COLLABORATIVE MODELS FOR MEDICATION-ASSISTED TREATMENT
Key Elements of Rhode Island Opioid Treatment Programs Health Home Model

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Articulated Goals

The Rhode Island Opioid Treatment Program (OTP) Health Home model began in 2013 as a Medicaid health home state plan amendment (SPA) authorized under Section 1945 of the Social Security Act that was created by Section 2703 of the Patient Protection and Affordable Care Act. The OTP Health Homes provide resources to opioid-dependent Medicaid recipients who currently are receiving or who meet the criteria for medication-assisted treatment (MAT) and are at risk of developing another chronic condition. The state undertook extensive planning efforts to design and develop the statewide OTP Health Home demonstration program including extensive clinical staff and program-level training, training for state Medicaid and Single State Agency staff, state-wide educational activities, team building, collaborative arrangements with key health care delivery system partners using memoranda of understanding, qualified services agreements, and financing. In 2016, Rhode Island received approval from the Centers for Medicare & Medicaid Services (CMS) to move its OTP Health Homes in-network for Medicaid managed care organizations (MCOs). By incorporating OTP Health Homes into a managed care environment, OTP providers received additional support for reporting and additional assistance in identifying eligible members in need of OTP Health Home services.

In 2013, during the inception of the OTP Health Homes, a leadership group was formed with its own personnel (partially funded by the State of Rhode Island). The leadership group is responsible for administrative coordination, auditing, data collection for quality metrics and submission of data to the state, and continuous training for all participating OTPs.

In 2016, Rhode Island received approval from CMS to create augmented services offered through the OTP Health Home by creating Centers of Excellence (COEs). COEs can be, but are not exclusively, OTP Health Home providers that the state has certified as demonstrating enhanced clinical and programmatic capacity consistent with the COE certification standards described in the Delivery System and Staffing section. The COE model is intended to expand and enhance the statewide capacity for providing MAT and improve quality of care and patient satisfaction. COEs provide assessments and treatment for opioid dependence, offer expedited access to care, and serve as a resource to community-based providers, including on-site training for physicians and other professionals in need of training.

The central goal of the Rhode Island COE model is to provide intensive services to individuals needing to stabilize on medication and begin the recovery process. Once stable, patients are referred to community-based providers but still have the opportunity to maintain connections to clinical or recovery support services offered by the COE.

The following are some additional goals of the COE:

- Expand the role of OTPs to include buprenorphine and other medications for opioid-dependent patients
- Increase the number of admissions to MAT
- Increase the number of clients receiving integrated care and treatment
- Decrease use of illicit opioids and prescription opioids used in a nonprescribed manner

- Provide care coordination for patients receiving MAT and referrals or linkages to primary care, community-based waivered physicians, mental health services, housing, and other recovery supports[1]
- Provide cost savings by reducing use of emergency departments and hospital admissions

Delivery System

Rhode Island operates much of its Medicaid program under a Section 1115 demonstration project through which many beneficiaries receiving primary and acute care services are required to enroll in MCOs, including fully capitated MCOs. The state currently is implementing its system transformation plan in which MCOs subcontract with accountable entities that are integrated provider organizations that are responsible for the total cost of care and health care quality and outcomes for an attributed population.

Medicaid Authority

The Rhode Island OTP Health Home program operates as a Medicaid Health Home SPA. Rhode Island received its first Medicaid Health Home SPA approval for the OTP Health Home initiative in 2013. The state later submitted a second Medicaid Health Home SPA to move the OTP Health Home model into managed care and establish COEs. The second Rhode Island Medicaid Health Home SPA was approved by CMS in 2016.

Clinical Model

Patients in OTPs are assigned to a nurse and care manager who—

- Conduct a clinical assessment
- Develop a treatment plan to meet patient needs for substance use disorder (SUD) treatment, mental health, and health care services
- Collaborate with a pharmacist and physician to support induction, administration, and monitoring of medications
- Provide referrals to appropriate levels of care outside of the OTP (if needed)
- Facilitate transitions between levels of care (as needed)
- Monitor patient treatment progress on a continuing basis for all SUD services provided by the OTP
- Assist patients in becoming engaged with a primary care physician to receive treatment for health conditions on an ongoing basis

Health Home participants receiving MAT and COE patients are identified via (1) provider or community partner referrals, such as the judicial system or emergency departments, and (2) outreach to prior patients who were discharged because of no contact. All eligible patients currently receiving services from OTPs automatically are enrolled into the OTP Health Home/COE model and are provided with a letter explaining the model and how to voluntarily opt out. Patients are offered the opportunity to meet with OTP Health Home/COE representatives to discuss their options.

[1] *Waivered physician* refers to a physician who has received a waiver from the Substance Abuse and Mental Health Services Administration to prescribe buprenorphine for opioid dependence treatment in accordance with the Drug Addiction Treatment Act of 2000 (https://www.samhsa.gov/medication-assisted-treatment/training-materials-resources/buprenorphine-waiver).

Opportunities for opting out are provided initially and annually. OTP Health Home/COE providers are required to have their clients sign an enrollment form and keep 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 participants.

Required Infrastructure

OTP Health Homes

All OTP Health Home providers are OTPs licensed by the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) as Behavioral Healthcare Organizations (BHOs). Licensed status indicates that all programs are required to abide by the rules and regulations for BHOs. All OTP Health Home providers are accredited by independent accrediting bodies such as the Commission on Accreditation of Rehabilitation Facilities International, The Joint Commission, the Council on Accreditation, and the National Commission on Correctional Health and certified by the Substance Abuse and Mental Health Services Administration as OTPs. As designated providers under the Medicaid Health Home SPA, all OTP Health Homes provide the following six required Health Home services: (1) comprehensive care management; (2) care coordination; (3) health promotion; (4) transitional care from inpatient to other settings, including follow up; (5) patient and family support; (6) referral to community and support services, if relevant; and the use of health information technology to link services, as feasible and appropriate.

Centers of Excellence (COEs)

COEs are an enhanced version of the OTP Health Home provider type that demonstrate additional clinical and administrative capacity and are eligible to receive additional state payments. If an OTP Health Home provider would like to be authorized to receive reimbursement for COE services, the OTP Health Home provider must submit an application to the state. The state assesses each application according to the COE certification standards.

Within a 6-month period of stabilization on medication and in a treatment regimen, patients are transitioned to Drug Abuse Treatment Act (DATA)-waivered physicians in the community for continuing care, including medication management, with ongoing clinical and recovery support services provided by the COE as appropriate. The COE certification standards include requirements for providing technical assistance and training to community-based DATA-waivered physicians with the goal of expanding MAT into mainstream primary care settings, as well as expedited referrals to SUD treatment and access to ongoing treatment, recovery, and supports for primary care providers and their patients.

COEs are certified at two levels to ensure timely access to MAT services:

- Level 1 COEs have the ability to admit all individuals within 24 hours of referral.
- Level 2 COEs have the ability to admit all patients within 48 hours Saturday through Thursday and within 72 hours for referrals made on Friday.

Level 1 COEs receive an enhanced rate for induction to support the requirement of having physician availability 7 days per week.

Staffing

OTP Health Home staffing is based on a ratio of 125 patients per team. Teams are organized by primary comorbid condition if numbers allow (i.e., a hepatitis C-specific Health Home team; a chronic obstructive

pulmonary disease-focused Health Home team). Otherwise, patients are organized on teams with many comorbid conditions or risk factors present.

Within the OTP Health Home framework, three collaborative positions are shared across all participating programs to ensure consistency in implementation at each site and fidelity to the Health Home model:

- Administrative Coordinator—100 percent
- Health Information Technology Coordinator—50 percent
- Training Coordinator—50 percent

The COE staffing requirements, as described in the COE Certification Standards, include DATA-waivered physicians, nurses (registered nurse or licensed practical nurse), 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. Staffing per COE team is as follows:

- Waivered physician
- Nurses (registered and/or licensed practical nurses)
- Master's-level clinician (ratio no greater than 1:100)
- A proposed combination of licensed chemical dependency professionals, case managers, and/or peer recovery coaches. Applicants must discuss staffing in the proposal and address relevancy to anticipated population as well as staff to patient ratios.
- COEs that are licensed OTPs also must include a pharmacist

Special Features

Rhode Island developed many protocols and guidelines to be used by participating programs in order to standardize procedures, practices, and collaboration. The following are some examples:

- Acuity Level Protocol that divides patients into three risk levels that identify (1) patient needs based on relative levels of use, risky behaviors, risk of developing another chronic condition, and support systems with appropriate prevention services for low-risk individuals, and (2) treatment needs (e.g., treatment referrals to prevent further progression of disease process for high-risk patients) and activities such as individual coaching, case management, family support services, care coordination, and monitoring
- Training on using a computerized American Society of Addiction Medicine assessment tool that provides standardized outcome measures
- Development of collaborative relationships, memoranda of understanding, and qualified service agreements with Medicaid MCOs, community mental health providers, recovery services, and private practitioners
- Reporting system established to identify Health Home outcomes, payment, and individual patient tracking—initially established in a state agency database and later moved to an OTP Health Home database maintained by the OTP Health Home Leadership Group
- Use of credentialed peer recovery coaches to provide individuals with educational and transitional support as they transition into the community, the workforce, and navigate state and local systems

Financing

The OTP Health Home payment is a weekly, bundled rate per patient of $53.50/week based on the utilization of OTP Health Home services. The OTP provider uses a new procedure code developed by the state specifically for OTP Health Home services to initiate a claim for the weekly rate. The provider may

make a weekly claim using the OTP Health Home code for a patient who receives an average of one encounter per week in 1 month. Encounters are recorded in 15-minute increments, and providers are required to submit monthly encounter data to BHDDH. The state reviewed expenditures from the onset of the OTP Health Home program in state fiscal year (SFY) 2014 to SFY 2016 under its existing rate structure to develop a blended rate for fee-for-service and managed care. The historical data also were trended for utilization and MCO enrollment going forward because the expectation is that more members will enroll in managed care and fewer members will remain out of plan. The Rhode Island Executive Office of Health and Human Services (EOHHS) is reviewing the encounter data for OTP Health Home and COE services in conjunction with MCO monitoring and BHDDH oversight as the substance abuse authority. EOHHS and BHDDH also will collect program cost data and rebase the rate for the SFY 2019 and annually thereafter.

OTP Health Home services initially were available to eligible Medicaid members through fee for service. In 2016, OTP Health Home services were brought into managed care in order to foster improved coordination of care, to increase efforts in identifying individuals who would benefit from this service, and to foster collaboration between providers and the MCOs. The rate accounts for only OTP Health Home services; it does not include the cost of medications and is based on past utilization of OTP Health Home services across all lines of business.

As of July 1, 2016, any OTP Health Home provider that is certified as a COE is able to bill for two new procedure codes in lieu of the two weekly payments described above (the weekly OTP Health Home services rate and the weekly methadone treatment rate). The additional COE-specific codes include a one-time procedure code for induction activities at the time of initial enrollment/assessment/medication induction and a procedure code for COE services to be billed weekly until date of discharge to the community, but no longer than 6 months. COE bundled rates do not include the cost of medications, which must be billed for separately.

The COE 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

Achievements

There are now four COEs with 14 sites that have achieved an enrollment of approximately 547 patients. In addition to the COEs, there are five OTP Health Home providers with 15 sites across Rhode Island that have achieved enrollment of about 6,240 individuals with a 10 percent patient opt-out rate. Overall, the OTP Health Homes see approximately 2,500 patients per month.

According to the Research, Data Evaluation, and Compliance Unit of the BHDDH, as of June 2018 outcome data estimates for OTP Health Homes and COEs are as follows:

- Emergency department visits per thousand: 97
- Hospitalizations per thousand: 46
- Percentage of unique inpatient stays that are readmitted within 30 days: 44