

**DRAFT REPORT**

# Rhode Island Substance Use Disorder Mid-Point Assessment

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## Introduction

As part of the Special Terms and Conditions (STCs) of its section 1115 demonstration, the State of Rhode Island (RI) is conducting an independent mid-point assessment to examine and evaluate the status of implementation milestones as it relates to the state's ongoing substance use disorder (SUD) programming. The RI Executive Office of Health & Human Services (EOHHS) has commissioned NORC at the University of Chicago (NORC) to conduct this independent assessment. As the assessor, NORC has worked closely with EOHHS to identify appropriate programs and key stakeholders for capturing implementation progress as well as gaps in performance measures as defined in the SUD Monitoring Protocol.

This mid-point assessment includes a review of information that will provide an understanding of the process and timeframe for programming, implementation efforts, factors that have affected achievement on the milestones to date, factors likely to affect future performance in meeting milestones, and a status update on budget neutrality requirements. The assessment seeks to better understand how particular opioid use disorder (OUD)/SUD initiatives, funding sources, and programming support the achievement of the milestones to date.

The RI Overdose Prevention and Intervention Task Force, an initiative set out to reduce the state's opioid overdose deaths, was instituted at the bequest of Governor Gina Raimondo in 2017. The Task Force is co-chaired by the Directors of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) and the Department of Health (RIDOH). Since its inception, the Task Force has created an Action Plan to address the state's overdose crisis that focuses on four key strategies: prevention, rescue, treatment, and recovery. This plan outlines public education and community outreach goals that are meant to address the stigma of addiction and reduce the number of lives lost to overdose. As part of these efforts, RI's SUD Medicaid section 1115 waiver became an integral component in increasing access to prevention, rescue, treatment, and recovery services for Rhode Islanders. The waiver allowed EOHHS and BHDDH to enhance and maintain Medicaid beneficiaries' access to behavioral health services in appropriate settings and ensure that individuals could receive care in the facility most appropriate to their needs.

Under assessment are the comprehensive array of treatment services overseen by BHDDH. These OUD/SUD services span the full continuum of care through licensed SUD providers, including outpatient services, intensive outpatient services, medication-assisted treatment (MAT), intensive levels of care in residential and inpatient settings, and medically supervised withdrawal management. BHDDH also oversees a wide range of other services and programming that focus on prevention, intervention, and recovery support. Programs/activities and funding streams which contribute to the milestones and targets in the approved BHDDH SUD implementation include:

## Programs/Activities

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- **Behavioral Health LINK (BH Link) Triage Center and Hotline.** BH Link is a behavioral health facility designed to provide immediate assistance to people in crisis by providing innovative crisis intervention services and connecting people to ongoing treatment and care.
- **Peer Recovery Support (PRS) Program.** The state continues to expand the PRS program. Peer Recovery Specialists are trained individuals who have lived experience with mental illness and/or addiction to alcohol and/or other drugs who can provide one-to-one strengths-based support to peers in recovery.
- **University of Rhode Island (URI)'s RHODE to Health Mobile Health Unit.** With funds from EOHHS and State Opioid Response (SOR) grant funding, the URI's Mobile Health Unit travels around RI in a 37-foot van with two exam rooms and clinical and case management staff, providing HIV screenings, immediate medication-assisted treatment services, and general health care to the community.
- **Prevent Overdose RI (PORI) Data Dashboard.** This public online dashboard, which draws from multiple data sources including Prescription Drug Monitoring Program (PDMP) data, provides community members, health professionals, and policymakers with timely data to track RI's progress toward reaching the goals outlined in the PORI Action Plan.
- **Drug Overdose Prevention Program: Public Awareness Campaign.** Utilizing State Opioid Response (SOR) grant funding, this is a public campaign tackling BH, OUD/SUD prevention and treatment resources, and stigma.
- **Institutions for Mental Disease (IMD) Waiver.** A waiver of the IMD exclusion that allows Medicaid coverage and federal financial participation for residential treatment services for Medicaid-eligible people in IMDs.

## Funding

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- **The State Opioid Response (SOR) Grant.** This Substance Abuse and Mental Health Services Administration (SAMHSA) grant provides funding to Rhode Island to help reduce overdose-related deaths through prevention, treatment, and recovery efforts.
- **Section 1003 SUPPORT Act Planning Grant.** This Centers for Medicare & Medicaid Services (CMS) grant program provides funding for activities designed to increase Medicaid providers' capacity to deliver SUD treatment or recovery services through: 1) an ongoing assessment of the SUD treatment needs of the state; 2) recruitment, training, and technical assistance for Medicaid providers that offer SUD treatment or recovery services; and 3) improved reimbursement for and expansion of the number or treatment capacity of Medicaid providers.

- State Innovation Model (SIM) grant to fund coaching, mentoring, and training.** The CMS SIM demonstration ran from 2015 to 2018 and offered a \$20 million grant to promote positive changes in Rhode Island’s health-care system and to improve population health within the state. The grant funded not only SUD-specific programming, but also supported other RI priorities such as the implementation of a care management dashboard and the creation of an all-payer claims database.

## Methodology

As part of the mid-point assessment, NORC conducted a comprehensive document review and a small set of both in-person and virtual key informant interviews from March to May 2020. In-person group interviews and meetings in March 2020 provided our team with a broad overview of the state’s existing programs and initiatives. This was followed by an extensive document review to gain a deeper understanding of the state’s ongoing efforts and informed protocol development for follow-up on virtual key informant interviews with state stakeholders. These virtual interviews, starting in April 2020, helped build a more complete and thorough understanding of the processes and implementation of each program, grant, or initiative. The goals of each virtual one-on-one interview were to review progress on established milestones, determine the priorities of each initiative, and contextualize SUD implementation activities within the broader health care environment.

NORC collaborated with EOHHS and BHDDH to develop the list of stakeholders included in Exhibit 1 below. We developed semi-structured interview guides for each stakeholder based on the milestones presented in the SUD implementation plan.

### Exhibit 1. Stakeholder Interviewees

Agency	Stakeholders
BHDDH	<ul style="list-style-type: none"> <li>Behavioral Health (BH) Division Director</li> <li>BH and Substance Use Disorder (SUD) Administrator</li> <li>Peer Recovery Specialist Project Manager</li> </ul>
EOHHS	<ul style="list-style-type: none"> <li>Director of Policy &amp; Delivery System Reform</li> <li>Associate CFO</li> <li>Director of Community Investments</li> <li>Project Manager</li> </ul>
RIDOH	<ul style="list-style-type: none"> <li>Communications Manager</li> </ul>

## Limitations

The COVID-19 public health emergency posed some challenges for coordinating interviews with key stakeholders in a timely fashion. State agencies, health-care systems, and managed care organizations (MCOs) have understandably focused their attention and priorities on quickly responding to Medicaid beneficiaries’ needs in the current pandemic environment. Interviewees from EOHHS, BHDDH, and RIDOH noted that the state’s resources were being redirected to address the pandemic and support state public health efforts. After discussion with EOHHS, the decision was made to not reach out to MCO

representatives for interviews, as their efforts were focused on the statewide COVID-19 response at this time. As such, while we have developed an overall understanding of existing SUD program implementation and noted when activities have shifted to focus on COVID-19, we have not yet been able to assess the impact of COVID-19 on milestone achievements. We are also unable to state when RI will be able to resume pre-COVID-19 levels planning and engagement for each SUD program.

## Implementation Status by Milestone

As noted above, RI has implemented five programs and used four funding sources to meet the milestones set forth in the SUD implementation plan. For each of the six milestones, we assessed implementation progress, challenges and approaches to addressing them, and future plans for the relevant programs and funding sources. The milestones in RI’s SUD Implementation Plan are as follows:

1. Access to critical levels of care for OUD and other SUDs
2. Widespread use of evidence-based, SUD-specific patient placement criteria
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
4. Sufficient provider capacity at each level of care, including MAT
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
6. Improved care coordination and transitions among levels of care

Milestone #1 – Access to critical levels of care for OUD and other SUDs
<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>● BH Link first opened in November 2019.</li> </ul> </li> <li>■ <u>Peer Recovery Support (PRS) Program</u> <ul style="list-style-type: none"> <li>● Implementation of the PRS program began in 2016 and the Medicaid billing certification process began in 2019.</li> </ul> </li> <li>■ <u>IMD Waiver</u> <ul style="list-style-type: none"> <li>● Final approval with RI’s 1115 Waiver Extension Request in November 2019.</li> </ul> </li> <li>■ <u>URI’s “RHODE to Health” Mobile Health Unit</u> <ul style="list-style-type: none"> <li>● The RHODE to Health Mobile Health Unit van began running in 2018 in partnership with the Governor’s Overdose Taskforce, the local university, BHDDH and community Opioid treatment organizations.</li> </ul> </li> </ul>
<p><b>Implementation to date</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>● <b>Infrastructure and staffing.</b> BH Link has three primary components: the onsite triage center, the hotline, and mobile capacity. The program addresses both SUD and mental health (MH) crises.                             <ul style="list-style-type: none"> <li>● The physical location of BH Link functions as a triage center with a 24/7 staffing pattern. Staff include nurses, peer-licensed physicians, certified PRS, Case Managers, prescribers (a psychiatric clinical nurse specialist and a psychiatrist), and qualified mental health professionals (QMHPs).</li> </ul> </li> <li>● <b>BH Link currently holds the contract for the National Suicide Hotline.</b> <ul style="list-style-type: none"> <li>● The line has also incorporated many relevant 24/7 call lines into the treatment center.</li> </ul> </li> </ul> </li> </ul>

- The hotline handles crises in addition to linking people to services in the community (e.g., SUD residential facilities).
  - **Successful competitive procurement for BH Link contractor.** The state awarded a contract to Horizon Health Partners, a consortium of mental health providers.
  - **Impact Measurement.** Since its implementation, the state has been measuring reductions in hospitalization for people with MH disorders/SUD, before and after their encounter with BH Link.
- Peer Recovery Specialists (PRS)
  - **In the state overall, there are 150 active PRS-certified individuals and** six provider groups/agencies certified as a provider of Peer-Based Recovery Support Services. However, only two of these groups were billing Medicaid as of April 2020.
    - The process for MH and SUD PRS certifications have been combined.
  - **Funding.** Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) funding from SAMSHA was the main funding source that initiated the PRS program. Training and internships are now funded through the combined MH and SUD block grant.
    - A Medicaid certification process has been developed so that smaller community providers can bill Medicaid for PRS.
- IMD Waiver
  - **Integration of the IMD waiver.** The IMD need is not new to the state; changes approved in the waiver added additional regulation of the amount of time someone can stay in a covered IMD.
    - More specifically, the waiver allows states to request an exemption from the IMD exclusion rule that bars Medicaid from paying for treatment for adults under the age of 65 in psychiatric residential facilities with more than 16 beds up to an average of 30 days.
  - **Use of IMD waiver-related funds.** Money has been collected through fines from commercial plans that had not been adhering to parity laws or clinical recommendations.
    - These charges go toward a fund to help non-profits providing BH services.
    - The existing fund is currently approximately \$5 million and organizations can apply for up to \$200,000. The state has directed this money toward improving BH programs and has made special allowances for SUD residential facilities that were disproportionately affected by the insurer's actions.
- URI's "RHODE to Health" Mobile Health Unit
  - **Initial implementation.** URI, with funding from EOHHS, implemented a new Rhode to Health Mobile Unit that includes multi-use exam rooms and an intake and screening area.
    - The van was funded by the state of Rhode Island through Health Resources and Services Administration (HRSA) Ryan White Part B funds. The \$400,000 vehicle was unveiled during a ceremony at the university's Robert J. Higgins Welcome Center and has been used primarily to screen potentially at-risk residents in the community for HIV.
  - **Partnerships.** The state had initially been working with the URI to provide health screenings until they lost funding. To resume the use of the van, BHDDH suggested leasing the "RHODE to Health received funding from BHDDH's" to a statewide Opioid Treatment Program to provide screening, inductions and outreach education directly in the community utilizing the available federal State Opioid Response grant to provide SUD service funds.
    - The first initial goal for RHODE to Health was to take their van into the suburbs and rural outlying areas that lacked the information available to the inner cities. To do this, BHDDH contracted with the state's largest opioid treatment center of excellence, CODAC, which provides full wrap-around service.
    - CODAC has multiple sites around the state and can offer a range of services, including HIV tests, buprenorphine inductions, mental health screening, and blood pressure testing. BHDDH and CODAC have coordinated with several faith groups, police departments, and fire departments in order to find safe location sites.
  - **Targeted outreach.** CODAC's "RHODE to Health" staff worked with the Governor's Overdose Task force, Treatment workgroup, and BHDDH staff to review "hotspot" ZIP codes and determine where overdoses were occurring in order to target the RV's placements. The van is staffed with a case management team that includes mental health and Substance treatment professionals, nurse practitioners (NPs), security and other multidisciplinary clinical staff.

**Implementation challenges (factors affecting progress toward milestones and measures)**

- BH Link Triage Center
  - **Minimal funding.** Prior to BH Link, the program had received minimal funding to set up a triage center for SUD, primarily focused on alcohol abuse. These efforts were not financially sustainable.
  - **Limited community outreach.** BH Link has the ability to send people into the community to provide care, but they have a limited radius.
    - While BH Link gets referrals from emergency medical technicians (EMTs), they have a difficult time working with the police who do not want to transport individuals to BH Link.
    - There are about 150-200 referrals to BH Link each month, which is lower than the state would prefer.
  - **Lack of billing incentives.** There are existing issues around billing regarding the mobile outreach van, including the lack of incentive to treat individuals in the field when the billing rates are so low. The rate is far lower than what they receive for on-site services.
- Peer Recovery Specialists (PRS) Program
  - **Some commercial MCOs were already paying for peer recovery services.** They found value in this work and funded it on their own. As a result, these plans are not limited to the state’s certification standards, nor do they have to use the certified providers or their rate. However, the state implemented peer group services, which the MCOs do not offer.
  - **Lack of Medicaid or billing experience.** There are provider agencies and organizations in the program that have no Medicaid or billing system/EMR experience.
    - Establishing the Medicaid billing certification process for these providers working with PRS was a lengthy process.
    - Providers struggle to navigate the current certification process, and small providers with limited funding struggle to find time for staff to complete the certification process.
  - **Attitudes and understanding about PRS roles and services** have posed challenges for integrating them into care networks.
    - There is little research on the impact of PRS and in what context their services work best.
  - **Staffing and Funding.** The director of the PRS program has recently retired; there is no current replacement due to a hiring freeze within the state and within BHDDH.
    - Funding continues to be a concern in growing and sustaining the program. Existing funding sources focus on building new programs and interventions for SUD and not for maintaining current programs.
    - COVID-19 effected the ability for peers to gain internships to complete the required hours of practical experience.
- IMD Waiver
  - **IMDs with patients in FFS could not bill to Medicaid directly.** The state paid for these services through the block grant, which also covered gap services.
    - Their facilities are struggling right now, especially with the rates that have been offered.
- URI’s “RHODE to Health” Mobile Health Unit
  - **Sustainable funding.** The state is still trying to figure out a way to make the funding more sustainable by doing things like billing for services through Medicaid for their Peer Recovery work or for their care management (through the Ryan White Fund). This would foster the sustainability of the program once the federal funds have expired.
  - **Slow initial implementation.** Startup was slow in rural areas due to lack of exposure. They eventually shifted their focus to targeted areas.
  - **COVID -19 social distancing requirement effected basic out-reach work.** The Rhode to Health vehicle changed its purpose for a 4-week period to provide primary community COVID-19 testing for the Department of Health. All Federally funded services could not be utilized for BH work during this time. The program will re-start once testing ends.

**Efforts to address challenges (identify strategies to address performance gaps)**

- BH Link Triage Center
  - **Addressing funding sources.** At the onset of BH Link, the program did not have enough funding at the time to pay for all of their projects. However, since the program’s inception, BH Link has received more funding through the SOR grant.
  - **Increasing community outreach.** BH Link has begun using community health center liaisons to increase referrals to BH Link facilities.



<ul style="list-style-type: none"> <li>● In order to address areas not covered by the physical BH Link, mobile outreach liaisons working within most of the state’s CMHCs have been funded to do mobile after hours and weekend work to provide care throughout the community.</li> <li>● BH Link received additional support from community providers such as Providence Center, who manages Anchor MORE (Mobile Outreach Recovery Efforts), a program that has peers conducting outreach on the streets and now operating across the state. Those that are in the Providence area refer individuals to BH Link.</li> </ul> <ul style="list-style-type: none"> <li>■ <u>Peer Recovery Specialists (PRS)</u> <ul style="list-style-type: none"> <li>● <b>Providing training on Medicaid and billing.</b> A contractor is training providers who have no EMR/billing system/Medicaid experience. In addition, BHDDH staff are working with the agencies that have submitted applications to participate in the Medicaid program. <ul style="list-style-type: none"> <li>● Feedback from providers who have gone through the Medicaid certification process was gathered and incorporated into new certification instructions and guidelines.</li> </ul> </li> <li>● <b>Tracking successes.</b> The PRS program uses Recovery Outcome Measures to track the success of PRS services with the hope that continued data collection will drive support for and the expansion of the program.</li> </ul> </li> <li>■ <u>IMD Waiver</u> <ul style="list-style-type: none"> <li>● <b>Increasing capacity.</b> The state is working to increase capacity and use SOR funding to help new facilities open. However, as they are unable to use federal grant funds for brick and mortar, there has been no response to the request for proposal (RFP) for the residential facility. <ul style="list-style-type: none"> <li>● Existing facilities are running efficiently, with one facility moving from 12 residents to 16 to address increased need.</li> </ul> </li> </ul> </li> <li>■ <u>URI’s RHODE to Health Mobile Health Unit</u> <ul style="list-style-type: none"> <li>● <b>Access to medications.</b> While there are still challenges in utilizing methadone on a vehicle per DEA rules, the state is awaiting to hear from its federal partners about these rules being overturned very soon.</li> </ul> </li> </ul>
<p><b>Future plans</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>● <b>Expanding the use of data.</b> The state is in the process of expanding the use of Medicaid data to track patients’ receipt of treatment.</li> <li>● <b>Expanding scope of work.</b> New providers have brought experience in the provision of mental health services, but less experience with respect to SUD services. There has been a lot of education in the treatment of co-occurring disorders. Providers have generally been able to induct people onto buprenorphine quickly due in part to work on 24/7 induction and connecting to other agencies. BH Link does not currently do inductions at the agency, but they would like to get there. <ul style="list-style-type: none"> <li>● While there is potential to expand to additional satellite sites, there are currently no plans to do so.</li> </ul> </li> </ul> </li> <li>■ <u>Peer Recovery Specialists (PRS)</u> <ul style="list-style-type: none"> <li>● <b>Plans to expand the network of provider</b> organizations that would be able to provide services. <ul style="list-style-type: none"> <li>● The program is not limited to Medicaid providers, which means there are new faces, including individuals who have no Medicaid experience or billing system/EMR experience.</li> </ul> </li> <li>● <b>Collaborating with commercial plans.</b> If the commercial plans stopped their internal programs for similar services, then BHDDH plans to ramp up their program. <ul style="list-style-type: none"> <li>● BHDDH is planning to meet with commercial plans in the future to discuss potential areas for streamlining these types of services.</li> </ul> </li> </ul> </li> <li>■ <u>URI’s “RHODE to Health” Mobile Health Unit</u> <ul style="list-style-type: none"> <li>● <b>COVID-19 response.</b> Due to COVID-19, the RHODE to Health van was able to go to group homes and test individuals at the site, instead of risking disturbing them or causing anxiety. Some group homes have significantly more SUD education needs than others. The next step would be taking the van to locations and communities that require the most assistance. Staff are firmly committed to the notion that people need to be treated with respect – stigma is still “alive and well,” especially for people who are afraid to go to doctors.</li> </ul> </li> </ul>

<b>Milestone #2 – Widespread use of evidence-based, SUD-specific patient placement criteria</b>
<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>■ EOHHS and BHDDH have not developed any specific program/activity for this milestone as both agencies have continued to use established practices to ensure the use of evidence-based, SUD-specific patient placement criteria (ASAM) prior to the approval of the waiver.</li> </ul>
<p><b>Implementation to date</b></p> <ul style="list-style-type: none"> <li>■ <b>BHDDH requires all licensed BH care programs to use the American Society of Addiction Medicine (ASAM) criteria at all levels of care.</b> <ul style="list-style-type: none"> <li>● As noted in the <a href="#">Rules and Regulations for Behavioral Healthcare Organizations</a>,                             <ul style="list-style-type: none"> <li>● Section 1.6.2.B- Each biopsychosocial assessment shall include an integrated summary that analyzes and synthesizes the findings of the assessment. Formulation of the integrated summary shall include: For persons assessed in need of substance abuse services, the assessment summary shall include recommendations for a level and type of service based on current American Society of Addiction Medicine’s (ASAM) criteria.</li> <li>● Section 1.6.7.C.2- The American Society of Addiction Medicine’s (ASAM) criteria shall be considered when providing services for persons with substance use disorder and/or dependence diagnoses.</li> <li>● Section 1.6.12.F.1- Residential Programs for Substance Use Disorders: The provider must utilize the ASAM Criteria (<a href="https://www.asam.org/resources/the-asam-criteria/about">https://www.asam.org/resources/the-asam-criteria/about</a>) to determine the appropriate level of residential care and be able to provide the array of services based on the appropriate placement level, including medication-assisted treatment options.</li> </ul> </li> <li>● <b>BHDDH requires that training and education programs for clinical and support staff include the use of ASAM placement and treatment criteria</b>, as noted in the Section 1.6.13.A.15.b.</li> <li>● <b>Prior to the waiver, EOHHS and BHDDH developed and implemented a utilization management approach</b> that ensured beneficiaries were provided access to SUD services at the appropriate level of care, interventions were appropriate for the diagnosis and level of care, and that there was an independent process for reviewing placement in residential treatment.</li> </ul> </li> <li>■ EOHHS and BHDDH have monitoring processes in place through the use of auditing teams, clinical peer reviews, and MCO utilization reviews to ensure adherence to appropriate ASAM levels of placement and types of service for Medicaid beneficiaries.</li> <li>■ BHDDH has contracted with Rhode Island Communities for Addiction Recovery Efforts (RICARES) to facilitate a peer review process. Independent peer review members include Program Directors and experienced clinical supervisors from licensed BH organizations. Members review clinical records, quality improvement, and systemic concerns.</li> <li>■ Medicaid Managed Care Organizations also use ASAM criteria in their management and coordination practices.</li> </ul>
<p><b>Implementation challenges (factors affecting progress toward milestones and measures)</b></p> <ul style="list-style-type: none"> <li>■ No challenges have been identified beyond COVID-19.</li> </ul>
<p><b>Efforts to address challenges (identify strategies to address performance gaps)</b></p> <ul style="list-style-type: none"> <li>■ No challenges have been identified beyond COVID-19</li> </ul>
<p><b>Future plans</b></p> <ul style="list-style-type: none"> <li>■ BHDDH will continue to monitor and review all licensed BH care programs to ensure adherence to the Rules and Regulations for Behavioral Healthcare Organizations.</li> </ul>

<b>Milestone #3 – Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications</b>
<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>■ <u>State Innovation Models (SIM) Initiative grant to fund coaching, mentoring, and training</u> <ul style="list-style-type: none"> <li>● Began in 2015 with \$20 million of funding</li> </ul> </li> </ul>
<p><b>Implementation to date</b></p> <ul style="list-style-type: none"> <li>■ <u>State Innovation Models (SIM) Initiative grant to fund coaching, mentoring, and training</u></li> </ul>

<ul style="list-style-type: none"> <li>● <b>A key investment concerned a workforce development project</b> that offered provider coaching and staff development for BH providers licensed by BHDDH.             <ul style="list-style-type: none"> <li>● These providers are Rhode Island’s primary resource for people who rely on publicly funded BH care (e.g., Medicaid). BHDDH has licenses with 31 providers, including Community Mental Health Centers (CMHCs) and SUD/BH organizations.</li> <li>● Together, these providers employ approximately 4,000 staff who serve approximately 5,000 children/adolescents and over 40,000 adults per year.</li> </ul> </li> <li>● <b>Continued supporting a demonstration program with 10 patient-centered medical homes (PCMHs) to integrate BH staff and services into practice workflow.</b> The integrated behavioral health (IBH) pilot, which ended in October 2018, had three components:             <ul style="list-style-type: none"> <li>● (1) implementing universal screening for depression, anxiety, and substance use disorders;</li> <li>● (2) embedding a BH clinician (social worker or clinical psychologist) in the practice to provide treatment and referrals, as needed; and</li> <li>● (3) onsite coaching from a licensed clinical psychologist to teach practices how to integrate BH practitioners into care teams and address other integration issues as they arise.</li> </ul> </li> <li>● <b>Behavioral Health Workforce Transformation: Practice Coaching at CMHC</b> <ul style="list-style-type: none"> <li>● For curriculum development and training for staff at 7 CMHCs, including Fellowship Health Resources.</li> </ul> </li> </ul>
<p><b>Implementation challenges (factors affecting progress toward milestones and measures)</b></p> <ul style="list-style-type: none"> <li>■ <u>State Innovation Models (SIM) Initiative grant to fund coaching, mentoring, and training</u> <ul style="list-style-type: none"> <li>● <b>Limited state resources are provided for programs like PRS, BH Link, IMD Waiver</b> – state resources that are provided are used to run the agency department/division rather than the program itself. Federal initiative funding is used to launch these programs (i.e., SIM funding had been used to promote training).</li> </ul> </li> </ul>
<p><b>Efforts to address challenges (identify strategies to address performance gaps)</b></p> <ul style="list-style-type: none"> <li>■ <u>State Innovation Models (SIM) Initiative grant to fund coaching, mentoring, and training</u> <ul style="list-style-type: none"> <li>● The SIM demonstration has ended.</li> </ul> </li> </ul>
<p><b>Future plans</b></p> <ul style="list-style-type: none"> <li>■ <u>State Innovation Models (SIM) Initiative grant to fund coaching, mentoring, and training</u> <ul style="list-style-type: none"> <li>● <b>Sustainability efforts.</b> While the SIM grant has ended, several sustainability efforts were put in place that included establishing case manager and SUD competencies, the creation of new undergraduate and graduate courses across health-related programs, and the integration of BH simulations in RI College’s nursing program.</li> </ul> </li> </ul>

<p><b>Milestone #4 – Sufficient provider capacity at each level of care, including MAT</b></p>
<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>■ <u>State Opioid Response (SOR) grant</u> <ul style="list-style-type: none"> <li>● In 2019, SAMHSA allocated nearly \$12.6 million to Rhode Island through SOR grants. These grants provide funding to states to help reduce overdose-related deaths through prevention, treatment, and recovery efforts.</li> </ul> </li> <li>■ <u>Section 1003 SUPPORT Act planning grant</u> <ul style="list-style-type: none"> <li>● 18-month plan starting in September 2019</li> <li>● Grant aims to enhance SUD provider capacity in the state, including:                 <ul style="list-style-type: none"> <li>● A general system review of the state’s BH provider network</li> <li>● Enhancing the workforce by making it more culturally/linguistically appropriate</li> <li>● Boosting numbers of BH workforce</li> <li>● Improving technology</li> <li>● Aligning with other Medicaid goals, including integrating into accountable entities and improved MCO contracting</li> </ul> </li> </ul> </li> </ul>
<p><b>Implementation to date</b></p> <ul style="list-style-type: none"> <li>■ <u>State Opioid Response (SOR) grant</u></li> </ul>

- **Supporting SUD residential treatment facilities.** One of SOR's goals is to support SUD residential treatment facilities across the state.
- Section 1003 SUPPORT Act planning grant
  - **\$50 million given to 15 states to improve provider capacity**
  - **Implementing Mirah Measurement-Based Care.**
    - The state has contracted with Mirah to track performance measures and conduct surveys. Mirah is subcontracting with the BH organizations so that these organizations can extend their use of the Mirah software.
    - This assessment routinely monitors and measures clients' symptoms to identify progress and areas for improvement in treatment plans. Clients respond to measures related to their own symptoms and treatment plan, including their risk of self-harm, feeling connected to their therapist, treatment efficacy, and personal strengths.
    - EOHHS and BHDDH are providing oversight for this contract.
  - **Needs assessment.** The state has an RFP out (currently delayed) for a needs assessment on the state's BH requirements. The grant is specifically for SUD but is being used for both MH and SUD needs due to the prevalence of many comorbidities. This review will provide data to inform a rate review or rate remodeling.
    - There was a rate review in the fall of 2019, but they are hoping to do one that is more comprehensive and explores value-based purchasing (VBP) and MCO contracting.
  - **Training.** The state is working with the Substance Use and Mental Health Leadership Council (SMHLC) to provide technical assistance and training to providers. Currently, they are providing a COVID-19 related training.
    - The state has contracted with John Snow, Inc. (JSI), who has started a pilot for a mentorship program to enhance the BH workforce for appropriate services. There are no initial data available yet.

**Implementation challenges (factors affecting progress toward milestones and measures)**

- State Opioid Response (SOR) grant
  - **Overall funding cuts.** The state's SOR funding was cut by 66% due to their national ranking in overdose deaths dropping out of the "top 10" states for annual overdose mortality.
  - **Lack of infrastructure funding.** As noted in Milestone #1, the state is unable to use federal grant funds for brick and mortar infrastructure. While there is political interest, there are no funds to back this type of investment.
  - **Lack of public response.** While RFPs to support the new SUD residential treatment facilities have been released, the state has not received any responses. BHDDH cited a lack of funding to support a new SUD residential treatment facility.
- Section 1003 SUPPORT Act planning grant
  - **The procurement and tracking process has been challenging.** Team members across agencies have tried to prioritize single sources as it is only an 18-month grant.
    - It has been challenging working with federal partners, especially with the different requirements across the board. For example, it is unclear who will pay for needle syringes, naloxone kits, etc.
  - **Outdated training.** The state had originally planned to provide Zoom training and licenses. However, since COVID-19 has forced providers to quickly take up telemedicine, the telemedicine training portion of the grant has become obsolete.
  - **Transition from Optum to Beacon.** In 2019, the transition from Beacon Health Strategies to Optum as its BH vendor was a challenge. Providers were struggled with timely filing of claims and saw higher rates of claim denials which impacted their solvency. Providers sought assistance and EOHHS created a workgroup to help them through the transition.

**Efforts to address challenges (identify strategies to address performance gaps)**

- State Opioid Response (SOR) grant
  - **Addressing lack of public response.** The state is planning on putting out the RFP for the residential facility for a third time and is hoping to identify additional funding to encourage bidders.
- Section 1003 SUPPORT Act planning grant
  - **Creating a safety net for providers.** The workgroup created by EOHHS helped providers navigate their claims, learn how to build their practices up and make them more stable for the long term. In addition, the workgroup set up requirements for MCOs to provide better information around denials, better communication around billing and pathways to escalate billing issues within their organizations.

<ul style="list-style-type: none"> <li>● <b>Infrastructure funding and updated trainings.</b> EOHHS is working with BHDDH and other agencies to ensure they are leveraging all funds (e.g., SOR grant, funds dedicated to COVID-19) appropriately to ensure providers have the right infrastructure.</li> </ul>
<p><b>Future plans</b></p> <ul style="list-style-type: none"> <li>■ <u>State Opioid Response (SOR) grant</u> <ul style="list-style-type: none"> <li>● <b>Seeking additional infrastructure funding.</b> As noted in Milestone #1, money has been collected through fines from commercial plans that had not been adhering to the rules and clinical recommendations. The state has directed this money toward improving facilities and building capacity.</li> </ul> </li> <li>■ <u>Section 1003 SUPPORT Act planning grant</u> <ul style="list-style-type: none"> <li>● <b>Plans for after the grant.</b> After the 18-month planning grant, there is a 3-year demonstration opportunity.                             <ul style="list-style-type: none"> <li>● The state plans to apply and show that, during the planning grant, they expanded SUD provider capacity. If they receive the CMS grant, the funds would pay for 80% of the increase in capacity in billing, based on the 2017 numbers.</li> </ul> </li> </ul> </li> </ul>

<p><b>Milestone #5 – Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD</b></p>
<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>■ <u>SOR grant, PORI, and public awareness campaign</u> <ul style="list-style-type: none"> <li>● <b>PORI was developed to create a strategic plan to address the epidemic.</b> Building on past accomplishments and progress from the original plan, the strategic plan was updated in 2019.</li> <li>● <b>“State-Wide Conversation Campaign”</b> <ul style="list-style-type: none"> <li>● Outcome of Governor’s Executive Order May 2018</li> <li>● Aligns the messaging of state agencies’ public service announcement (PSA) campaigns</li> </ul> </li> </ul> </li> </ul>
<p><b>Implementation to date</b></p> <ul style="list-style-type: none"> <li>■ <u>SOR grant, PORI, and public awareness campaign</u> <ul style="list-style-type: none"> <li>● <b>PORI has their own data counsel subgroup task force.</b> All of the 28 metrics that they track are available online; BHDDH is responsible for half of the metrics.</li> <li>● <b>Public involvement.</b> PORI holds public meetings every month and they are well-attended with a number of different groups represented.</li> <li>● <b>RIDOH works closes with Brown University and other community partners</b> (e.g., RIDOH Health Equity Zones, RI Center for Excellence, recovery community centers, recovery housing RI Care, and street outreach teams that focus on harm reduction) to develop website content.</li> <li>● <b>“State-Wide Conversation Campaign.” The state utilized the SOR grant to launch a public campaign tackling BH stigma.</b> <ul style="list-style-type: none"> <li>● Topics included BH Link, SUD, and SUD needs of construction workers. These PSAs played on all four of the local PBS stations on December 14, 2019. This was an unprecedented event for the state and was held at no cost.</li> <li>● After the materials aired, the state fielded a midpoint survey to over 1,200 people and had planned to have a public meeting to discuss the results. However, they have postponed this meeting to take place after the COVID-19 pandemic.</li> <li>● The state hosts a monthly meeting with stakeholders across the state. The main goal is to align communication efforts and identify opportunities for collaboration.</li> </ul> </li> </ul> </li> </ul>
<p><b>Implementation challenges (factors affecting progress toward milestones and measures)</b></p> <ul style="list-style-type: none"> <li>■ <u>SOR grant, PORI, and public awareness campaign</u> <ul style="list-style-type: none"> <li>● <b>Delayed survey results.</b> As the midpoint survey was fielded after the December television broadcast, results were not available until early March. However, due to COVID-19, the state has been unable to schedule a meeting to discuss the survey results.</li> <li>● <b>Impact of COVID-19.</b> The public health emergency changed the state’s messaging priorities.</li> </ul> </li> </ul>
<p><b>Efforts to address challenges (identify strategies to address performance gaps)</b></p> <ul style="list-style-type: none"> <li>■ <u>SOR grant, PORI, and public awareness campaign</u></li> </ul>

<ul style="list-style-type: none"> <li>• <b>Additional surveying.</b> The state has fielded additional surveys to measure and study public perceptions since the onset of the campaign. For instance, a public opinion survey about stigma associated with MH and SUD was fielded to measure the impact of current campaigns. Results will be presented to RIDOH's SUD communication director.</li> </ul>
<p><b>Future plans</b></p> <ul style="list-style-type: none"> <li>■ <u>SOR grant, PORI, and public awareness campaign</u> <ul style="list-style-type: none"> <li>• <b>Continuation of public campaign.</b> The state will continue airing the PSAs until the end of 2020.           <ul style="list-style-type: none"> <li>• Ongoing campaigns include those focused on destigmatizing medication-assisted treatment (MAT), fentanyl, and overdose prevention. The state just received an additional grant through the Department of Health Services and Practice at Brown's School of Public Health.</li> <li>• The state is also launching a domestic violence campaign in response to COVID-19 stay-at-home orders.</li> </ul> </li> </ul> </li> </ul>

<p><b>Milestone #6 – Improved care coordination and transitions among levels of care</b></p>
<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>• BH Link first opened November 2019.</li> </ul> </li> <li>■ <u>Peer Recovery Specialists (PRS)</u> <ul style="list-style-type: none"> <li>• Implementation of the PRS program began in 2019.</li> </ul> </li> </ul>
<p><b>Implementation to date</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>• All referrals are tracked at BH Link.</li> </ul> </li> <li>■ <u>PRS</u> <ul style="list-style-type: none"> <li>• <b>Partnerships and care coordination.</b> PRS has a contract with the Office of Healthy Aging (OHA) for 1-2 positions.           <ul style="list-style-type: none"> <li>• Anyone over age 60 works with a staff member from OHA who can refer individuals to an aging service or skilled nursing.</li> </ul> </li> </ul> </li> </ul>
<p><b>Implementation challenges (factors affecting progress toward milestones and measures)</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>• <b>Referrals from detoxification to the next level of care are difficult,</b> especially to out-of-network providers. The state has heard of people getting discharged directly into the parking lot.</li> <li>• <b>Limited community outreach.</b> BH Link has the ability to send people into the community to provide care, but they have a limited radius.           <ul style="list-style-type: none"> <li>• While BH Link gets referrals from emergency medical technicians (EMTs), they have a difficult time working with the police who do not want to transport individuals to BH Link.</li> <li>• There are about 150-200 referrals to BH Link monthly, which is lower than the state would prefer.</li> </ul> </li> </ul> </li> <li>■ <u>PRS</u> <ul style="list-style-type: none"> <li>• <b>Patient reluctance to see a PRS.</b> Patients have been hesitant to see a peer after an overdose or crisis. The state has been looking for ways to integrate these peers as part of the staff at the hospital.</li> </ul> </li> </ul>
<p><b>Efforts to address challenges (identify strategies to address performance gaps)</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u> <ul style="list-style-type: none"> <li>• While not directly related to BH Link, admissions, discharges, and transfers (ADT) feeds are being extended to RI Accountable Entities (AEs) and, in certain circumstances, the primary care physician is able find out if their patient was admitted somewhere else. However, there are still hospitals that refuse to submit their ADT feeds because of concerns that they would violate 42 CFR.</li> </ul> </li> <li>■ <u>PRS</u> <ul style="list-style-type: none"> <li>• <b>Data collection.</b> The state is collecting data on when and where PRS are interacting with patients and when patients are most open to seeing a PRS.</li> </ul> </li> </ul>
<p><b>Future plans</b></p> <ul style="list-style-type: none"> <li>■ <u>BH Link Triage Center</u></li> </ul>

- **Expanding the use of data.** The state is in the process of expanding the use of Medicaid data to track patients' receipt of treatment.
- **Expanding scope of work.** New providers have brought experience in the provision of mental health services, but less experience with respect to SUD services. There has been a lot of education in the treatment of co-occurring disorders. Providers have generally been able to induct people onto buprenorphine quickly due in part to work on 24/7 induction and connecting to other agencies. BH Link does not currently do inductions at the agency, but they would like to get there.
  - While there is potential to expand to additional satellite sites, there are currently no plans to do so.
- Peer Recovery Specialists (PRS)
  - **Plans to expand the network of provider** organizations that would be able to provide services, which would allow for greater coordination between needed services and providers.

## Budget Neutrality

EOHHS is developing a methodology and process for capturing the claims necessary to accurately report on spending on IMD services. As IMD expenditures are currently rolled up into the capitation rate, EOHHS is exploring how best to capture actual expenditures incurred in IMDs. EOHHS has proposed to CMS that they multiply the number of IMD patients by the capitation rate and report that on a quarterly basis. CMS has noted that, while it is acceptable to report the entire capitation spend as the cost of an IMD, it is difficult to identify which people are in an IMD and thus which budget populations are affected. To help address this challenge, EOHHS will also use encounter claims to help target IMD expenditures.

To date, EOHHS has not provided any quarterly expenditure reports to CMS, but is aiming to provide a retroactive report that dates back to July 1, 2019, before the end of the current federal fiscal year on September 30, 2020. Once they have finalized the methodology for capturing IMD costs, they will calculate IMD spend since July of last year and will use this methodology going forward. Since they have been reporting based on capitation since last July, they will need to pull out the IMD portion for that period. EOHHS will also use this methodology to calculate the forecast moving forward.

## Lessons Learned

Through its implementation of BH Link, PRS, RHODE to Health, PORI, and the SUD public awareness campaign, Rhode Island is on track to meet the six milestones in the SUD implementation plan. However, there are several factors that may affect the state's ability to meet its milestones in the future.

**Program funding sources are limited and short-term.** All of the programs relied primarily on one-time federal funds (i.e., SIM, BRSS, SOR, section 1003 Support Act). A majority of funding sources are dedicated to program start-up and not to maintaining current programs, which is necessary for sustainability. Limited state resources are provided for these programs as they are generally used to run agency departments/divisions rather than support program operation. If funding is cut, it can have a tremendous impact on a program. For example, the state's SOR funding was cut by 66%, which has resulted in the termination of funding for a number of projects. The state is also unable to use federal grant funds for brick and mortar infrastructure. While there is political interest in developing additional residential facilities, there are no funds to back those types of investments.

**Limited staff and resources to oversee programs.** For state staff, the development and funding of new programs does necessarily mean that additional staff can be hired. Instead, staff need to integrate new responsibilities into their existing workloads. This can lead to competing priorities and capacity constraints. For example, staff can be pulled away to focus on public health issues such as COVID-19. The current public health emergency also changed the state's messaging priorities; while the state continues its SUD public awareness campaign, they have also launched a domestic violence campaign in



response to COVID-19 stay-at-home orders. SUD technical assistance and training to providers have also shifted to focus on COVID-19 related training, which may delay existing program activities.

**Coordination challenges between community stakeholders and state and federal agencies.** Each program utilizes resources from multiple federal agencies as well as partnerships with different state agencies and community stakeholders for needed services. This can lead to challenges with understanding requirements and coordination of the various funding sources. For example, for some programs it is unclear which fund should pay for needle syringes, which fund should pay for medications, etc. There is a need for open and frequent communication and coordination among partners as well as buy-in from appropriate agencies and community organizations. While BH Link gets referrals from EMTs and uses CHC liaisons to increase referrals, police officers are reluctant to transport those in need to the Onsite Triage Center. Receiving referrals from detoxification to the next level of care is also difficult, especially from providers not in their network

**Challenges with integration between SUD and MH services.** In an effort to increase coordination and recognize how often there is an interplay between SUD and MH issues for individuals, the state moved to combine the process for SUD and MH PRS certifications. However, the SUD and MH communities were reluctant to combine the certification process as they feared it would conflate the issues of both groups. The understanding about the PRS role and services has also been a challenge in integrating them into care networks. In addition, providers that have been brought in for BH Link have extensive experience providing MH services, but limited experience providing SUD services.

**Minimal Medicaid billing due to low rates, a lengthy certification process, and a lack of provider Medicaid billing experience.** For BH Link, due to low rates for crisis response services,<sup>i</sup> there is a lack of incentive to treat individuals in the field. Establishing the Medicaid billing certification process for organizations participating in the PRS program that were not previously enrolled in Medicaid was a lengthy process, especially for small practices with limited resources. Providers struggled to navigate the current certification process and had limited resources for internal staff to complete the certification process. Prior to the Medicaid billing certification process, health plans already covered the cost of individual services only. As a result, these health plans are not limited to the state's certification standards, nor do they have to use the state's rate. The new provider certification process also allows for group services.

## Conclusion

Rhode Island's current efforts to address behavioral health and substance use disorders within the state align with the milestones outlined in the SUD implementation plan. These coordinated statewide programs and initiatives outlined in the report highlight the integration of four key strategies: prevention, rescue, treatment, and recovery. Rhode Island's PRS program serves as a model for other states interested in providing peer-based support to individuals in substance use and MH treatment. BH Link continues to see an increase in the number of referrals to community health centers post-outreach. In addition, the work of PORI and funding through the SOR grant and Section 1003 has provided the state opportunities

to develop their patient data capabilities and overall MH/SUD system infrastructure. Furthermore, the Statewide Conversation on Behavioral Health has worked to incorporate the lived experiences of Rhode Islanders into communication plans and to align all messaging across state agencies. The mobile efforts organized by URI's RHODE to Health have increased access to care and the delivery of essential treatment in communities across the state. Lastly, additional regulation provided through the IMD waiver has allocated funds for physical infrastructure development.

Despite these achievements, the state of Rhode Island acknowledges that many of these initiatives are nascent in their implementation. While some of the programs evaluated are the products of existing efforts, others still are at the onset of their performance period. The establishment of sustainable funding structures, the collection of reliable performance measurements, and the coordination across programming, agencies, and stakeholders, both at the state and community level, remains dynamic. Understanding the context and potential of the programs under the SUD Medicaid 1115 waiver will be vital in future evaluations.

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<sup>i</sup> Maximum billing for this service was reduced to 38% of what was formally allowable in 2016, \$49.04 per unit for up to sixteen 15 minute units to one flat rate of \$150, in Medicaid FFS.