Managed Care Operations Memorandum
General Operations
MCOPS Memo 2025-02

Date: January 9, 2025

Subject: Use of Fidelity Guidelines to Oversee Opioid Use Disorder Centers of Excellence (OUD-COE) Operations

To: All Physical Health (PH), Behavioral Health (BH) and Community HealthChoices (CHC) Managed Care Organizations (MCOs) – Statewide

From: Juliet Marsala, Deputy Secretary for Long Term Living; Sally A. Kozak, Deputy Secretary for Medical Assistance Programs; and Jennifer Smith, Deputy Secretary for Mental Health and Substance Abuse Services

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Purpose:

The purpose of this memorandum is to provide guidance regarding the use of standardized Fidelity Guidelines by all MCOs to oversee the operations of providers designated as Specialty Type 232 - Opioid Centers of Excellence (COEs) for the purposes of ensuring alignment with program goals and objectives.

Background:

On January 1, 2019, the Department of Human Services (DHS) implemented a State Directed Payment Arrangement requiring PH MCOs to pay $277.22 per member per month for services rendered by COEs using procedure code G9012. On June 7, 2022, DHS received approval of a State Plan Amendment, effective January 1, 2022, adding COE care management services to the Pennsylvania Medical Assistance Program State Plan. This State Plan Amendment was announced via Medical Assistance (MA) Bulletin 01-22-02 on February 14, 2022, and via Public Notice at 52 Pa.B. 98 on January 1, 2022. As a result of this approval, DHS allowed the State Directed Payment Arrangement to expire on December 31, 2022. Exhibit G to the HealthChoices Physical Health Agreement, Appendix G to the Behavioral HealthChoices Program Standards and Requirements, and Exhibit EE to the Community HealthChoices Agreement were updated to reflect COE services as In Plan Services no longer subject to a State Directed Payment Arrangement.

Since January of 2023, MCOs have been responsible for maintaining adequate networks of COE providers who offer services in alignment with the State Plan and relevant provisions of their respective Agreements, as indicated above. While the State Plan, the HealthChoices Agreements, MA Bulletin 01-20-08/08-2011/11-20-02/19-20-01/21-20-01/31-20-08, and MCOPS Memo # 11/2023-016 have all

provided additional detail and guidance regarding COE operations and services, the Department has noted an additional need for guidance.

To promote consistency in COE operations and in MCO oversight of COE providers, the Department convened stakeholders over the course of eighteen months to develop a series of Fidelity Guidelines, which were announced to COEs and MCOs on August 1, 2024. These guidelines are intended to ensure that all COEs provide consistent evidence-based care to individuals seeking treatment for opioid use disorder. The goals of these guidelines are to:

1. Promote standardization of the COE program while allowing flexibility for COEs to adapt to populations served and their geographic landscape;
2. Streamline workflows such as the intake and enrollment process which should lead to increased engagement; and
3. Provide increased specificity to the COE requirements that were released when the COE program began.

The guidelines not only outline expectations for COEs, but also the expectations for MCOs in how the COE program can be monitored.

Discussion:

The Fidelity Guidelines are organized into six categories, with several elements included in each category. The categories are COE Inclusion, Identification, Client Enrollment, Client Initial Assessment, Care Management, and Enhanced Care Management Discharge/Transition. Some elements are mandatory and must be implemented by each COE. Other elements are suggested best practices, which COEs are encouraged to implement but that COEs and MCOs may agree are not applicable to or practical for a specific COE's operational model. When monitoring COE activities, MCOs must ensure that mandatory elements of the Fidelity Guidelines are adhered to but may not require alignment with non-mandatory elements. Instead, MCOs should identify suggested best practices with which a COE is not in alignment and discuss strategies for implementation.

These guidelines, including those that are referenced as mandatory, must be applied to each individual COE client's circumstances. If the application of a guideline to a specific client's case is not justified clinically or would result in harm to that client, MCOs should not penalize the COE for exercising professional judgment to deviate from the guideline as long as the reason justifying that deviation is documented in the client's records.

Throughout the attached Fidelity Guidelines document, instructions and guidance are provided to both MCOs and COEs. In general, in any instance where the terms "must" or "will" are used, the requirement is mandatory and must be adhered to by either the MCO or COE, as applicable. In general, unless otherwise noted below, any instance where terms such as "it is recommended," "are encouraged,"

"consider," "should," "can," or "may" are used, the element is considered a suggested best practice and not a requirement.

1. **The following guidelines are considered mandatory and must be implemented as soon as practical.**

COE Inclusion

- Age
- Medical Assistance eligibility or enrollment
- Opioid Use Disorder diagnosis[1]

Identification

- Documented outreach process
- Documented warm handoff process
- Staff training requirements[2]

Client Enrollment

- Formal, interactive, non-automated enrollment process that includes a brief description of the COE program and consent to participate in the COE program[3]
- Process for 24-hour induction of Medication for Opioid Use Disorder (MOUD), as clinically appropriate
- No requirement to receive MOUD in order to receive COE care management services
- REDCap documentation of enrollment
- Confirmation of COE eligibility at time of enrollment
- Completion of intake assessments and screenings, not to exceed 120 minutes and all completed on the date of enrollment
- Development of rapid care management plan (see Client Initial Assessment section below)
- Completion of COE-specific Enrollment paperwork
- Introduction to case manager
- Staff training requirements

Client Initial Assessment

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[1] Generally, the client's Opioid Use Disorder (OUD) should not be in sustained remission. However, there may be clients who have non-clinical reasons they would benefit from enhanced care management (e.g., Social Determinants of Health (SDOH) needs, other active Substance Use Disorder (SUD) diagnoses, or risk of harm). The COE may provide enhanced care management services to these individuals in sustained remission if they document the reasons that individual wouldn't be best served by another program or service.

[2] Specific staff trainings are not prescribed or required and are to be tailored to the COE's model and makeup; the requirement is that the COE train staff appropriately, not that specific trainings be provided to specific staff.

[3] Consent must be provided by a person who is legally capable to do so. Formal enrollment must be delayed in the event of an individual's inability to consent at the time of enrollment.

- Training of staff involved in assessment process within 1 year of employment in a role that performs in assessments
- Assessment of social determinants of health/health related social needs using a validated tool within 7 days of enrollment in COE services
- Documentation of delays in assessments
- Documentation of identified needs in REDCap
- Validated suicide risk screening
- Availability of medical staff or trained non-medical staff to provide overview of MOUD options
- Conducting or referring to an ASAM Level of Care Assessment that is conducted within 72 hours of enrollment[4]
- Conducting a Brief Assessment of Recovery Capital assessment within 30 days of enrollment

Care Management

- Offering specific care management activities[5]
- Individualizing duration and frequency of engagement to individual client's needs, with at least one interaction per month lasting at least 15 minutes
- Offering mobile engagement services[6]
- Adherence to DHS telehealth/telemedicine policies
- Development and maintenance of care plan[7]
- Addressing emergent medical or mental health needs in-house or through referrals within first 30 days
- Focusing on harm reduction within first 30 days
- Conducting the BARC-10 assessment within the first 30 days and repeating every 6 months
- Completing all screenings and assessments and making connections to all needed services referenced in MA Bulletin 01-20-08/08-2011/11-20-02/19-20-01/21-20-01/31-20-08

Enhanced Care Management Discharge/Transition

- Discharging from enhanced care management where care plan is complete, no new needs are identified, and client can navigate community resources independently
- Discharging from COE when unable to contact client for 60 days, client is incarcerated, client declines services, client transfers care to another provider, or client is deceased
- Discharge documentation requirements

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[4] MCOs may only hold COEs accountable for timely American Society of Addiction Medicine (ASAM) Level of Care Assessments completed by the COE; COEs should not be held accountable if a referral partner was unable to complete a timely referral within 72 hours.
[5] Not all clients will require all listed services, nor will all services be offered during every interaction.
[6] Not every client will want or need to be seen outside of the COE's business location. The COE must have the ability to see clients in locations other than the office.
[7] Care plans are highly individualized documents that should include elements relevant to the client's situation and should be updated as frequently as needed.

- Prohibiting discharge for positive urine drug screen results or lack of improvement in BARC-10 scores

While not expressly included as a Fidelity Guideline, the requirement that all COEs must include a Certified Recovery Specialist (CRS) as a member of the community-based care management team, as communicated in MA Bulletin 01-20-08/08-2011/11-20-02/19-20-01/21-20-01/31-20-08, is considered a mandatory requirement.

2. **The following guidelines are suggested best practices. MCOs should encourage COEs to align with these guidelines to the extent possible and practical, prioritizing implementation and alignment only after all mandatory guidelines described above have been operationalized.**

COE Inclusion
- Duration of enrollment in a substance use treatment program

Identification
- Written strategy for disparity reduction
- Use of Pennsylvania department of Drug and Alcohol Programs (DDAP) trainings and documentation of trainings
- Records of potential referral partner outreach

Client Enrollment
- Identification of the COE as the client's provider of choice
- Rapid access to MOUD prior to formal enrollment in COE services
- Post-consent enrollment activities, including:
    - Meeting with a COE team member[8]
    - Receipt of contact information
    - Determination of residency
    - Rapid assessment of needs
    - Review of screening results

Client Initial Assessment
- Reviewing ASAM Level of Care Assessment results during enrollment
- Documentation of Level of Care Assessment date of completion in medical record
- Obtaining a copy of the Level of Care Assessment with client consent when the assessment is not performed by the COE
- Frequency of repeated assessments of social determinants of health/health related social needs
- Use of MOUD Placement Guide
- Risk screening

[8] Enrollment activities and subsequent care management interactions may be conducted via telehealth when that is the client's preference, when clinically appropriate, and when conducted in conformance with Department telehealth policy.

Care Management

- Continuous assessment of appropriateness of enhanced care management services at the recommended intervals
- Use of a stepped care approach for care management services using the recommended phases
- Engaging family members in care management
- Substance use monitoring approaches
- Conducting interdisciplinary care team meetings that include all providers rendering services to the client within the facility

Enhanced Care Management Discharge/Transition

- Continuing to provide Medication for OUD, primary care, or other services from the COE when enhanced care management is no longer needed
- Continuing services to non-MA eligible individuals using available funding from the Single County Authority

Next Steps:

MCOs must allow COEs until December 31, 2025 to come into alignment with all mandatory elements of the Fidelity Guidelines. MCOs may collect information from COEs regarding their implementation of and progress toward alignment with these guidelines prior to that date but may not take any action against a COE if misalignment is indicated.

MCOs must work collaboratively with COEs to determine the possibility and practicality of implementing suggested best practices and develop an implementation plan for those that apply.

To assist with interpretation and application of these guidelines, MCOs must consult the most current available version of the Fidelity Guidelines Frequently Asked Questions document posted to the OUD-COE webpage of the Department's website Centers of Excellence | Department of Human Services | Commonwealth of Pennsylvania. The version of that document that is current as of the date of the publication of this memorandum is attached.

MCOs must develop review tools and processes that evaluate the COEs' alignment with the Fidelity Guidelines. MCOs must identify required corrective actions and associated timelines for areas of misalignment between COE practices and the Fidelity Guidelines and may not withhold payment from a COE unless a COE has failed to make required corrective action within the agreed-upon timeframe.

Attachments:


Fidelity Workgroup Criteria 2024.pdf


Fidelity Guideline FAQs_20241029.pdf