Opioid Replacement Therapy Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial (including Tufts Health Freedom Plan)[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

Providers contracted for this level of care or service will be expected to comply with applicable regulations set forth in the Code of Massachusetts Regulations and all requirements of these service-specific performance specifications, in addition to the General Behavioral Health Performance Specifications. All Performance Specifications are located online at tuftshealthplan.com in the Provider Resource Center.

DEFINITION

Opioid replacement therapy is medically monitored administration of methadone, buprenorphine, or other U.S. Food and Drug Administration (FDA)-approved medications to opiate-addicted individuals, in conformance with FDA and Drug Enforcement Administration (DEA) regulations. It is an organized, ambulatory addiction treatment program for opiate-addicted persons, providing opioid agonist treatment medication and counseling and other services needed to assist the Member in achieving stability. Opioid replacement therapy includes both maintenance and detoxification.

The goals of treatment include eliminating opiate use and/or IV drug use, evaluating, reducing, and eliminating the use or abuse drugs, improving the Member's health status, and improving the Member's level of functioning.

COMPONENTS OF SERVICE

Opioid replacement therapy may be offered on a short-term (detoxification) basis or a long-term basis, though the duration of service will vary depending on individual need.

Prior to initiating treatment, the provider shall:

1. Verify that the Member with a positive drug screen is not enrolled in another opioid replacement therapy program
2. Complete a medication reconciliation of the Member's current prescription medications in relation to interactions with opioid agonist medications, which may be prescribed in the course of treatment
3. For all women of child-bearing age, complete a pregnancy test before dispensing or administering an approved opioid agonist medication
4. Ensure, through the Medical Director, that the initial dose of an opioid agonist treatment medication is ordered by a program physician and does not exceed the federal dosage guidelines for the specified opioid. Dosing thereafter is by appropriate guidelines.
5. Complete a clinical assessment every day prior to dosing
6. Individual, family, and group counseling are a required part of treatment and are available and scheduled as clinically appropriate.

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[1] Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

7. Psycho-educational individual and group sessions are available on topics such as relapse prevention, medical aspects of treatment, and adjustment to clean and sober living.
8. Psychiatric, medical, and/or medication evaluation is provided as needed.
9. Case Management by a master's-level clinician will be provided.
10. The provider shall provide services as specified in 105 CMR 164.074 Minimum Treatment Service Requirements.

STAFFING REQUIREMENTS

1. All staff providing clinical services must meet the qualification standards of the Department of Public Health regulations, Chapter 105 CMR 164.314.
2. A physician medical director with knowledge and experience in addiction medicine shall be responsible for administering or overseeing all medical services provided by the program.
3. The provider shall establish a staffing pattern in sufficient numbers and positions necessary for the level of care provided. The staffing pattern shall include the following positions:
   - Senior Licensed Clinician among direct service staff who shall be responsible for the clinical/educational operation of the substance abuse service
   - Registered nurse, nurse practitioner, physician assistant or licensed practical nurse on staff and on-site during hours when medication is dispensed
4. The facility is responsible for providing staffing and supervision in accordance with THPP Behavioral Health General Performance Specifications, DPH and BSAS Licensing requirements.
5. If serving pregnant women, an obstetrician/gynecologist should be available either on staff or through an affiliation agreement.
6. Sufficient staff will ensure coverage on all shifts.
7. Supervision: In addition to supervision requirements set forth in 105 CMR 164.044 Training and Supervision, the provider shall ensure that supervision of nursing staff is overseen by a registered nurse.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. Programs will maintain active affiliation agreements with other providers, including but not limited to:
   - Emergency service providers
   - Acute levels of care
   - Outpatient levels of care
   - Psychiatrist
   - Psychologist substance abuse therapies
   - Mental health services, including psychopharmacological
   - Other services and practitioners necessary to appropriately provide care to Members
2. Program staff coordinates treatment planning and aftercare with the Member's primary care clinician, outpatient, and other community-based providers, involved state agencies, community supports and family, guardian, and/or significant others when applicable. If consent for such coordination is withheld or refused by the parent or guardian of a minor, then this is documented in the member's record.
3. Programs will provide case management including referrals based on a continuum of care and Member educational, vocational, financial, legal and housing needs.
4. Programs will ensure clear communication and coordination of care for members referred from residential, hospital, or detox levels of care.

QUALITY MANAGEMENT (QM)

1. The program will develop and maintain a quality management plan that is consistent with that of Tufts Health Public Plans and which utilizes appropriate measures to monitor, measure, and improve the activities and services it provides.
2. A continuous quality improvement process is utilized, and will include outcome measures and satisfaction surveys, to measure and improve the quality of care and service delivered to Members, including youth and their families.

3. Clinical outcomes data must be made available to Tufts Health Public Plans upon request, and must be consistent with Tufts Health Public Plans' performance standard for acute inpatient services.
4. All Reportable Adverse Incidents will be reported to Tufts Health Public Plans within one business day of their occurrence per Tufts Health Public Plans policy and DMH licensing requirements.
5. A Reportable Adverse Incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services managed by Tufts Health Public Plans or has recently been discharged from services managed by Tufts Health Public Plans.
6. The program will adhere to all reporting requirements of DPH and/or DMH regarding Serious Incidents and all related matters.
7. The facility must submit to DPH/BSAS the data required by DPH.
8. The facility must track by referral source:
    - Referrals for services
    - The outcome of each referral (i.e., admission, etc.)
    - If the substance use disorder treatment provider refuses to accept a referral, the reason for the refusal

PROCESS SPECIFICATIONS

Treatment Planning and Documentation

On admission to the program and prior to treatment, the provider will:
1. Complete a psychosocial assessment, including alcohol and drug history, confirmation of addiction history, treatment plan and initial discharge plan
2. Complete a medical history, physical examination, and a medical clearance of the Member
3. Complete a comprehensive nursing assessment

The provider shall ensure that the Member voluntarily chooses treatment and has signed consent to treatment document. The information listed below shall be provided to the Member and recorded on a consent form, which shall be signed by the Member. A copy shall be provided to the Member. If the Member is under the age of 18, the consent form shall be signed by the Member and the Member's parent or guardian. The information shall also be provided orally:
1. The nature of opioid agonist medications used in opioid replacement therapy, including benefits and risks
2. the distinction between detoxification and maintenance and the availability of short-term detoxification treatment for a period not less than 30 days nor more than 180 days

Provider must complete an assessment of the possibility of: infectious diseases, including HIV, TB, viral hepatitis and sexually transmitted diseases; pulmonary, liver, and cardiac abnormalities; dermatological and neurological sequelae of addiction; and possible concurrent surgical problems.

The assessment shall include the following laboratory tests, results of which must be returned no later than 14 days after admission:
1. Tests to determine liver function;
2. Tests to screen for anemia, coronary risk factors; and
3. Complete blood count and differential blood tests

The treatment plan, with measurable goals and time frames, including detoxification if appropriate, will be completed within the first two days of treatment.

The treatment plan and all subsequent updates shall include documentation of, at a minimum, the following information:
1. A statement of the Member's strengths, needs, abilities, and preferences in relation to his or her substance abuse treatment, described in behavioral terms
2. Evidence of the Member's involvement in formulation of the treatment plan, in the form of the Member's signature attesting agreement to the plan
3. Service to be provided
4. Service goals, described in behavioral terms, with timelines
5. Clearly defined staff and Member responsibilities and assignments for implementing the plan

6. Description of discharge plans and aftercare service needs
7. Aftercare goals
8. The date the plan was developed and revised
9. Signatures of staff involved in the formulation or review of the plan
10. Documentation of disability, if any, which requires a modification of policies, practices, or procedures and record of any modifications made.

Each Member will have his or her own treatment record containing written, signed documentation of each visit and each assessment based on DPH record keeping requirements in Chapter 105 CMR-160.000 and 750.000.

The provider shall ensure that individual treatment plans are reviewed with the Member and amended as necessary. When treatment continues for three months or more, treatment plans shall be reviewed at least once every three months. The Member and staff reviewing the plan shall sign it, and it shall be incorporated into the Member's record.

Discharge Planning and Documentation

Discharge planning begins upon admission to the program and incorporates all aspects of the Member's community life and needs, including but not limited to finances, housing, transportation, social supports, educational needs, and vocational/occupational concerns.

Discharge planning includes Members, and with the Member's permission and as appropriate, parents and/or legal guardians.

Ensure upon discharge that all clinically indicated services are given within seven days of discharge.

Procedures for planning the discharge in consultation with the Member when one of the following conditions is met:

1. Member has received optimum benefit from treatment and further progress requires either the Member's return to the community or the Member's referral to another type of treatment program
2. The Member has achieved the goals of the individual treatment plan

The provider will ensure that the Member has a hard copy of his or her discharge plan and clearly understands what his or her next steps are and how he or she needs to get there.

DOCUMENT HISTORY

- August 2020: Template updates