

1 STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS  
2 EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

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PUBLIC HEARING IN RE:

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6 STATE PLAN AMENDMENT OPIOID  
7 TREATMENT PROGRAMS HEALTH HOME

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10  
11 ARNOLD CONFERENCE CENTER  
12 JOHN O. PASTORE COMPLEX  
13 111 HOWARD AVENUE  
14 CRANSTON, RI 02920

15 AUGUST 19, 2016  
16 10:00 A.M.

17  
18  
19 BEFORE: LISSA DiMAURO, HEARING OFFICER  
20 ALSO PRESENT: DEBORAH FLORIO

21  
22 M.E. HALL COURT REPORTING  
23 108 WALNUT STREET  
24 WARWICK, RI 02888  
25 (401) 461-3331

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1 (COMMENCED AT 10:03 A.M.)  
2 HEARING OFFICER DIMAURO: I  
3 think we are going to call the meeting to  
4 order. Welcome. We are here today regarding a  
5 public hearing concerning Rhode Island's  
6 submission of a proposed Medicaid State Plan  
7 Amendment to the Centers for Medicaid and  
8 Medicaid related to Opioid Treatment Program  
9 Health Home Services. The State Plan Amendment  
10 seeks to bring OTP HH Services into managed  
11 care in order to foster improved coordination  
12 of care, to increase efforts in identifying  
13 individuals who would benefit from this service  
14 and foster collaboration between providers of  
15 managed care organizations.  
16 This proposal also seeks to set  
17 one rate for OTP health home services  
18 regardless of the member's line of business.  
19 The proposed rates of accounts for only OTP HH  
20 services does not include the cost of  
21 medications and is based on the past  
22 utilization of OTP HH services across all lines  
23 of business.  
24 The hearing is being conducted

1 under the provisions of Chapter 40-6, 40-8,

2 40-7.2, and 42-35 of the Rhode Island General  
3 Laws, as amended. Today is Friday, August 19,  
4 2016. My name is Lissa DiMauro, and I will be  
5 the Hearing Officer for today's proceeding.  
6 Before we start, so as not to  
7 interrupt, if folks could turn off their cell  
8 phones, that would be fabulous or pagers or  
9 whatever.  
10 The purpose, as you probably  
11 know, of the hearing today is to afford  
12 interested parties an opportunity to comment on  
13 the State Plan Amendment. This hearing is  
14 intended for your participation only. It's not  
15 intended as a means of providing a forum for  
16 discussing, debating, arguing or otherwise  
17 having any dialogue on the record with members  
18 of the Executive Office of Health and Human  
19 Services.  
20 Many of you have signed on to  
21 speak. If there are people in the room who  
22 have not signed in to speak and would like to,  
23 just see Crystal at the desk. Also, if you  
24 would like copies of the testimony, please also

1 make sure you sign in with your e-mail address  
2 and we will get that out to you. We will try  
3 to allow around five minutes per presentation.  
4 I think we are going to be okay with time; but  
5 if we getting close to the 11:30, then we may  
6 end up cutting testimony a little short. I  
7 don't think we are going to run into that.  
8 If you would, when you come to  
9 the podium, could you state your name and  
10 agency that you're with clearly so that our  
11 Stenographer can take your information down.  
12 If you have copies of written testimony, we  
13 would love to have that as well for our  
14 records. Let's see. After the time has  
15 elapsed for submission of written testimony,  
16 the Executive Office of Health and Human  
17 Services has three options under State law.  
18 The first is file the proposed  
19 State Plan Amendment as is with the Centers for  
20 Medicare and Medicaid.  
21 Second option is to file with  
22 minor changes like spelling, punctuation, et  
23 cetera.  
24 And the third option is to make

1 major changes in what you see before you today,  
2 which would necessitate a new public hearing.  
3 Are there any questions on how the public  
4 hearing is run today?  
5 (PAUSE)

6 HEARING OFFICER DIMAURO: What  
7 I'm going to do now is -let's see. I'm going  
8 to call the first speaker, and again, once you  
9 come -when you come to the podium, if you  
10 could just clearly state your name and agency;  
11 but, the first speaker today is David Spencer.  
12 MR. SPENCER: My name is David  
13 Spencer. I'm president CEO of the Substance  
14 Abuse and Mental Health Leadership Council of  
15 Rhode Island. The Council represents 27 mental  
16 health and substance abuse treatment and  
17 prevention agencies in the State of Rhode  
18 Island. I'm here today to express concern over  
19 the State Plan Amendment affecting our five  
20 opioid treatment programs. Several speakers  
21 will follow to address the specifics of these  
22 issues, however, I would just like to give an  
23 overview of some of our concerns.  
24 Approximately one year ago our

1 community mental health centers went through a  
2 transition to health home; and to be candid, it  
3 was a disaster. Despite the weekly meetings  
4 held, the key planning was essentially held  
5 behind closed doors and driven by BHDDH. The  
6 communication was fragmented and the  
7 implementation was rushed. As an example, the  
8 retooling of provider billing systems was  
9 delayed to accept payments because they weren't  
10 given the specifics until after the January 1  
11 implementation date. The State wasn't even  
12 prepared to accept a bill when the roll-out  
13 began.

14 Because of the lack of  
15 communication, the mental health centers ended  
16 up with an unintended cut of \$5 million. The  
17 impact with three mental health centers ended  
18 up maxing out lines of credit and essentially  
19 cash flow stopped to all the agencies. One  
20 CMHC even had to cut staff salaries by 10  
21 percent.  
22 It's now August, eight months  
23 later, and they are, there are still  
24 reimbursement and payment problems with the

1 mental health centers. Does this kind of  
2 planning make any sense?  
3 Recognizing these past problems  
4 and trying to avoid a reoccurrence, the OTP's,  
5 the MCO's, OHSS and BHDDH started meeting nine  
6 months ahead of the July 1 start date. The  
7 minutes from those meetings reflect that we  
8 were consistently given assurances that no  
9 major changes were needed. The rates and

10 services were not going to change. I recall  
11 MCO and State officials stating, why change  
12 programs and systems that work and meet the  
13 needs of their patient? Why would we want to  
14 relieve the problems experienced by the CHMO  
15 health home transition?  
16 But unfortunately, there were no  
17 lessons learned from the disastrous roll-out of  
18 the mental health centers health home  
19 implementation. Watching this unfold prompted  
20 the Leadership Council to request help from the  
21 State Legislature.  
22 A Senate resolution was  
23 submitted, passed and signed and became part of  
24 the 2016 budget. I'm just going to read two

1 pieces from that resolution. Whereas, levels  
2 of care within the existing patient acuity  
3 model should be defined and agreed upon by  
4 stakeholders including the opioid treatment  
5 program providers. And whereas, staffing  
6 models and reimbursement rates should be  
7 designed with input from the opioid treatment  
8 programs. Those are just two sentences from  
9 that resolution. And in our view, the Senate  
10 resolution has clearly been violated and  
11 basically ignored. OTP providers have not been  
12 involved in discussions and planning. It was  
13 even acknowledged by the State that  
14 communications could have been little better.  
15 Just to give you two examples.  
16 On January 1st of 2016, all the methadone  
17 treatment services went into plan. There were  
18 no, there was no communication to the agencies  
19 in this regard and most found out after the  
20 January 1 start date. Also, on May 30, one  
21 month before the July 1 start date for health  
22 homes, the Leadership Council was contacted  
23 that a discussion on changing the rates needed  
24 to occur. The intent was to reduce the

1 reimbursement for the health program from \$87  
2 to \$53 while increasing the rate by five  
3 dollars for methadone treatment. Why did the  
4 State wait until one month before  
5 implementation to inform the programs of this  
6 significant change especially with biweekly  
7 meetings taking place for months? Why are we  
8 taking a potential evidenced-based program with  
9 excellent outcomes and decimating it by  
10 reducing the funding by 40 percent? The Rhode  
11 Island OTP health home program was cited  
12 recently at an overdose summit held in  
13 Washington and also at the annual Hill Day held

14 in Washington by the President's drug policy  
15 director, Michael Botticelli, as a model for  
16 the country. This program, Rhode Island  
17 program was a model for the rest of the  
18 country. This model will cease to exist and  
19 positive outcomes will be lost if these changes  
20 are approved.

21 In summary, we are concerned  
22 about the negative impact this is going to have  
23 on health home staffing, patient care and the  
24 financial audit of the program and also

1 potential concerns from CMS with the State's  
2 plan of taking funding from treatment to  
3 subsidize the health home program, which is not  
4 treatment. It's care coordination. Here we  
5 are in mid August, nearly two months after the  
6 start date of our OTP programs. They have  
7 receivables that total almost a million  
8 dollars, and there's no word as to when  
9 payments will flow.

10 Just as we feared, this is the  
11 CHMO transition to health homes revisited. Our  
12 opioid treatment programs have been doing an  
13 outstanding job preventing overdoses and saving  
14 lives for 40 years with no waiting lists.

15 Don't these programs and their patients deserve  
16 better?

17 HEARING OFFICER DIMAURO: Thank  
18 you, Mr. Spencer. The next person to speak is  
19 Herbert Brennan.

20 AUDIENCE: If you don't mind, we  
21 had a, we had an order of speaking that perhaps  
22 did not get communicated to you.

23 HEARING OFFICER DIMAURO: Okay.

24 MS. FLORIO: It's the way it

1 is -

2 AUDIENCE: You want to do it by  
3 sign-up?

4 MS. FLORIO: Yes. That's the  
5 way we are supposed to do it. Go ahead.

6 DR. BRENNAN: Good morning.

7 Everyone. Thank you for the opportunity to  
8 speak here this morning, particularly Lissa and  
9 Crystal.

10 MS. FLORIO: Just state your  
11 name, please.

12 DR. BRENNAN: I'm sorry.

13 Dr. Herbert Brennan. Crystal, for being so  
14 dignified, of course; and then the decorum -  
15 from my own experience, the decorum of these  
16 meetings is everything, and it's clear that you  
17 have done this before. So, thank you. My name

18 is Dr. Herbert Brennan. I'm a general  
19 internist, a primary care physician in my own  
20 private practice in East Greenwich, the  
21 hometown where I grew up. I have been in  
22 practice for 21 years there. And how do I, how  
23 do I come to be involved in this issue, in this  
24 topic, in this vein of health care? I have

1 tried to remain civically involved for all of  
2 my adult years, and of course, much of that is  
3 in the health care realm itself.  
4 Currently, I'm a member of the  
5 Board of Directors of the Rhode Island Primary  
6 Care Physicians Corporation, a 25-year  
7 independent practice association, a group of  
8 independent small business, private practices;  
9 and I'm their treasurer as well as an officer.  
10 I had the honor of sitting on the advisory  
11 council to our health insurance commissioner  
12 and have done so since the inception of that  
13 advisory council. So, I have tried to keep my  
14 fingers in and my heart and mind in issues that  
15 relate to our community and particularly  
16 community health given by, given my profession.  
17 So, what do I bring to this, if  
18 anything? Certainly, with my training as an  
19 internist and with my own practice, as you can  
20 imagine in East Greenwich, I was no and am no  
21 expert on the treatment of opioid addicted  
22 patients when I started with this. I was  
23 invited by Mr. Ken Richardson, who's the  
24 principal in The Journey, to help him with the

1 health home aspect of what you all, what the  
2 OTP's do. What I could bring or lacked in  
3 opioid management, what I could bring was my  
4 experience from what we know as the  
5 patient-centered medical home, which is really  
6 the health home equivalent in the primary care  
7 world.  
8 This idea of identifying the  
9 social determinants of illness, identifying the  
10 high-cost illnesses, the social determinants of  
11 those illnesses and working to increase quality  
12 and value, that is, as we have heard, right  
13 treatment, right place, right time.  
14 Practically speaking, it's about pulling costs  
15 out of medical care because we know there's so  
16 much, there's so much waste and that revenue  
17 needs to be put to work, needs to be put to  
18 work to lower the cost of health care and  
19 provide better care.  
20 We, my own personal goal in all  
21 of this, aside from any medical clinical

22 training or the like, honestly, is to try to  
23 help restore dignity to these human beings that  
24 we treat; because such has not been the case

1 traditionally. Our patients in the vernacular  
2 were second-class citizens. They were junkies  
3 and they haven't been afforded the dignity that  
4 they deserve just not just as patients but as  
5 human beings, and I will say having since been  
6 involved with you all through the OTP's, I'm  
7 just in awe in how you share that goal; and at  
8 the core of it is human dignity in treating  
9 others as we would like to be treated  
10 ourselves. That's my own personal goal to  
11 this.  
12 The economics of it, of course,  
13 cost of medical care in this country is on an  
14 expedient and unsustainable rise. I have  
15 heard it said that, if we are not careful,  
16 we will have the most expensive health care  
17 system in the world but we won't have roads and  
18 bridges and trains and buses to get to the  
19 hospital. It will consume all of our GNP, so  
20 clearly that needs to be mitigated. What we do  
21 know and we have good data to support this  
22 particularly through Medicaid is that resources  
23 devoted to primary care and behavioral health  
24 do not raise the cost of health care. They are

1 the only two caveats that lower that cost of  
2 care. Revenue driven virtually to any other  
3 specialty care, cardiology, pulmonology, you  
4 name it, increases that and worsens that  
5 problem. It's primary care and behavioral care  
6 alone that will show that if we devote adequate  
7 resources to it we can bend that cost curve  
8 down.  
9 Relative to our experience with  
10 the patient-center medical home, the resources  
11 that have been devoted to the patient-center  
12 medical home, in the analogous to your health  
13 home have been very significant. Even the  
14 health insurance commissioner, Chris Kohler  
15 (phonetic) and Dr. Hitner, that succeeded him,  
16 were his or her affordability initiatives are  
17 really working very, very hard in devoting  
18 significant resources to try to solve this  
19 issue on the primary care side. The results  
20 have been limited, to be quite frank, and they  
21 are quite difficult to measure and to imagine;  
22 and this is because I would partially argue  
23 that this is because the traditional and  
24 somewhat cumbersome approach or insufficient

1 plan-based approach that we have taken to the  
2 patient-center medical home. We should be  
3 seeing, I think, far greater return on  
4 investment in that program than we have, and  
5 this approach emanates our stuttering, failing  
6 approach to both the primary care in general.  
7 Here in Rhode Island we have our beautiful  
8 medical school. We have our several residency  
9 programs. We are an engine for producing young  
10 doctors, hopefully primary care doctors, yet, I  
11 don't know. None of them stay. They go to  
12 higher paying subspecialty programs, and they  
13 certainly flee Rhode Island.  
14 Once again, this year U.S. News  
15 Report rated us right there with Arkansas as  
16 the last place in the country that the primary  
17 care physician should practice. Again, we are  
18 working hard on the primary care patient  
19 medical home aspect but we are not bringing the  
20 return of investment that we should see. The  
21 Rhode Island health home model and experience  
22 has, as was mentioned, has been a break through  
23 nationally. The performance has been breath  
24 taking.

1 In March of 2015, I had attended  
2 the AATOD meeting, national AATOD meeting where  
3 we were thrilled that the office, the office  
4 itself, BHDDH, had released early data 18  
5 months into the program that the member per  
6 month savings was in the neighborhood of \$1500  
7 per member per month. Now, with -you know,  
8 however many, 2600 patients that are enrolled,  
9 if you do the math there, and the savings are  
10 just astonishing, and again, I only wish we  
11 would emanate that on the primary care side of  
12 things.

13 Here's our chance, and I don't  
14 know what drives all of this, be it funding  
15 source changes for the sake of convention or  
16 conformity. Be they blanket State budget cuts,  
17 I don't know. Whatever the prevailing impetus  
18 is, I think we are about to throw our beautiful  
19 baby out with the bath water, and that would be  
20 an error.

21 Instead we, do we prove to the  
22 country that Rhode Island can lead in  
23 something? Indeed, we are leading here. We  
24 have some very, very talented civilian talent

1 at work here. The OTP owners and their staff,  
2 Mr. Spencer who spoke, Senator Tassoni, who's a  
3 strong advocate, Dr. Susan Storti, a nationally  
4 recognized leader in this realm among others.

5 The size and collaborative nature of Rhode  
6 Island make this a perfect incubator for what  
7 we are trying to do. The need, relative to  
8 opioid dependence and morbidity and mortality  
9 with it. Rome is burning, and I think here,  
10 from what I understand, we may be about to blow  
11 it.

12 I urge you to recognize what you  
13 have, what you have built. Get back together  
14 with the OTP's. Build upon and enhance what  
15 together this program can be, and that is a  
16 national leader. It's been so long. It's been  
17 too long since Rhode Island has distinguished  
18 itself positively as an industry leader. If we  
19 can resist conformity here and brace  
20 innovation, we can make our mark in history. I  
21 thank you very much for taking my testimony  
22 this morning.

23 HEARING OFFICER DIMAURO: Thank  
24 you, Dr. Brennan. The next speaker is Greg

1 McWilliams.

2 MR. McWILLIAMS: Good morning,  
3 folks. I'm Gregg McWilliams. Executive  
4 director of Addiction and Recovery Institute.  
5 I'm here to talk about the significant decrease  
6 in the reimbursement rate to the health home  
7 program. OTP health homes have provided  
8 improved health, cut Medicaid cost's and  
9 provided positive outcomes to our patient  
10 population as well as received national  
11 recognition at the last AATOD conference. All  
12 OPT health home service providers are deeply  
13 concerned about a significant decrease in the  
14 reimbursement from 87.52 per patient weekly to  
15 52.50 to per patient weekly.

16 Health homes team configuration  
17 originally created in the state plan amendment  
18 was based on the 87.52 rate; and according to  
19 the state plan amendment, this staffing  
20 configuration must remain intact. The  
21 approximately monthly salary cost for each  
22 health home team is \$36,000. Between the five  
23 OPT providers there are over 20 teams. With  
24 the 53.50, reduced rate salaries will not be

1 able to be paid because the reimbursement will  
2 not cover the bare minimum staffing  
3 requirements set forth by the SPA.

4 It was suggested by BHDDH to draw  
5 money for the treatment dollars to pay for the  
6 case managers that are currently non-clinical  
7 employees working for the OPT'S health home  
8 program. The shift case managers over to the

9 treatment team would be putting them in a  
10 clinical role. This makes little sense.  
11 That's not why they were hired. They do not  
12 have the appropriate credentials and are not  
13 working toward those credentials, which is a  
14 State regulation. They do not want to fill  
15 that role. To put them in a clinical role will  
16 call for an increase in salary making the  
17 increased money on the treatment side basically  
18 a wash. There is a good possibility they would  
19 resign. Shifting case managers to treatment is  
20 not the solution.  
21 OTP's are required under their  
22 license to receive CARF accreditation for  
23 health home. This cost each clinic \$3,000 to  
24 receive this accreditation. OTP's are not able

1 to operate with this rate reduction. The  
2 fallout will be staff layoffs and most  
3 importantly our patients who have been thriving  
4 and improving the quality of their lives will  
5 be the ones who have to pay the ultimate price.  
6 It is also important for us to  
7 point out that since there was no communication  
8 with the providers, EOHHS and the MCO's have  
9 been unable to come to an agreement regarding  
10 their contracts. The result of this is that  
11 the MCO's have received their funding to pay  
12 the providers both July 1 and August 1 but will  
13 not make payments until their contract is  
14 completed with EOHHS.  
15 So, there is a sum of money to be  
16 allocated to the providers that is sitting in  
17 an account, no doubt collecting interest, while  
18 the providers continue with uncompensated  
19 services and struggle to make payroll. Some  
20 are utilizing lines of credit, which are  
21 accruing interest, at the same time the MCO's  
22 are both unwilling to provide advanced payment  
23 for services even though they have received the  
24 funding.

1 HEARING OFFICER DIMAURO: Thank  
2 you, Mr. McWilliams. The next speaker is  
3 Victoria DaPonte.  
4 DR. DaPONTE: Good morning. My  
5 name is Dr. Victoria DaPonte. I'm the clinical  
6 director for the Center for Treatment and  
7 Recovery. And following up with what  
8 Mr. McWilliams was talking about, the contracts  
9 that will drive our payments have also raised  
10 some other issues that I'm sure people, other  
11 clinicians haven't given much consideration to.  
12 United Health specifically will

13 require, if we expand our services, that any  
14 service that's provided by a non-clinical staff  
15 who does not have an MPI be paid for using  
16 another person's MPI. That, to me, constitutes  
17 fraud. Although the insurance company may say  
18 that that's okay, and even if CMS were, at some  
19 point, to say it's okay, most of us who are  
20 licensed or members of professional  
21 organizations and those organizations have  
22 codes of ethics, the codes of ethics which I  
23 fall under, which is the American Counseling  
24 Association is clear. I would be committing

1 fraud for my MPI number to go on to a billing  
2 form means, according to my code of ethics,  
3 that I have provided that service myself. I  
4 have not supervised that service. I haven't  
5 developed that service. I provided that  
6 service.  
7 Taking that into consideration,  
8 to provide that number without my permission  
9 would be causing the clinic to also commit  
10 fraud. And I would venture to guess also  
11 United Health, as they are saying this is what  
12 they want us to do. As a clinical director, I  
13 know I assume liability for the people who work  
14 for me and with me. I certainly take on direct  
15 and vicarious liabilities and I accept that as  
16 part of my role. With the use of the MPI  
17 number and the way that it's been proposed, I  
18 will now assume liabilities that are unknown to  
19 me, and I, as a professional with independence  
20 license who works for a clinic who's licensed  
21 and accredited, we cannot accept that  
22 liability.  
23 In closing, because of these risk  
24 management concerns requiring the use of one

1 person's MPI number to bill for the health home  
2 services provided by another person, it's  
3 prohibiting some of us, as providers, from  
4 extending the treatment services much needed in  
5 our community, which goes against,  
6 realistically speaking, what the Governor is  
7 hoping to do with the opioid epidemic. Thank  
8 you.

9 HEARING OFFICER DIMAURO: Thank  
10 you, Dr. DaPonte. The next speaker is Jamie  
11 Savage.

12 MR. SAVAGE: Hi. Good morning.  
13 My name is Jamie Savage. I'm the director of  
14 the Discovery House in Providence. So, I'm  
15 going to provide a brief history. Research has  
16 shown that methadone maintenance is more

17 effective when it includes individual  
18 counseling. As an evidenced-based and  
19 best-practice intervention for opioid  
20 addiction, methadone has been a leading  
21 treatment intervention for over 40 years.  
22 Clinics like Discovery House, Additional  
23 Recovery Institute, Center for Treatment  
24 Recovery, CODAC and the Journey save lives.

1 Methadone and other  
2 evidenced-based medications has provided, has  
3 proved, excuse me, to be clinically effective  
4 and to significantly reduce the need for  
5 inpatient detox. services. Individuals in  
6 opioid treatment programs receive a more  
7 comprehensive individually tailored program of  
8 medication and behavioral therapy. With the  
9 addition of health homes, our clinics can now  
10 effectively provide support services that  
11 address the needs of most of our patients.  
12 Prior to health homes, clinicians and OTP's  
13 were required to provide case management and  
14 counseling.

15 Having an identified structured  
16 team has allowed clinicians to focus on the  
17 therapy that they provide. Health home teams  
18 can then focus on filling the gaps to support  
19 improvement in individual's psychologies and  
20 sustainability in their lives. The ultimate  
21 goal of medication-assisted treatment like  
22 methadone is full recovery, including the  
23 ability to live a self-directed life. This  
24 treatment approach has been shown to improve

1 patient survival, increased retention in  
2 treatments, decrease illicit opioid use,  
3 increase patient's ability to gain and maintain  
4 employment and improve birth outcomes among  
5 women who have substance abuse disorders.  
6 Research has also shown that  
7 these medications and therapies contribute to  
8 lower a person's risk of contracting HIV.  
9 Although the evidence clearly talks about the  
10 benefits individuals receiving treatment in  
11 opioid treatment facilities, discrimination,  
12 stigma against folks on methadone has not  
13 changed. Other factors include lack of  
14 training for physicians and negative opinions  
15 towards methadone in communities among  
16 professionals and health care providers.  
17 So, why health homes in OTP? I  
18 have six points. Patients receiving methadone  
19 maintenance would benefit from health care  
20 coordination. OTP clients, patients usually

21 present with multiple issues, co-occurring  
22 disorders. OTP clients often have poor  
23 connections for primary care, do not attend  
24 wellness groups or appointments and are not

1 necessarily connected to the special providers  
2 and community that they need. OTP patients  
3 often fear stigma associated with methadone  
4 maintenance and treatment. OTP patients may  
5 have difficulty accessing health care.  
6 OTP's -this is an important one. OTP's see  
7 the majority of the population every day,  
8 leading to increased access to provide  
9 interventions unlike like any other health home  
10 in the State of Rhode Island.  
11 Through linkages, health home  
12 teams have enabled OTP's to provide the  
13 capacities to manage and coordinate a continuum  
14 of specialty and primary care health services  
15 along with the long-term care services and  
16 other supports. Health home teams with an  
17 existing structure of OTP's work to minimize  
18 disruption in care and provide coordination  
19 internally and external.  
20 So, what does this mean to the  
21 people that we serve? With the current team  
22 configuration -and here's an example of the  
23 supportive services that we provide to assist  
24 patients towards their recovery. There was a

1 patient admitted into Discovery House.  
2 Although the patient had some downfalls, you  
3 know, for the most part, he was sticking with  
4 the program. He was working, living in a sober  
5 house. Later on, he presented back to our  
6 clinic confused, physically battered. Health  
7 home team asked what happened, and he went into  
8 history. He had been using illicit medication.  
9 He claimed that he was kicked out of his sober  
10 living environment. His truck was stolen and  
11 then he was jumped for his money. He claimed  
12 that he was kicked out and decided that it  
13 was -I'm sorry. So, the health home team  
14 contacted his place mate. There was an  
15 argument. He had gotten kicked out. The RN  
16 developed a care plan. Vitals were taken for  
17 base line. Patient was alert. Had difficulty  
18 remembering events that happened before he was  
19 attacked. The health home team was able to  
20 contact the sober house, was able to find out  
21 what was going on with his truck. And due to  
22 the patient's head trauma memory laps, the  
23 health home decided he needed medical attention  
24 right away.

1 With the patient's permission,  
2 the team arranged for the patient's parents to  
3 pick up his vehicle from the sober house. His  
4 case manager walked with him down the road  
5 because he did not have transportation. We  
6 could not get transportation from Logistic  
7 Care. Walked him to the hospital. After a few  
8 nights in the hospital, he stabilized. After  
9 discharge arrangements were made to allow the  
10 patient back into the house home -I'm sorry,  
11 into the sober house. Patient is now, our  
12 patient is now working daily, is living on his  
13 own and continues to be on a positive path to  
14 recovery.

15 So, part of that is their  
16 outcomes. That is an example of an outcome.  
17 We have developed patient satisfaction scales.  
18 97.8 percent of our patients felt that our  
19 health home staff respected them and listened  
20 to them. They were satisfied in the assistance  
21 and coordination of care that they were  
22 receiving and that was 94.6 percent. They  
23 believed in their health home and their well  
24 being were considered as part of the services

1 received, and they agreed that there were more  
2 learning skills to be more effective and more  
3 efficient and more effective in their living  
4 and would address daily problems and they would  
5 follow through with their provider given the  
6 support from the health homes.

7 So, in closing, health homes in  
8 Rhode Island has become nationally recognized  
9 for its design and its outcomes. When changes  
10 are made -and this is basic research, basic  
11 program design -even the slightest unassumed  
12 change can impact outcomes. Changes made to  
13 the programming should be and have to be  
14 supported and driven by data to improve those  
15 outcomes. The OTP health home is not broken.  
16 It is unclear that the suggested changes to the  
17 State Plan Amendment is data driven based on  
18 the lack of information and transparent  
19 communication from those that have developed  
20 the new amendments.

21 The ideas presented in the  
22 amendments are valuable, but the conversation  
23 needed to include all the stakeholders. As the  
24 representative of Discovery House and a

1 representative of our patients that we treat,  
2 we are requesting to open the State Plan  
3 Amendment. We need to be active participants

4 in creating a document for submission to CMS  
5 that Rhode Island can be proud of and continue  
6 to be considered leaders in this field. Thank  
7 you.

8 HEARING OFFICER DIMAURO: The  
9 next speaker is Michael Rizzi.

10 MR. RIZZI: I would like to let  
11 Linda Hurley -

12 MS. HURLEY: We didn't realize  
13 the procedures.

14 HEARING OFFICER DIMAURO: Okay.  
15 No problem.

16 AUDIENCE: And Meg.

17 HEARING OFFICER DIMAURO: Okay.

18 MS. HURLEY: I'd like to thank  
19 you as well for the opportunity this morning to  
20 provide comment, the comment for the record.  
21 I'm going to skip a bit of what I have written  
22 because there isn't a lot of sense in the  
23 redundancy here. Everyone has been quite  
24 eloquent about the tremendous outcomes that we

1 have seen for our patients, for our community  
2 and what we have experienced as a group of  
3 service providers committed to a mission that  
4 we share.

5 My name is Linda Hurley. I'm  
6 the current CEO of CODAC Behavioral Health  
7 Care, a member of OTARI and have been  
8 practicing in the substance abuse field for 30  
9 years, 26 of which have included the provision  
10 of medication assisted treatment.

11 Today I would like to speak to  
12 the remarkable gift the health home program has  
13 been to the population served. A population  
14 who's often been discriminated against,  
15 disparate population and marginalized. They  
16 are the highest, I represent, the highest in  
17 multiple comorbidities and co-occurring  
18 behavioral health care diagnoses, as well as  
19 the highest users of Medicaid and public  
20 dollars.

21 To reiterate, the collected data  
22 and related outcomes speak to the success of  
23 this initiative as it was designed. The  
24 concern I'm representing is the unintended

1 consequence that we, as service providers, may  
2 not be providing this proven successful level  
3 of health home services as we move forward on  
4 the new structures. We have addressed the  
5 vulnerabilities and resulting needs of our  
6 population currently by creating an acuity  
7 structure that takes into account each

8 patient's unique needs and then applies one of  
9 these three approaches to meet those needs.  
10 Level three acuity category  
11 represents those patients who are known to have  
12 chronic conditions. Here the intervention is  
13 to assist them in maintaining or improving  
14 their self management of that condition.  
15 Level two is that of highest  
16 risk, acute conditions, and requires most of  
17 our current resources. These patients are  
18 being diagnosed with untreated medical and  
19 mental health conditions, needs of social  
20 services like housing, legal services and  
21 others, and may be continuing to practice in  
22 high-risk behaviors. Here the health home team  
23 provides a high level of medical and other case  
24 management.

1 Level one acuity is that of  
2 low-to-moderate need with low-to-moderate  
3 motivation for change. The services provided  
4 to patients in this level of acuity are of less  
5 intensity and focus greatly on prevention to  
6 preclude advancement into the Levels two and  
7 three that we just described. So, here in  
8 acuity Level one, quality of life can be  
9 impacted greatly, future public dollars saved  
10 and the health of our communities improved in  
11 an extremely cost effective manner because the  
12 intervention at this level is that of least  
13 intensity. This cost effective preventive  
14 approach is the approach which will be most  
15 threatened by a decrease in health home dollars  
16 and a resulting decrease in home health  
17 entities ability to provide the services.  
18 Decreased dollars force its providers to triage  
19 potentially leaving prevention services behind.  
20 A second unintended consequence  
21 is the emergence of Medicaid populations in  
22 opioid treatment programs who are not receiving  
23 services reimbursed by the methadone bundle.  
24 As we move forward into the intended blended

1 model, as it has been referenced, using  
2 treatment funds to support health homes is not  
3 an option for those patients receiving other  
4 medications in the treatment of their opioid  
5 dependence. For example, OTARI members -this  
6 is, this is critical because this is an example  
7 of probably one of the first concrete  
8 unintended consequences we have found, and we  
9 don't know how many more there will be as a  
10 result of the lack of discussion with all  
11 participants in the development of this new

12 proposed model.  
13 So, OTARI members discussed with  
14 representatives of BHDDH, Rebecca Boss, acting  
15 executive director, Linda Mahoney, administer  
16 BHDDH, two weeks ago at the leadership, the  
17 proposed structures of Centers of Excellence.  
18 Within that presented structure is a population  
19 of patients who receive buprenorphine as a  
20 pharmacological intervention and will have the  
21 option to continue to receive their services at  
22 that Center of Excellence after six months.  
23 And in parentheses here, I have, one, it is  
24 important to understand that one of the primary

1 goals of the COE is to assist the patients into  
2 office-based community primary care practices  
3 after a six-month stabilization period. That's  
4 a goal.  
5 So, if the patient chooses to  
6 remain at the COE after six months, the  
7 reimbursement model moves to that of fee for  
8 service. I know this is complex and probably  
9 what folks would refer to as being in the  
10 weeds, but this is a serious administrative and  
11 financial unintended consequence. This  
12 population is also eligible for health home  
13 services. However, at this point, OTP health  
14 home providers have no treatment bundle from  
15 which to borrow to reconcile the decrease in  
16 health home dollars with the, along with the  
17 continued mandated intensity of services. This  
18 borrowing or blending, borrowing from treatment  
19 to support health home services is suggested in  
20 the model presented. It's ultimately either  
21 OTP health home entities provide the mandated  
22 services from a regulated mandating staffing  
23 structure at a 39 or a 40 percent reduced rate,  
24 or due to the simplistic, if not flawed

1 accounting reflected in the health home COE  
2 blending, this vulnerable population becomes  
3 even more vulnerable. So, thank you so much  
4 for your time and listening to our concerns.  
5 HEARING OFFICER DIMAURO: Thank  
6 you, Miss Hurley. The next speaker is Megan  
7 Clingham.

8 MS. CLINGHAM: Good morning,  
9 everyone. My name is Meg Clingham. I am the  
10 director of the State Mental Health Advocates  
11 Office. Just for the record we are a small  
12 semi-independent State agency. We are a law  
13 office who represent people with mental health  
14 and substance abuse issues. As everybody in  
15 this room knows, mental health issues and

16 substance abuse issues are very, very often  
17 co-occurring, and many of the clients who I see  
18 on a daily basis struggle with both mental  
19 health issues and substance abuse issues. I'm  
20 not going to purport to be an expert at all on  
21 funding and on Medicare. I can't get into the  
22 weeds on that, but I think other people have  
23 explained it well.  
24 My concern is that with -we

1 already have a struggling system of providing  
2 treatment to the most vulnerable citizens in  
3 Rhode Island. People with substance abuse  
4 disorders and people with mental health issues.  
5 I fear that with these cuts, and correctly they  
6 are cuts in reimbursement, that the providers  
7 will not be able to provide sufficient  
8 treatment, adequate treatment to prevent people  
9 with substance abuse disorders and their mental  
10 health disorders from being exacerbated to the  
11 point where it is much more costly to treat.  
12 Part of the staff mandate in my  
13 office is to protect the civil rights of people  
14 with mental health and substance abuse issues.  
15 And one of those fundamental civil rights, both  
16 morally and legally, is the right to adequate  
17 treatment.  
18 As the option for treatment  
19 erode, I fear that the result is going to be  
20 much more costly to the State in the long run.  
21 For example, when people are not able to get  
22 coordinated substance abuse treatment and  
23 mental health treatment at a sufficient level  
24 that they need, in a timely manner, and as I

1 say coordinated, the results that I have seen  
2 personally in my 25 years of experience as a  
3 lawyer both as a public defender as now as the  
4 mental health advocate is much more costly,  
5 hospitalization, criminalization of people,  
6 prison, court costs, homelessness. And as I  
7 said, we have a moral obligation to people, a  
8 legal and moral obligation. The State  
9 leadership is very supportive of efforts to  
10 address the opioid crisis. There's a lot of  
11 talk about it. We read about it in the paper  
12 every day, and I applaud that because it is  
13 very, very necessary.  
14 I don't understand how the  
15 funding, reducing the rates by 40 percent is  
16 addressing the opioid crisis and addressing  
17 people's needs. I'm very, very concerned that  
18 the centers will reduce their ability to keep  
19 qualified staff, to provide comprehensive

20 individual treatment plans, which include  
21 necessary coordination for substance abuse and  
22 mental health treatment; and with the erosion  
23 of the system, then we are just going to see  
24 more of the opioid crisis, more people with

1 untreated mental health needs who are going to  
2 be homeless, on the streets, in jail and costly  
3 hospitalizations. So, I am very concerned  
4 about any further erosion of the treatment  
5 that's available to my clients. Thank you.  
6 HEARING OFFICER DIMAURO: Thank  
7 you. I believe the last speaker is Michael  
8 Rizzi.

9 MR. RIZZI: Good morning. Thank  
10 you. I apologize for the sunglasses. I'm not  
11 trying to be anything other than responsive to  
12 dilated pupils, so I'm not just trying to be  
13 cool. I was -well, first of all, thank you  
14 for the opportunity to provide comment today.  
15 My name is Michael Rizzi. I'm the chair of the  
16 Opioid Treatment Association of Rhode Island,  
17 OTARI, O-T-A-R-I, which is comprised of the  
18 five licensed and accredited opioid treatment  
19 programs in Rhode Island, Addiction Recovery  
20 Center, the Center for Treatment and Recovery,  
21 CODAC, Discovery House and The Journey to Hope,  
22 Health and Healing. In addition to having the  
23 privilege of serving as OTARI's chair, I  
24 currently represent OTARI on the board of the

1 American Association for the Treatment of  
2 Opioid Dependence as well as being AATOD's  
3 treasurer and chair of the Association's  
4 International Committee. I'm also the  
5 treasurer of the World Federation for the  
6 Treatment of Opioid Dependence, a nonprofit -  
7 non-governmental organization with special  
8 status to the World Health Organization in the  
9 United Nations.  
10 I have retired from CODAC after  
11 42 years, 16 years as the president. I  
12 referenced AATOD and the World Federation to  
13 suggest that opioid treatment and the disease  
14 of opioid dependency is a worldwide, a national  
15 and worldwide concern. This is not something  
16 that's confined to Rhode Island. It's not  
17 Rhode Island's project or problem in and of  
18 itself, but it's something that's facing the  
19 world; and everyone is looking to find the most  
20 appropriate and efficacious way of dealing with  
21 the dependency.  
22 OTARI members provide treatment  
23 and support for patients who live with the

24 disease of opioid dependence, and we are

1 committed to providing care that is  
2 comprehensive and respectful. We have been  
3 actively engaged in efforts to respond to the  
4 tragic increases in overdoses, and we are  
5 working with the Governor's Task Force to  
6 expand and enhance access to care.  
7 As Rhode Island looks to  
8 establish the Centers of Excellence, for the  
9 treatment of opioid dependency, OTARI members  
10 have agreed to be the first organizations to  
11 apply for and receive this certification.  
12 Currently over 4500 Rhode  
13 Islanders are establishing, maintaining and  
14 celebrating their recovery in opioid treatment  
15 programs at OTARI member organizations. Our  
16 organizations provide treatment using methadone  
17 at 13 locations. Collectively, we have been  
18 saving lives, restoring families, preventing  
19 overdose, providing a full range of recovery  
20 services since 1974. I might also add, which  
21 is not in the documents I provided, we have  
22 been saving Rhode Island incredible amounts of  
23 money by keeping people out of jail, out of  
24 hospitals and out of any other system that's a

1 high cost system.  
2 If it were not for the OTP  
3 providers, 4500 patients would be at risk. We  
4 are the last bastion of prevention for a  
5 population that's incredibly vulnerable and  
6 incredibly costly to maintain.  
7 We believe that OTARI members  
8 provide a critical element in responding to  
9 opioid overdose and addiction; and in this  
10 regard, I believe we are Rhode Island's  
11 greatest unsung and unrecognized asset. The  
12 members of OTARI are in a particularly unique  
13 position to assess and provide the medically  
14 and clinically indicated medication assisted  
15 treatment and related recovery support services  
16 for this growing and vulnerable population and  
17 have been doing so since 1974. Likewise, we  
18 are positioned to provide response and access  
19 for those rescued from overdose.  
20 Each of the five-member  
21 organizations is licensed by Rhode Island's  
22 Department of Behavioral Health Care,  
23 Developmental Disabilities and Hospitals, the  
24 Department of Health. Certified by the

1 Substance Abuse and Mental Health Services  
2 Administration. Registered with the Drug

3 Enforcement Administration and accredited by  
4 the Commission on Accreditation of  
5 Rehabilitation Facilities, otherwise known as  
6 CARF. Collectively, they impose over 3,000  
7 standards for quality, safety and best  
8 practice. 40 years of experience combined with  
9 evidenced-based best practice standards makes  
10 Rhode Island's OTP experts in treating this  
11 chronic disease. I say that because we know  
12 what we are doing. We are not in the business  
13 of creating problems. We are in the business  
14 of solving problems.  
15 OTARI has enjoyed a long and  
16 collaborative relationship with BHDDH as well  
17 as other State departments. Our services are  
18 designed to meet the needs of our patients as  
19 well as the mission we share with BHDDH. Were  
20 we not able to do what we do on a daily basis  
21 the departments would not be able to meet their  
22 mandate.  
23 So, it is with great pleasure and  
24 enthusiasm that we welcome an invitation from

1 BHDDH to partner -and I use the word  
2 partner -with them and collaboration with CMS  
3 to submit an amendment to the State Plan to  
4 create a health home for eligible patients.  
5 The process took over 18 months of weekly  
6 meetings, was approved by CMS; and as a result,  
7 we have created a health home service for over  
8 2600 active patients demonstrating how  
9 coordinated care and support reduces overall  
10 health care costs.  
11 These services are supplemental  
12 to the existing array of counseling, medical  
13 and other recovery supports, and include but  
14 are not limited to case management,  
15 accompanying patients to appointments, care  
16 coordination with primary and specialty medical  
17 practices, tobacco cessation, nutritional  
18 guidance, housing, legal, and other activities  
19 associated with improving and supporting health  
20 and wellness. I get a little excited.  
21 The patients we serve have always  
22 been marginalized and have always been subject  
23 to the stigma and discrimination so commonly  
24 experienced by those with substance abuse

1 disorders. The implementation of the health  
2 home and the employment of over 60 new staff  
3 across our providers have enabled our patients  
4 to better negotiate a complex system.  
5 Coordinating their care, collaborating with and  
6 educating primary specialty services and

7 eliminating the many barriers, including stigma  
8 and discrimination, will ultimately result in  
9 healthier, happier, more productive Rhode  
10 Islanders.

11 The health home has allowed,  
12 enabled and encouraged our patients to more  
13 fully participate in the health and wellness  
14 opportunities enjoyed by others. At the same  
15 time, health home participation has resulted in  
16 early identification and intervention of acute  
17 and previously undiagnosed chronic conditions  
18 as well as demonstrated cost savings. It is  
19 also providing our patients with increasing  
20 competence and comfort when dealing with  
21 medical providers and to become better  
22 advocates for their own health and wellness.  
23 We are concerned that this progress would be  
24 undermined if we are not included in any and

1 all of the conversations related to  
2 modifications, changes and sustainability of  
3 the health home plan.

4 Our patients have embraced their  
5 health home as a clear message that they have a  
6 right to compassionate and comprehensive care  
7 and a rightful place and voice in their health  
8 and wellness, both of which have been  
9 previously denied for many reasons, including  
10 stigma and discrimination. The health home and  
11 support staff have provided advocacy and an  
12 opportunity for meaningful participation and  
13 improved health. Change that does not  
14 recognize the value, expertise and experience  
15 of the patients and providers revisits the  
16 perception of marginalization, stigma and  
17 discrimination.  
18 As mentioned above, OTARI members  
19 have been providing opioid treatment services  
20 to Rhode Island's most disenfranchised  
21 population since 1974. We are accredited and  
22 vetted by SAMHSA, BHDDH and DEA. Our providers  
23 and patients deserve the same level of respect  
24 and consideration as any other chronic disease

1 specialty practice.  
2 Our OTP health home has been  
3 presented at national conference, has been the  
4 subject of a SAMHSA White Paper and recognized  
5 by Michael Botticelli, Director of the Office  
6 of National Drug Control Policy.  
7 The importance and success of  
8 Rhode Island's Health Home for OTP patients has  
9 also been recognized by the Rhode Island Senate  
10 in the form of a resolution dated June 23,

11 2013, which David Spencer previously  
12 referenced. However, I would like to add two  
13 additional bullets to that, where the  
14 resolution states, whereas, the health home  
15 model opioid treatment program results and  
16 impacts should be recognized and successful  
17 practices should be supported on a going  
18 forward basis. Whereas, levels of care within  
19 the existing patient acuity model should be  
20 defined and agreed upon by stakeholders,  
21 including the opioid treatment program  
22 providers.  
23 We are concerned today that the  
24 spirit of collaboration and partnership has

1 been eroded. Likewise, we believe the spirit  
2 and intent of the previously mentioned Senate  
3 resolution has not been honored. I mentioned  
4 earlier that the development of the health  
5 home, as an example, was predicated on open  
6 discussion and creative planning to assure that  
7 suggested changes and modifications addressed  
8 and understood not only the complexity of the  
9 population of the disease, but the unintended  
10 and down-side consequences of changes that did  
11 not include consultation for OTARI and respect  
12 for our wisdom and expertise.  
13 We believe changes in the manner  
14 in which health home and other services  
15 provided must be considered. The care and  
16 support that services that OTARI members  
17 provide are based on trust and respect.  
18 Likewise, the relationship between OTARI and  
19 our State partners must be based on that same  
20 trust and respect. In the face of early  
21 success of the health home, we are concerned  
22 that there are changes under consideration and  
23 changes planned for implementation without our  
24 wisdom and without our experience and without

1 regard for patient safety and program service  
2 integrity.  
3 Since we are often informed after  
4 the fact, we find ourselves being reactive  
5 rather than proactive. We find ourselves in a  
6 shoot first and ask questions environment. We  
7 believe that many of the proposed changes and  
8 the timing of these changes have not considered  
9 the unintended consequence on patients served  
10 and the programs that support these services.  
11 In some instances, we believe that without our  
12 import or voice, proposed changes will lead to  
13 compromised safety and recovery. Staffing  
14 challenges and difficulty meeting and almost

15 impossibility meeting state, federal and  
16 accreditation mandates and requirements. Some  
17 of these changes, as proposed, will force us to  
18 be out of compliance with the mandates that  
19 provide us with our opportunity and license to  
20 operate.  
21 OTARI -I was supposed to go  
22 first. The previous members of OTARI have  
23 spoken eloquently on what we believe has been a  
24 lack of respect for the knowledge and the

1 wisdom of the providers. We believe we know  
2 what's best. We believe we also know what  
3 changes, what these changes, as proposed, will  
4 mean in terms of our ability to treat our  
5 patients and the outcomes that the State is so  
6 desperate to have. I'd like to say that again.  
7 The State is desperate to have good outcomes.  
8 If we are not able to provide the services that  
9 were originally intended in the initial spa,  
10 then we will not be able to provide you with  
11 those outcomes. If you want those outcomes,  
12 you need to listen to us. You need to hear  
13 what we have to say. You need to understand  
14 our concerns. You need to realize that our  
15 patients who have been finally gotten into a  
16 place where they feel that they are worthwhile  
17 and respected may have the rug pulled out from  
18 under them.  
19 Another element or another aspect  
20 of how it feels to be discriminated against  
21 because you have a particular illness. So, if  
22 the State is looking for outcomes and the State  
23 is looking to be successful and the State is  
24 looking to save money, then my concern is

1 whether or not saving \$2.00 here today is going  
2 to be worth the \$7, \$8 or \$9 you're going to be  
3 spending in a year from now.  
4 So, I ask you, as was mentioned  
5 previously that -the third option, as was  
6 mentioned earlier today, which is to pull this  
7 plan off the table and sit down and discuss and  
8 fully understand what it means to operate an  
9 opioid treatment program, what it means to  
10 provide those services, and what it means to be  
11 a patient in a treatment program, I think will  
12 result in a better defined and a more  
13 eloquently and elegantly written new State Plan  
14 Amendment.  
15 HEARING OFFICER DIMAURO: So,  
16 are there any other individuals here who didn't  
17 sign up to speak who would like to speak at  
18 this time?

19 AUDIENCE: On behalf of the  
20 Leadership Council -my name is John Tassoni,  
21 T-A-S-S-O-N-I. If it's possible, I could get a  
22 copy of the Stenographer's report when it's  
23 complete?  
24 HEARING OFFICER DIMAURO: Yes.

1 Did you sign in?  
2 MR. TASSONI: I did not.  
3 HEARING OFFICER DIMAURO: Anyone  
4 who would like copies of the testimony and the  
5 transcript, please make sure you signed in  
6 with, especially with your e-mail address and  
7 we will get that out to you. If there are,  
8 there's no other testimony to be taken, we want  
9 to thank you for your attendance here and the  
10 testimony provided, and the hearing is now  
11 closed.

12 (HEARING CLOSED AT 11:12 A.M.)

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## 1 C E R T I F I C A T E

2  
3 I, Mary Ellen Hall, hereby certify that the  
4 foregoing is a true, accurate and complete  
5 transcript of my notes taken at the  
6 above-entitled hearing.  
7 IN WITNESS WHEREOF, I have hereunto set my  
8 hand this 5th day of September, 2016.

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MARY ELLEN HALL, NOTARY PUBLIC/

CERTIFIED COURT REPORTER

AUGUST 19, 2016

STATE PLAN AMENDMENT OPIOID TREATMENT  
PROGRAMS HEALTH HOME

M.E. HALL COURT REPORTING (401) 461-3331

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