HARI
Hospital Association of Rhode Island

Teresa Paiva Weed
President

February 12, 2018

Senator Orrin G. Hatch
Senator Ron Wyden
Members of the U.S. Senate Finance Committee
Washington, DC 20503

Dear Senator Hatch, Senator Wyden, and the Members of the U.S. Senate Finance Committee:

On behalf of our member hospitals and health systems, the Hospital Association of Rhode Island (HARI) appreciates the opportunity to present recommendations that may assist the Committee to address the opioid epidemic that is devastating families, not just in Rhode Island but across the country.

At the request of HARI, several of our member hospitals submitted specific responses to the request for stakeholder inquiries which HARI has incorporated herein. In addition, CharterCARE Health Partners provided a direct response, which is attached hereto.

In addition, HARI would submit the following additional information:

Question 2, posed by the Committee:

What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid?

HARI members suggested that limited and, in some cases, no coverage is available for alternative and holistic interventions which include but are not limited to PT/OT, massage therapy, acupuncture, Rieke, yoga, and that access to mental healthcare is limited.

Prospect CharterCARE specifically suggest in the correspondence attached hereto that Medicaid and Medicare add alternative therapies to the benefit structure with zero co-pay or member liability.

Telehealth reimbursement is limited. Prospect CharterCARE asks that telehealth for behavioral health be reimbursed through standard E/M codes.

Question 3, posed by the Committee:

How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to ensure beneficiaries receive evidence-based prevention, screening, assessment, and treatment for OUD and other SUDs to improve patient outcomes?

Eliminating Barriers to Treatment Caused by the Medicaid Institutions for Mental Disease (IMD) Exclusion.

HARI supports the elimination of the IMD exclusion. As you are aware, the IMD exclusion prohibits federal financial participation for important psychiatric care for individuals age 21-64,

provided in an IMD with more than 16 beds. If the exclusion was eliminated, IMDs could expand access to services for patients with substance use disorders.

The IMD exclusion presents barriers to individuals in need of detoxification services as well as residential services provided by behavioral health systems, such as Butler Hospital in Rhode Island. Although the expertise is available it is often inaccessible to these patients. Currently, Butler Hospital does provide inpatient detoxification services on a unit they run for another hospital within their health system, Kent Hospital.

In addition, Butler Hospital has an inpatient unit (ASAM Level 3.7) which provides a comprehensive detoxification program for individuals suffering from substance use disorders including opioid detoxification. The difference in the patient's experience of a patient receiving treatment on a general treatment unit versus on a unit with staff specifically trained to work in addiction is significant. Patients benefit from treatment on a unit where patients share common challenges and can benefit from receiving treatment with others in similar circumstances.

If this exclusion were eliminated, IMDs could expand access to services with substance use disorders. It could also reduce wait times for treatment. The IMD exclusion is an outdated law that unfairly limits access to mental health and addiction treatment for individuals who are often most in need of these services.

Question 5, posed by the Committee:

How can Medicare and Medicaid better prevent, identify and educate health professionals who have high prescribing patter of opioids?

HARI members and the AHA support prescriber education through medical/dental school training as well as continuing medical education.

Question 7, posed by the Committee:

What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

Rhode Island has established standardized *Levels of Care for Emergency Departments and Hospitals Treating Overdose and Opioid Disorder.*

The State of Rhode Island has demonstrated a continued commitment and innovative approach to address the opioid epidemic.

In March 2017, Rhode Island became the first state in the nation to release standardized *Levels of Care for Rhode Island Emergency Departments and Hospitals for Treating Overdose and Opioid Use Disorder*. The Levels of Care were launched to ensure patients treated in Rhode Island's hospitals receive consistent, high-quality and evidence-based care. With a focus on comprehensive discharge planning, the Levels of Care establish clear clinical protocols, organizational policies and

required infrastructures proven to best serve our community members facing opioid use disorder and overdose. This state-wide policy requires that all hospitals and emergency departments maintain a minimum Level 3 certification. Of note, the Levels of Care promote 48-hour overdose reporting requirements, fentanyl laboratory screenings, safe storage and disposal education, recovery support services, referral to appropriate community services and medication assisted treatment (MAT) resources.

Status of RI hospitals:

- Level 1:
  - Butler Hospital (CNE)
  - Fatima Hospital (CharterCARE)
  - Roger Williams Hospital (CharterCARE)
  - Miriam Hospital (Lifespan)
  - Newport Hospital (Lifespan)
  - Rhode Island Hospital (Lifespan)

- Level 2:
  - Women and Infant's (CNE)

- Level 3:
  - Kent County Hospital (CNE)
  - South County Hospital

- "In process"
  - Landmark Hospital
  - Providence VA
  - Westerly Hospital

Hospitals necessarily are required to make investments to achieve and maintain the levels of care described. Financial incentives rewarding hospitals for their commitment to providing high quality care and encouraging investment in the resources necessary to maintain these levels of care could be part of innovative Medicaid policies.

Question 8, posed by the Committee:

What human services efforts (including specific programs or funding design models) appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

<u>Community Health Workers in Rhode Island.</u>

Community Health Workers (CHWs) are frontline public health workers who concern themselves with the social determinants of health (SDOH). CHWs' often work in centers in low-income and

marginalized constituencies who have high health risk and poor access to healthcare. Traditionally, CHWs come from the same communities as their clients, so they are familiar with their cultures, values, strengths, challenges and barriers to care.

CHWs serve a unique role within Rhode Island's healthcare system. From the start of the healthcare receiving process, CHWs are often well trusted by their clientele as a direct result of their shared background. A CHWs knowledge of the community and its resources enables CHWs to help patients navigate social service and healthcare systems in the least stressful and most productive way. Furthermore, CHWs' advocacy and empowerment of clients helps improve the quality and cultural responsiveness of healthcare and social service providers.

CHW's in Rhode Island are funded through a broad array of sources and methods, from philanthropic foundations to payers to a State Innovation Model (SIM) test grant from the federal Centers for Medicare and Medicaid Services (CMS). Long term sustained funding and reimbursement opportunities are challenges.

A recent report on Rhode Island Community Health Workers reflects increasing recognition of their substantial value to a health team. The full report can be found at:

www.health.ri.gov/reports/CommunityHealthWorkersInRhodeIsland.pdf.

HARI supports full funding and implementation of the Comprehensive Addiction and Recovery Act and the 21st Century Cures Act.

Thank you for your leadership in addressing this public health priority. HARI and its members look forward to working with you to reduce the growing opioid epidemic.

Sincerely,

M. Teresa Paiva Weed
President
Hospital Association of Rhode Island

February 8, 2018

Office of U.S. Senator Sheldon Whitehouse
170 Westminster Street, Suite 200 (Note: NEW FLOOR)
Providence, RI 02903
Attn: Rele Abiad, Deputy State Director

Dear Senator Whitehouse,

Thank you for the opportunity to provide policy recommendations that can advance improving member health outcomes, reduces the number of preventable overdoses, and allows both Prospect CharterCARE, LLC and other community providers to secure innovative payment reimbursement methodologies that enables us to invest in resources and technology to address the Opioid Epidemic. We thank you in advance for your consideration of our response below and welcome the opportunity to meet with you to review our response.

1. How can Medicare and Medicaid payment incentives be used to promote evidence-based care for beneficiaries with chronic pain that minimizes the risk of developing OUD or other SUDS.

   A primary focus of Prospect Chartercare, LLC is to contract with Medicare and Medicaid as well as other payers to assume contractual risk to manage the healthcare services of members under value-based reimbursement arrangements. Core to our mission is to better the health outcomes of members who have who have Opioid Dependence, Alcohol Dependence, and/or additional co-morbid conditions. Although many of our patients are identified through our continuum, we routinely receive referrals from other hospitals (including Butler Hospital and the VA Medical Center), community primary care physicians, self-referrals, and from other Suboxone providers.

   Prospect Chartercare, LLC developed a formal Medication Assisted Treatment risk proposal that was submitted to EOHHS, NHPRI, Optum, and BCBSRI in November 2016. We determined over a year and half ago that we were uniquely positioned to accept full delegation and risk for members in need of comprehensive and fully integrated services that were flexible in nature to advance member recovery even in times of relapse. Although we convened multiple key stakeholder meetings throughout 2017, the only payer we were able to accept a 6 month case rate from was BCBSRI.

   We would request that our proposal is given reconsideration to accept risk given we have a full continuum of care including the only Level 4 detox in the state, a 3.7 ACSU, and an Outpatient Addiction Service Center that provides MAT, Vivitrol, PHP, IOP, Peer Recovery, and General Outpatient Services. We were also the first Level 1 Certified provider in the state for the Treating Overdose and Opioid Use Disorder.

2. What barriers to non-pharmaceutical therapies for chronic pain currently exist in Medicare and Medicaid?

Prospect CharterCARE, LLC fully supports alternative and holistic interventions which include but are not limited to massage therapy, yoga, and brief and longer term counseling interventions through Telehealth. We would request that Telehealth reimbursement is available beyond rural areas. We would ask that Medicare and Medicaid add alternative therapies to the benefit structure with zero co pay or member liability as co pays and coinsurance significant constrain members from seeking care.

We are currently finalizing our plan to launch Telehealth for behavioral health and would ask to secure reimbursement through standard E/M codes in 2018.

3. How can Medicare and Medicaid payment incentives be used to remove barriers or create incentives to receive screenings and assessment to improve patient health outcomes?

   Prospect CharterCARE, LLC has adopted several validated and reliable screening tools including the CORE-10, PHQ 2/9, and GAD2/7. We have launched a formal work group to move toward the implementation of SBIRT. Our primary constraint is having resources to roll out SBIRT. We would ask that there is state funding available that is easy to access and secure so that providers are financially supported to make meaningful and smart investments into SBIRT.

4. Are there changes to the Medicare and Medicaid prescription drug program rules that can minimize the risk of developing o=OUD and D=SUDS while promoting efficient access to appropriate medications?

   Prospect CharterCARE, LLC supports the recent state requirements that further ensure there are limits of frequency and dosing of Narcotic medication and dispensing. Our concern is that primary care physicians and specialists do not have adequate training to ween members off Narcotic medication to limit negative side effects. We have seen an uptick in members in both of our Emergency Rooms and in our 3.7 ACSU who were not provided a discontinuation of Narcotic medication that was based in best practices and left members in both physical withdrawal and emotional distress.

   In some circumstances, although the exception, some members will benefit from Narcotic medication. Further prescriber training is needed so that for these members they are supported in pain management.

5. How can Medicare and Medicaid better prevent, identify and educate health professional who have high prescribing patterns of opioids?
   It should be required that all prescribers attend a mandated Opioid CME 6 hours training annually that addresses our concerns in #4 above.

6. What can be done to improve data sharing and coordination between Medicare, Medicaid, and state initiatives, such as PDMP?

   Prospect CharterCARE, LLC has been impressed with the efforts set forth by the Rhode Island Department of Health. We would request that we partner closely with the state and payers to develop a comprehensive approach to understanding the member's latest treatment and prescribers in real time.

7. What best practices employed by states through innovative Medicaid policies or the private sector can be enhanced through federal efforts or incorporated into Medicare?

   Please see our responses above.

8. What human services efforts appear to be effective in preventing or mitigating adverse impacts from OUD or SUD on children and families?

   Further statewide education is needed in school settings as well as primary and pediatric care settings. We need to join forces across provider, payers, and our broader community to educate families of the sign and symptoms of Opioid misuse, safe storage and disposal, and appropriate dosing.

   Our state has been recognized for pioneering best practices to address this epidemic however much work is needed to strengthen our knowledge of implementing and adopting best practices through innovative payment structures that allow providers like us to flex services that meets the needs of members in all stages of their recovery.

- John Holiver, Chief Executive Officer, CharterCARE Health Partners