program.
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.

- [x] The state provides assurance that it will clearly communicate the individual's right to opt out of the Health Homes benefit or to change Health Homes providers at any time and agrees to submit to CMS a copy of any letter or communication used to inform the individuals of the Health Homes benefit and their rights to choose or change Health Homes providers or to elect not to receive the benefit

Name	Date Created	Type
Health Home Opt-out Form - Final	9/17/2016 9:46 PM EDT	DOC

RI - Submission Package - RI2016MH0004O - (RI-16-006) Follow

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Health Homes Geographic Limitations

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

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- (●) 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

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Health Homes Services

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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. Per BHDDH licensing regulations, the bio-psychosocial assessment must be completed at intake, reviewed annually, and updated in entirety every five (5) years. 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

Description

Qualified Behavioral Health Specialists will conduct initial bio-psychosocial assessments and work with patients and other team members to develop care plans. Behavioral Health professional shall have the following qualifications: be a Licensed Independent Practioner; Licensed Chemical Dependency Supervisor; Licensed Chemical Dependency Professional, or Certified Co-Occurring Disorder Professionals-Diplomate, or Certified Co-Occurring Disorder Professional who has completed a Clinical supervision course approved by the Department or be a Clinician with a relevant Master's degree and licensed, at least 2 full years or a Registered Nurse with ANCC certification as a Psychiatric and Mental Health Nurse with 2 years' experience. Each professionally licensed staff shall have a current license to practice.

Within the organization no less than 50% of the staff will hold a RI license in behavioral health clinical specialty with certification in chemical dependency from a nationally recognized entity or shall be licensed chemical dependency specialists, or certified co-occurring disorder professionals or Diplomate, the remaining 50% will be actively engaged in the process of meeting the requirements.

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. Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☑ Nurses

Description

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.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

☐ Medical Specialists

☑ Physicians

Description

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.

☐ Physician's Assistants

☑ Pharmacists

Description

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.

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

- [ ] Nutritionists
- [ ] Other (specify)

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

- [x] Behavioral Health Professionals or Specialists

Description

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.

Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners

- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Peer Recovery Coaches	Peer Recovery Coaches will be available to participants to support clients in accessing community-based resources, recovery, health and wellness support, and employment plans. A prospective Peer Recovery Specialist must meet the following criteria: a. Credentialed, or be in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at http://www.ricertboard.org/. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC). b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS. c. Individuals who have undergone periods of homelessness may also apply for this credential.

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:

- Promoting individual's health and ensuring that all personal health goals are included in person centered care plans;
- Promotion of mental health treatment, smoking prevention and cessation, nutritional counseling, obesity reduction, and increased physical activity;
- Providing health education to individuals and family members (where appropriate) about chronic conditions;
- Providing prevention education to individuals and family members (where appropriate) about health screening and immunizations;
- Providing self-management support and development of self-management plans and/or relapse prevention plans so that individuals can attain personal health goals; and
- Promoting self-direction and skill development in the area of independent administering of medication.
- 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

- [x] Behavioral Health Professionals or Specialists

Description

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. Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses

Description

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.
Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

- [ ] Medical Specialists
- [x] Physicians

Description

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

- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Peer Recovery Coaches	Peer Recovery Coaches will provide the following: serve as a role model for the integration of recovery, health and wellness, and employment; provide education to individuals regarding services and benefits available to assist in transitioning into and staying in the workforce; navigating state and local systems (including addiction and mental health treatment systems); mentoring individuals as they develop strong foundations in recovery and wellness; and promoting empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences. A prospective Peer Recovery Specialist must meet the following criteria: a. Credentialed, or in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at http://www.ricertboard.org/. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC). b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS. c. Individuals who have undergone periods of homelessness may also apply for this credential.

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. OTP HH Program manual defines the care transition protocols that OTP HHs must implement. 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

- [x] Behavioral Health Professionals or Specialists

Description

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.
Case managers in OTPs and COEs must meet the state's behavioral

healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

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.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses

Description

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.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

- [ ] Medical Specialists
- [x] Physicians

Description

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.

- [ ] Physician's Assistants
- [x] Pharmacists

Description

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.

- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [ ] Other (specify)

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

- [x] Behavioral Health Professionals or Specialists

Description

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. Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [x] Nurses

Description

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

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

- [ ] Medical Specialists
- [x] Physicians

Description

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

- [ ] Physician's Assistants
- [x] Pharmacists

Description

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

- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Peer Recovery Coaches	Peer Recovery Coaches will promote empowerment and a sense of hope through self-advocacy by sharing personal recovery experiences and provide education to individuals regarding services and benefits available to assist in transitioning into and staying in the workforce. Peer Recovery Coaches will also assist in navigating state and local systems (including addiction and mental health treatment systems. A prospective Peer Recovery Specialist must meet the following criteria: a. Credentialed, or in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at http://www.ricertboard.org/. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC&RC). b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS. c. Individuals who have undergone periods of homelessness may also apply for this credential.

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

Description

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.

Case managers in OTPs and COEs must meet the state's behavioral healthcare regulations whereby agencies develop staff qualifications and provide the training to allow them to meet the job duties required of them. Trainings include but are not limited to, cultural competency, trauma-informed care, HIPAA and 42 CFR. For OTP and COE case managers this means that they must be able to provide OTPs and COE services but do not have to acquire specific qualifications or certifications.

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☑ Nurses

Description

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.

Qualifications: Registered nurse with ANCC certification as a Psychiatric and Mental Health Nurse or, at least, two (2) years full time experience providing relevant behavioral health services.

☐ Medical Specialists

☑ Physicians

Description

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.

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Peer Recovery Coaches	Peer Recovery Coaches will provide education to individuals regarding services and benefits available to assist in transitioning into and staying in the workforce and will support individuals in accessing community based resources, recovery, health and wellness support, and employment services. A prospective Peer Recovery Specialist must meet the following criteria: a. Credentialed, or in the process of being credentialed, by the Rhode Island Certification Board (RICB) as a Peer Recovery Specialist, pursuant to the standards available at http://www.ricertboard.org/. RICB credentialing standards meet minimum standards of the International Certification and Reciprocity Consortium (IC and RC). b. Acknowledges a mental illness, addiction, chronic illness, or intellectual/developmental disability (I/DD), and has received or is currently receiving treatment and/or community support for it. People who have lived experience with a family member or loved one with one of these experiences are also qualified to be a PRS. c. Individuals who have undergone periods of homelessness may also apply for this credential.

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.

Name	Date Created	Type
OTP HH Flow Chart	9/17/2016 9:56 PM EDT	PDF

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Health Homes Providers

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

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Approval Date 12/9/2016

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Initial Submission Date 9/29/2016

Effective Date 7/1/2016

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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

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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 will be required to maintain a specific staffing pattern dedicated solely to the implementation of the six service domains identified by CMS. Staffing will be based on a ratio of a 125 patients per team. Teams will be 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 will be 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 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 will be 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 will oversee the implementation of Health Home services at all agencies and act as the liaison to the State agencies supporting Health Homes. This Coordinator will participate in team meetings and work with staff to achieve fidelity to this proposed model. The coordinator will strategize 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. This will be one of the first tasks of the HIT Coordinator. The HIT coordinator will work effectively with RI's Health Information Exchange – Current Care – to capitalize on the work that has already been done to include behavioral healthcare information compliant with all confidentiality requirements. The HIT coordinator will work effectively with the State Medicaid office and MCOs to establish linkages for the sharing of outcome data. In addition, the HIT coordinator and Administrative Level coordinator will continue work begun by BHDDH and SAMHSA to incorporate a pilot of the ASAM electronic assessment tool as a standardized assessment in the EHR.
Finally, the State intends to create a 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. Having a centralized training coordinator not only makes practical sense, but also promotes consistency. This person will ensure 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

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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

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The state's requirements and expectations for Health Homes providers are as follows

OTP HHs must submit signed agreements to BHDDH attesting that the provider agrees to adhere to the requirements set forth in the OTP HH Certification Agreement. Such agreement describes the OTP HH's care coordination responsibilities, staffing requirements, reporting requirements, and activities related to collaboration with other healthcare providers.

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

Name	Date Created	Type
No items available		

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RI - Submission Package - RI2016MH0004O - (RI-16-006) Follow

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Health Homes Service Delivery Systems

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

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Initial Submission Date 9/29/2016

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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

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.
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 provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.

Name	Date Created	Type
No items available		

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

◉ Yes
○ No

Assurances

☑ The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:

- Any program changes based on the inclusion of Health Homes services in the health plan benefits
- Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)
- Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)
- Any risk adjustments made by plan that may be different than overall risk adjustments
- How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM

☑ The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services

☑ The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found

☐ Other Service Delivery System

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Health Homes Payment Methodologies

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

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Payment Methodology

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

- [ ] Fee for Service
- [ ] PCCM (description included in Service Delivery section)
- [x] Risk Based Managed Care (description included in Service Delivery section)
- [x] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

- [x] Tiered Rates based on
  - [ ] Severity of each individual's chronic conditions
  - [x] Capabilities of the team of health care professionals, designated provider, or health team
  - [ ] Other

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

There is no variation in payment for OTP HH. 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. Level 1 providers will receive a payment of $600 and Level 2 providers will receive a payment of $400 for induction.

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.

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, 2016, 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.

Assurances

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☑ 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 (IHH) and Assertive Community Treatment (ACT) 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, IHH 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).

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Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID - Health Homes - RI Opioid Treatment Program Health Home Services - RI - 2016

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

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Initial Submission Date 9/29/2016

Effective Date 7/1/2016

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Monitoring

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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 expenditures 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

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☑ 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

Go to HHQM Reports