IAP | Medicaid Innovation Accelerator Program

Overview of Medication-Assisted Treatment Clinical Pathway and Rate Design Approach

Medicaid IAP Tools for States

February 2017

Background

The Medicaid Innovation Accelerator Program (IAP) has been working with Medicaid and behavioral health agencies to develop robust approaches for addressing substance use disorders (SUD). Through our close work with states under various IAP SUD activities, we have developed tools and resources designed to support state efforts to introduce policy, program, and payment reforms appropriate for a robust SUD delivery system. This document provides an overview of resources developed under the IAP related to designing episodes of care and payment rates for medication-assisted treatment (MAT) services delivered to individuals with opioid use disorder.

In July 2015, the Medicaid IAP received a request from a state to support their efforts to develop a payment rate for MAT with buprenorphine to treat opioid dependence. In response to that request, the IAP team began by identifying strong examples of MAT service delivery models currently in use in state Medicaid programs as a basis for developing the payment approach.

The models selected include:[i]

1. an office-based opioid treatment program (OBOT) model based on the “Spoke” component of Vermont’s “Hub and Spoke” program;[ii]
2. an OBOT model in operation in Massachusetts;[iii] and
3. a model that uses specialty providers to begin MAT and transfers patients to primary care practices for continuing care, based on the “Baltimore Buprenorphine Initiative” in Maryland.[iv]

The next step was to develop a rate design tool that reflects the costs of providing the clinical services in each model by: constructing a clinical pathway corresponding to each MAT service delivery model; identifying distinct phases of treatment; and delineating the sites, types and time requirements of professional staffing for each phase.

Clinical Pathways

For each MAT service delivery model, the IAP developed a clinical pathway document that articulates the services that underlie the rates. While each MAT service delivery model is composed of unique clinical steps and services, the following phases of treatment are common to all three MAT models and form the payment approaches:

- assessment and induction;
- stabilization;
- maintenance; and
- discontinuation and medical withdrawal (if discontinuation is the patient’s choice).

States can use the clinical pathway and rate design tools to develop similar pathways and corresponding rates.

Note to State Medicaid Agencies

The IAP is providing these clinical pathway and rate design tools as general resources to support states' discussion and planning around MAT services and payments. The services and rate design approaches described herein are not approved or endorsed by CMS.

For regular state plan coverage under Medicaid, each proposed service must meet the requirements of a benefit under Section 1905(a) of the Social Security Act, must set forth any limitations on amount, duration and scope of the service, and must include a reimbursement methodology. In addition, all state plan amendments must meet requirements for comparability, statewideness and free choice of provider.

Further, should a state be interested in pursuing a MAT payment rate in managed care, 42 CFR 438.6(c) gives states the flexibility to design and implement delivery system and provider payment initiatives under managed care contracts. Under these regulations, a state may require managed care plans to implement or participate in value-based purchasing models, multi-payer delivery system reforms, or performance improvement initiatives.

Rate Design Tools

The rate design tools (see worksheets) allows states to adjust factors to reflect local practice and costs, including the composition of professional staff, time required for each step, staff costs, and other direct and indirect costs. The duration and frequencies of services and phases of treatment described are intended to be averages for purposes of developing the rates. All services apply to 100% of clients unless otherwise indicated and the rate excludes medication costs.

Requirements need to be developed to determine minimum service levels and outreach activities that constitute qualifications for a provider's eligibility to bill the rate or assure the delivery of all services included in the rate. In Model One, the specialty treatment organization could be the qualified provider and would receive the rate until the maintenance phase where the payment would shift to the primary care physician. In Model Two, the rate could be paid to the health center, and in Model Three, the primary care practice could receive the rate.

Guiding Principles

While more extensive observations on the service delivery and rate design models may be included in future IAP documents, the following principles guide these models and the corresponding rates:

1. Development of any rate setting approach must start with an articulation of the clinical pathways that underlie the rate.
2. Analysis of successful OBOT models underscores the importance of creating a clinical infrastructure for the physician, in the way that Vermont and Massachusetts have done.
3. Sufficient resources must be available for MAT, including waivered physicians[v] with integrated clinical staff, referral networks, and formal affiliations between specialty treatment providers and primary care.
4. Rate approaches must be periodically evaluated, like any innovation, in order to determine whether they are enhancing quality, improving patients' health status and meeting the objectives established by the purchaser.

Additional Resources

We recommend that states interested in developing payment approaches reach out to the Center for Medicaid and CHIP Services (CMCS) and share draft payment methodologies for guidance

early on in the process. Contact Asher Mikow, Technical Director, Financial Management Group, CMCS (Asher.Mikow@cms.hhs.gov).

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[i] Drafts of the clinical pathways for Vermont and Massachusetts were reviewed with individuals familiar with those programs and revisions made based on their input; one of the IAP authors had worked on implementation of the Baltimore model and provided details on its components.

[ii] *Integrated Treatment Continuum for Substance Use Dependent: "Hub/Spoke" Initiative*, Vermont Agency of Human Services, January 2012.

[iii] The Massachusetts Collaborative Care Model ("OBOT-B Collaborative Care Model") in LaBelle, C. et al, *Statewide Implementation of the Massachusetts Collaborative Care Model in Community Health Centers*, Journal of Substance Abuse Treatment, 60 (2016) 6-13.

[iv] Initiated through the Robert Wood Johnson Foundation funded *Advancing Recovery* program that assisted governmental jurisdictions and their community provider partners to install evidence-based practices with the use of NIATx process improvement techniques.

[v] "Waivered physician" refers to a physician that has received a waiver from SAMHSA to prescribe buprenorphine for opioid dependence treatment in accordance with the Drug Addiction Treatment Act of 2000 (https://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management).