



Medicaid Innovation Accelerator Program (IAP)



**Clinical Pathways &
Payment Bundles for
Medication Assisted
Treatment**

National Webinar Series

January 17, 2017

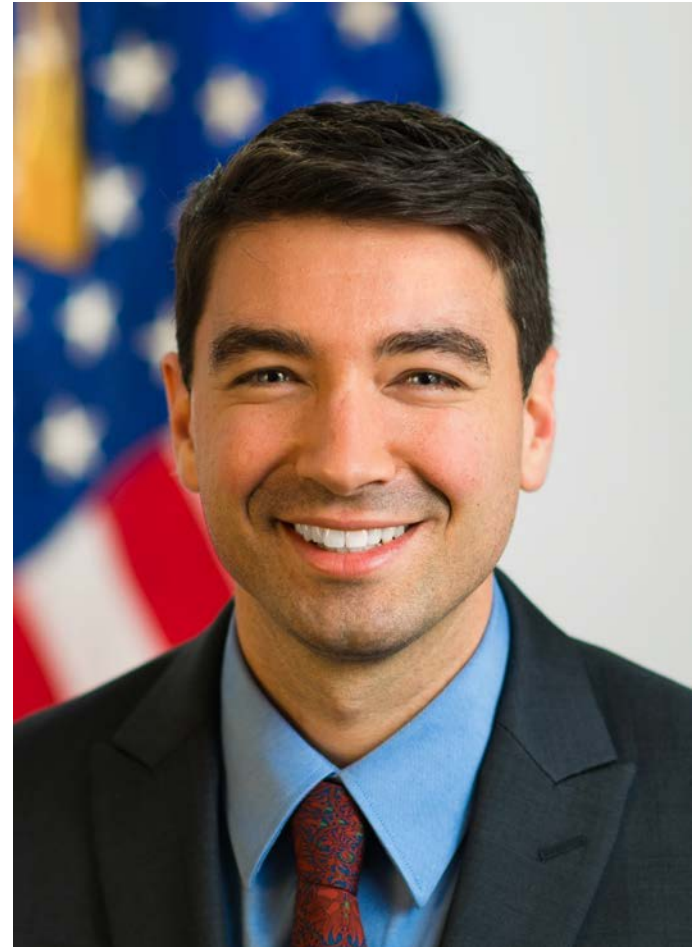
3:30pm – 5:00pm EST

Logistics


- Please mute your line & do not put the line on hold
- Use the chat box on your screen to ask a question or leave comment
 - Note: chat box will not be seen if you are in “full screen” mode
 - Please also exit out of “full screen” mode to participate in polling questions
- When spreadsheets are shared “full screen” mode is recommended
- Moderated Q&A will be held periodically throughout the webinar
 - Please submit your questions via the chat box
- Please complete the evaluation in the pop-up box after the webinar to help us continue to improve your experience

Welcome and Overview

- **Tyler Sadwith**
- Medicaid Innovation Accelerator Program SUD Lead, Health Insurance Specialist, Disabled and Elderly Health Programs Group, CMS



Purpose & Learning Objectives

- 
- States will discuss key clinical elements & planning strategies for implementing medication-assisted treatment (MAT)
 - States will explore components of bundled rate models for MAT & learn how to adapt these prototypes for use

Agenda

- Introduction to Clinical Pathways & Payment Bundles for MAT
- State Experience: Vermont
- State Experience: Massachusetts
 - *Discussion Break*
- In-Depth Look at Clinical Pathway & Payment Bundle Models
 - *Discussion Break*
- Wrap Up & Resources

Note to State Medicaid Agencies

- The Medicaid Innovation Accelerator Program (IAP) is providing these clinical pathway and rate model tools as general resources to support states' discussion and planning around MAT services and payments. The services and payment methodologies 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, describe provider qualifications and must include a reimbursement methodology. In addition, all state plan amendments must meet requirements for comparability, statewideness and free choice of provider.

Speaker (1/5)

- **Mady Chalk, PhD, MSW**
- Senior Policy Advisor,
Treatment Research
Institute

TREATMENT
RESEARCH
INSTITUTE

TRI

Science

Addiction



Speaker (2/5)

- **John Brooklyn, MD**
- Assistant Professor, Family Medicine & Psychiatry, University of Vermont, College of Medicine
- Medical Director, Chittenden Clinic; BBHS Vermont



Speaker (3/5)

- **Anthony Folland**
- Clinical Services Manager and Opioid Treatment Authority Director, Alcohol and Drug Abuse Programs, Department of Health, Vermont



Speaker (4/5)

- **Colleen LaBelle, MSN, RN-BC CARN**
- Program Director, State Office-Based Addiction Treatment. Nurse Manager, Office-Based Addiction Treatment, Boston Medical Center



Speaker (5/5)

- **Susan Parker, CPA, MT**
- Executive Vice President and Founder, Parker Dennison & Associates

Parker Dennison
Behavioral Healthcare Consultants



Facilitator

- **Colette Croze, MSW**
- Private consultant, Croze Consulting



Introduction to Clinical Pathways & Payment Bundles for Medication Assisted Treatment

Mady Chalk, PhD, MSW, Senior Policy Advisor,
Treatment Research Institute

Colette Croze, MSW, Private Consultant, Croze
Consulting

Context

- Medications have become an important component in the treatment of opioid use disorders
 - A request was made by a participating state in the IAP for tools to aid in the development of bundled services & rates for MAT
-
- **Goal:** To align clinical services & waived physicians to improve quality of care & accountability, thereby requiring a description of the clinical pathway (service components) necessary for implementation

Rationale for Selecting Models

- Rationale for selecting three models: MA, MD, VT
 - Each model has been sustained state-wide for a significant period of time following pilots
 - Each model has clear roles for the primary care, specialty systems & for waived physicians & additional necessary staffing
 - Each model identified specific objectives within a clinical framework at the outset



State Experience: Vermont

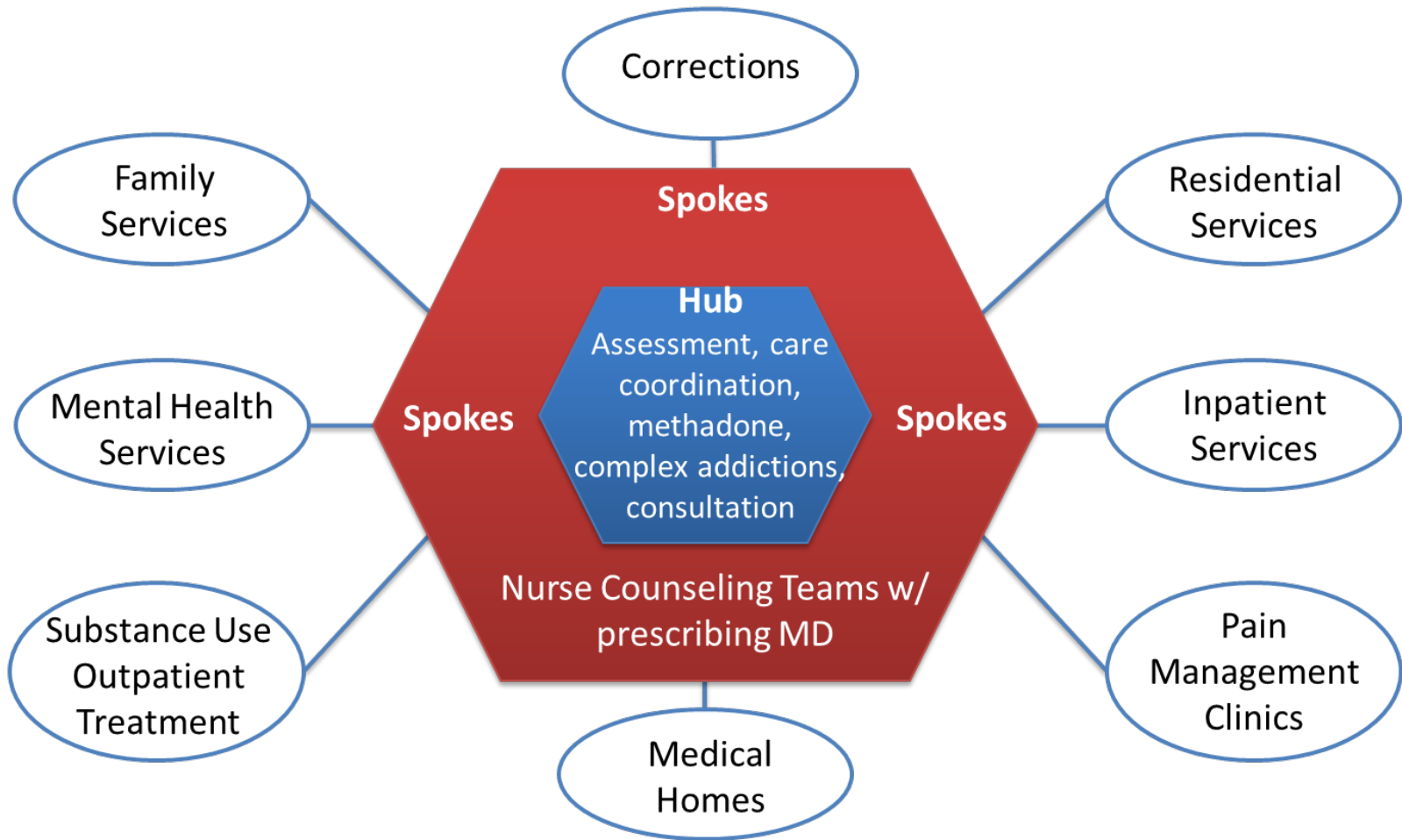
John Brooklyn, MD, Assistant Professor of Family Medicine & Psychiatry, University of Vermont; Medical Director, Chittenden Clinic, BBHS Vermont

Anthony Folland, Clinical Services Manager & Opioid Treatment Authority Director, Alcohol & Drug Abuse Programs, Vermont Department of Health

Impetus for Developing Hub & Spoke: Policy Goals

- For beneficiaries with opioid addiction at risk of developing another SUD and with co-occurring mental health issues in opioid treatment program (OTP) & office-based opioid treatment (OBOT) settings
 - Improve access to addictions treatment
 - Integrate health & addictions care for Health Home beneficiaries
 - Better use of specialty addictions programs & general medical settings
 - Improve health outcomes, promote stable recovery

Hub & Spoke Model: Integrated Health Systems for Addictions Treatment



Spokes:

Overview & Practice Setting

- **Spoke:** The ongoing care system comprised of a prescribing physician & collaborating health & addictions professionals who monitor adherence to treatment, coordinate access to recovery supports, & provide counseling, contingency management, & case management services
- **Spokes can be any of the following practice settings:**
 - Blueprint Advanced Practice Medical Homes
 - Outpatient Substance Use Treatment Providers
 - Federally Qualified Health Centers
 - Primary Care Providers
 - Independent Psychiatrists

Spokes:

Staffing & Payment Model

- All existing buprenorphine providers are eligible to become Spokes
 - Initially ~120 physicians were designated as Spoke providers
- Spokes provide 1 full-time equivalent (FTE) case manager and nurse per 100 buprenorphine or naltrexone patients
- Services can be provided in-house or via outside consultations through regional contracts with hospitals or mental health service providers
- Payment Model:
 - \$163.75 Per member per month
 - Payment through Blueprint Community Health Team

Determining Intensity of Care

- Treatment Needs Questionnaire
 - 21 item checklist
 - Based on Addiction Severity Index topics
 - Legal, work, social, drugs use, psychological, medical
- Required use for Hub providers, encouraged use for Spoke providers to develop consistent triage screening process

Scoring

- **Scores up to 26 with lower scores predicting good Spoke outcomes**
- **0-5:** Excellent candidate for office-based treatment
- **6-10:** Good candidate for office-based treatment
- **11-15:** Candidate for office based treatment by board certified addiction physician in a tightly structured program with supervised dosing & on-site counseling or HUB
- **16-26:** Hub program

Office-Based Opioid Treatment (OBOT)

Stability Index

- Developed by Dartmouth College to quickly assess stability of patients in OBOT settings
- Provides a common understanding of stability for physician practices & their teams
- Recommendations for frequency of visits are based upon patient stability
 - Weekly or monthly visits

Spoke Challenges

- Polled OBOT physicians regarding most significant expansion concerns
- Consistent feedback:
 - Patients require more time, care coordination than physicians have in their schedules
- Response to feedback:
 - Community Health Team model physicians were offered in-office supports
- Supports:
 - Affordable Care Act Section 2703 Health Home funding for 2 FTE, non-billing responsible staff per 100 patients
 - 90/10 funding split in Spokes
 - 1 FTE licensed behavioral health provider
 - 1 FTE nurse provider
 - Funding lasted 8 quarters, infrastructure supports continue since the 90/10 match ended

Successes:

Increase in Waivered Physicians

- FTE nurse & licensed behavioral health clinicians deployed to support over 80 settings
- Over 2600 Medicaid patients in OBOT providers
- Increased number of physicians becoming waivered since implementation of infrastructure MAT Team staffing
 - Increased numbers of physicians becoming waivered for 100 patients
 - Physician feedback to infrastructure supports is overwhelmingly positive

Successes: Improvements in Access to Care

March 2012

OTP: 650 patients
OBOT Medicaid: 1,700 patients

February 2015

Hub: 2,723 patients
OBOT Medicaid: 2,143 patients

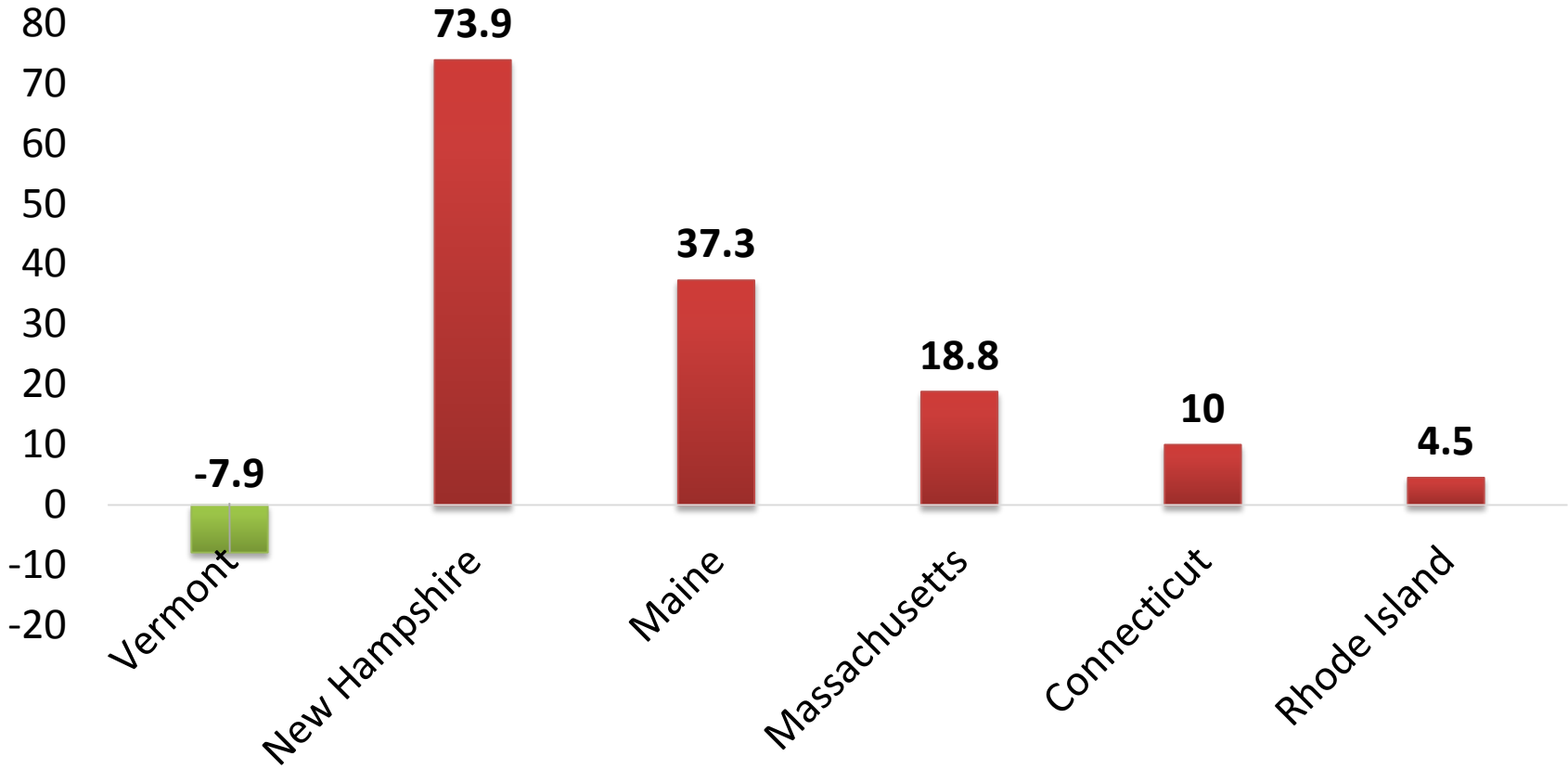
October 2016

Hub: 3,178 patients
Spoke: 2,196
Medicaid Only
OBOT all payers: 3,457 patients
(68% Medicaid)

- **Growth in waived physicians & waived cap between 2003– 2012**
 - 30 patient: 169
 - 100 patient: 37
- **Totals as of August 2016**
 - 30 patient: 269
 - 100 patient: 73

Successes: Reduction in Overdose Deaths

Percent Change in Deaths Per 100,000 People, 2013 to 2014



Successes: Medicaid Financial Impacts

- Higher MAT treatment costs offset by lower non-opioid medical costs
- MAT associated with lower utilization of non-opioid medical services
- MAT suggested to be cost-effective service for individuals with opioid-use disorder
- Initial Medicaid savings of \$6.7 million
 - Plans to reinvest in ongoing treatment

Challenges and Opportunities: Buprenorphine in OTPs

- Opportunity
 - Allows for Buprenorphine to be offered in either structure (OTP or OBOT) depending upon patient's assessed needs
- Challenges
 - How to provide buprenorphine in OTPs
 - Reimbursement
 - Costs
 - Defining stabilization/blending cultures
- Solutions
 - Worked with multiple regulatory agencies for reimbursement
 - Learning collaboratives
 - Finding correct balance and triage of patients to OTP/OBOTs

Polling Question (1/2)

- Which of the following represents the greatest challenge to your state's ability to increase access to MAT?
 - (1) Financing / reimbursement
 - (2) Infrastructure
 - (3) Number of waived physicians
 - (4) Culture
 - (5) Not a high priority for state
 - (6) Other challenges



State Experience: Massachusetts

Colleen LaBelle, MSN, RN-BC, CARN

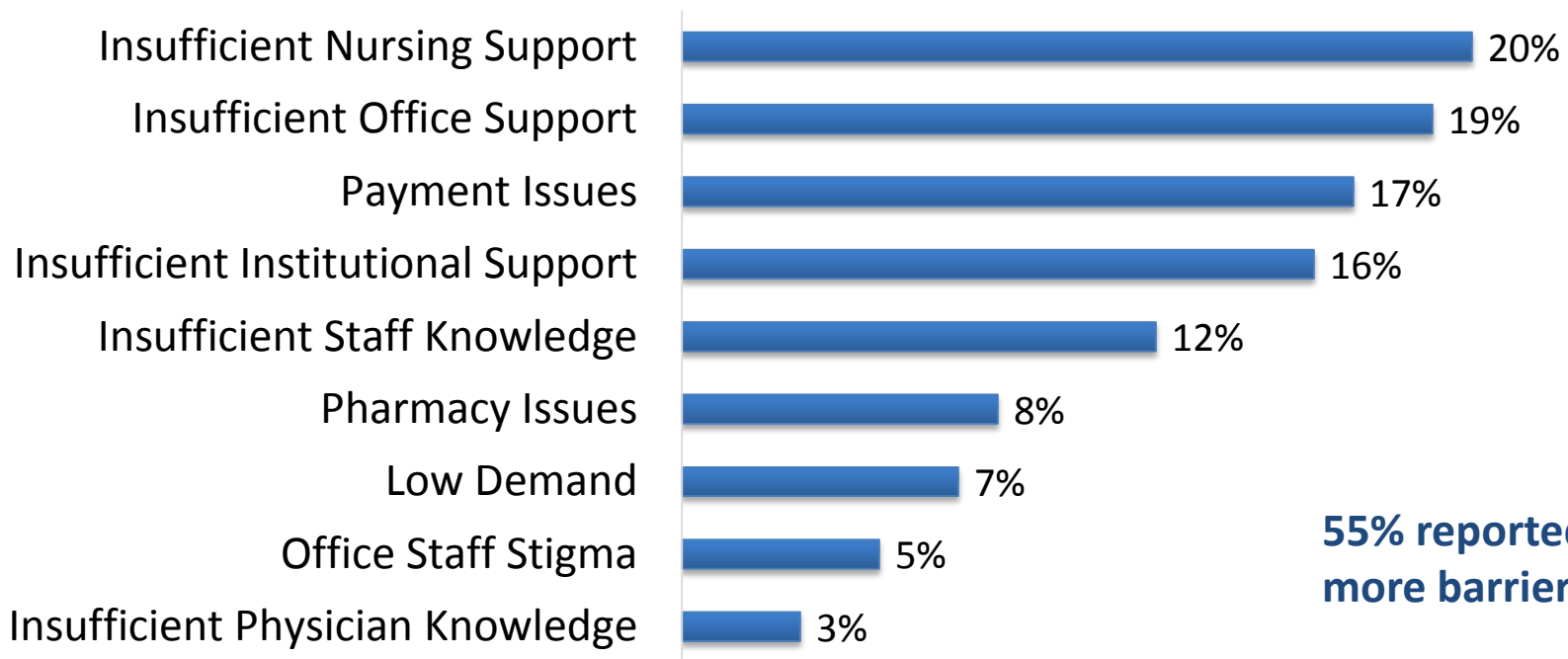
Program Director, State Office-Based Addiction Treatment,
Nurse Manager, Boston Medical Center Office-Based
Addiction Treatment

Impetus for Developing the Collaborative Care Model

- High rates of substance use and overdose
- Long waits for medication-assisted treatment
 - Not enough MA physicians had DATA 2000 waivers
 - In 2005, ~1% of physicians were waived, and many were not prescribing
- Increases in opioid-related hospitalizations
- Expansion of office-based treatment included as part of the 2005 MA state strategic plan

Barriers to Prescribing Buprenorphine

Barriers to Office-Based Buprenorphine Prescribing for Opioid Dependence, N=156 waived physicians



55% reported 1 or more barriers

■ Percent of Prescribers Reporting Barrier

Source: Walley et al. Office-based management of opioid dependence with buprenorphine: clinical practices and barriers. J Gen Intern Med 2008; 23(9): 1393-8

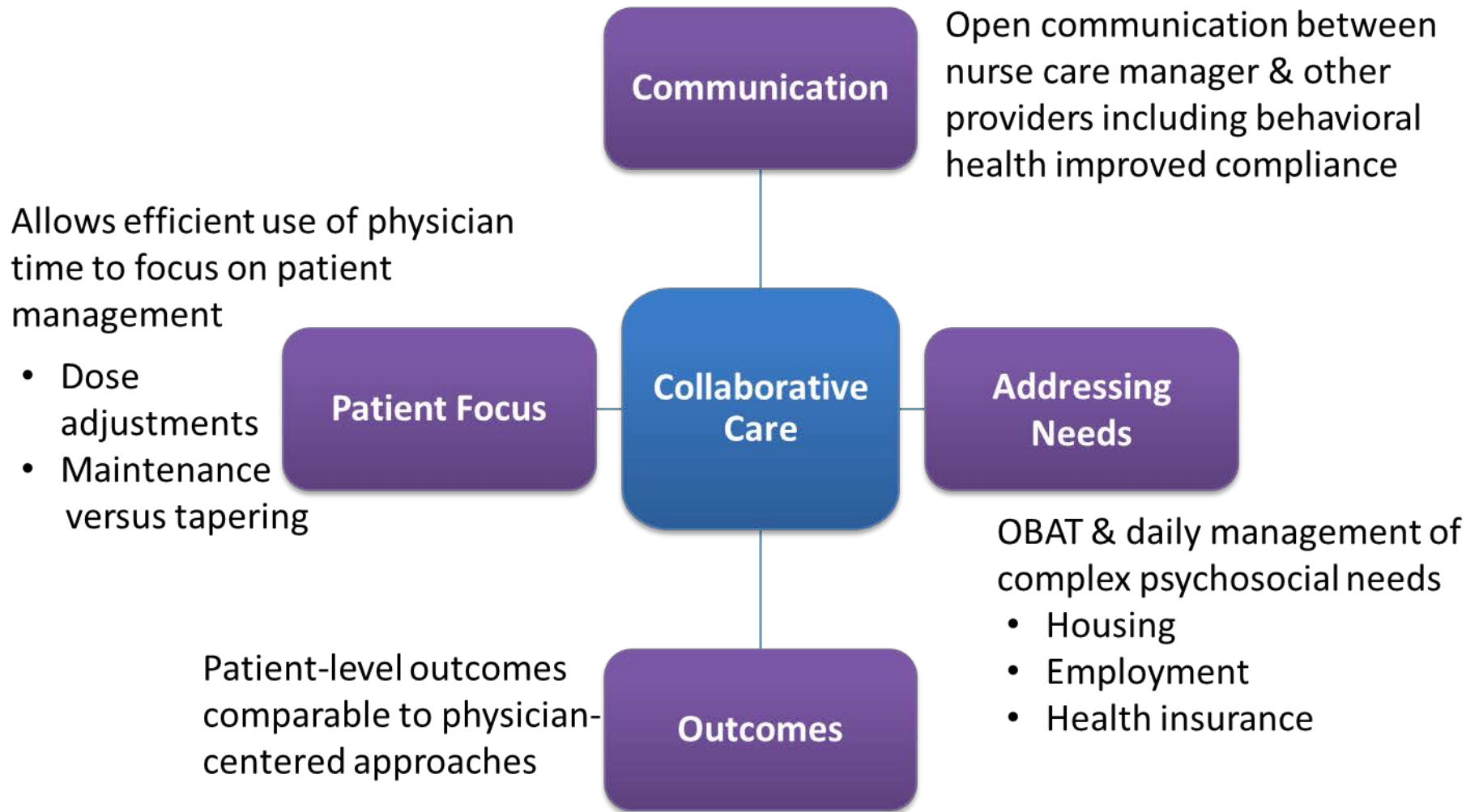
Boston Medical Center Collaborative Care Model – The “MA Model”

- **Model**
 - Collaborative Care / Nurse Care Manager Model
 - Nurse care managers work with physicians to deliver outpatient addiction treatment with buprenorphine & injectable naltrexone
- **Settings**
 - Primary Care Practices
 - Community Clinics
- **Staffing**
 - Nurse Care Manager Model
 - Collaborative care with pharmacists
 - Less emphasis on physicians promotes lower costs

Nurse Care Manager (NCM) Model

- Training
 - Registered nurses
 - 1-day training in addiction & treatment of SUDs
- Fidelity
 - Perform patient education & clinical care following treatment protocols
 - Maintain compliance with federal laws
- Collaboration
 - Coordinate care with Office-Based Addictions Treatment (OBAT) physicians
 - Collaborate care with pharmacists (refills management)
 - Off-site counseling services
- Additional Services
 - Urgent care drop-in hours
 - Manage insurance issues (i.e. prior authorizations)

BMC Collaborative Care Model



Expansion of OBAT Model to MA Community Clinics

- 2007: State Technical Assistance Treatment Expansion OBAT Program was created to expand BMC model to community clinics across MA
- Program started with 14 CHCs, BMC now provides capacity building to >30 community health providers

OBAT Goals with Community Clinics

Access (Expand treatment & access to buprenorphine)

- Increase the number of waived MDs
- Increase the number of individuals treated for opioid addiction
- Integrate addiction treatment into primary care settings

Delivery (Effective delivery model for buprenorphine services)

- Modeled after BMC's Nurse Care Manager program

Sustainability (Post-program funding)

- Develop a long-term viable funding plan
- Collect & analyze outcomes data

Technical Assistance & Training for Practices & Clinics (1/2)

- Training
 - RNs & MAs complete 1-day buprenorphine training
- Site Visits
 - Conducted w/ RN, MDs, team members
 - Trainings in addiction MAT, stigma, management, start-up
- Quarterly Meetings
 - Educational, networking, support

Technical Assistance & Training for Practices & Clinics (2/2)

- Support for RNs, Waivered MDs
 - Navigate prior authorization, insurance, DEA
 - Leaving providers/practice closures
 - Patient issues
- Facilitating Listserv for Addiction Providers
 - Relevant articles, resources, group discussion
 - Regulations, reimbursement, jobs

Successes in Community Clinics

- Nurse Care Model housed in community health centers has
 - Expanded treatment
 - Between 2007-2013, 14 community health centers successfully initiated OBAT
 - Physician’s “waivered” increased by 375%, from 24 to 114
 - Serving more than 10,000 patients since 2007. Annual admission of OBOT patients to community health centers increased from 178 to 1,210.
 - Treatment available in patients’ communities
 - Developed a sustainable reimbursement model
 - Federally Qualified Health Centers (FQHCs)
 - Insurance
 - Implemented best practices as the standard of care

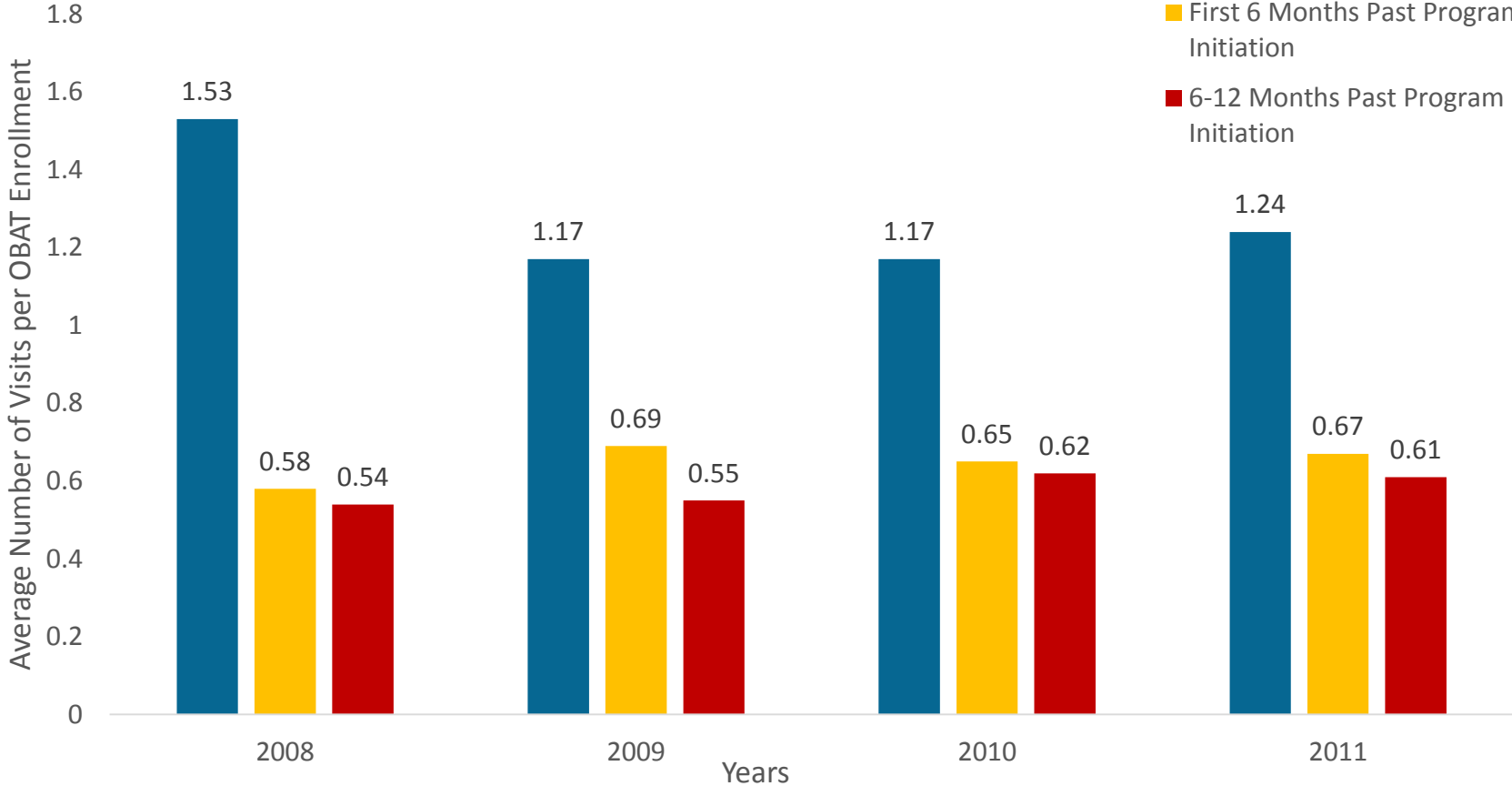
Successes in Community Clinics CONT'D

- Nurse Care Model housed in community health centers has
 - Improved health outcomes
 - Retention in care: 65.2% of OBOT patients enrolled in FY 2013/2014 remained in treatment \geq 10 months
 - Decreased mortality
 - Lower cost to Medicaid for those on buprenorphine versus those not in care

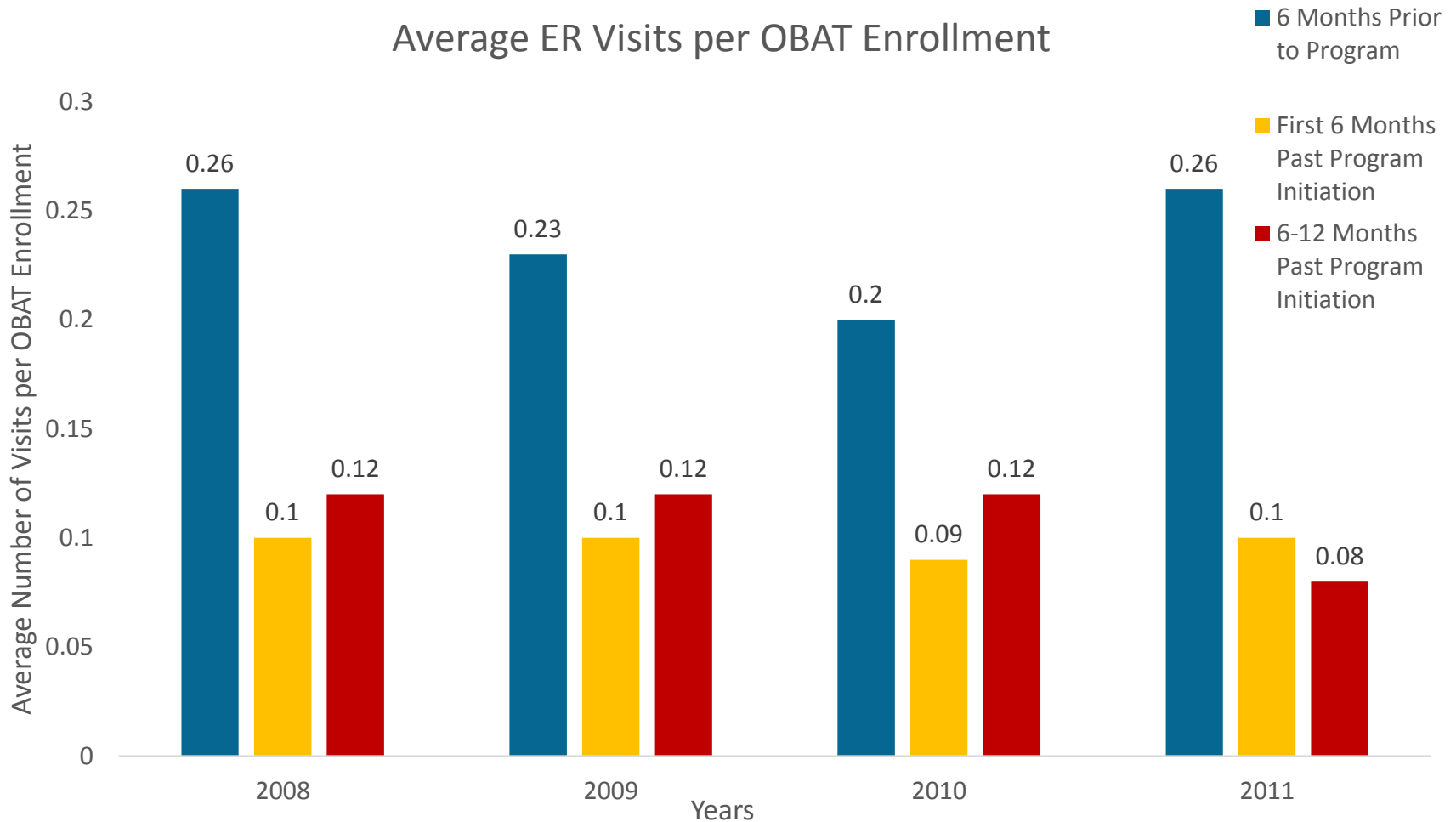
Successes in Community Clinics: ER Visits

Average ER Visits per OBAT Enrollment

- 6 Months Prior to Program
- First 6 Months Past Program Initiation
- 6-12 Months Past Program Initiation



Successes in Community Clinics: Hospital Admission

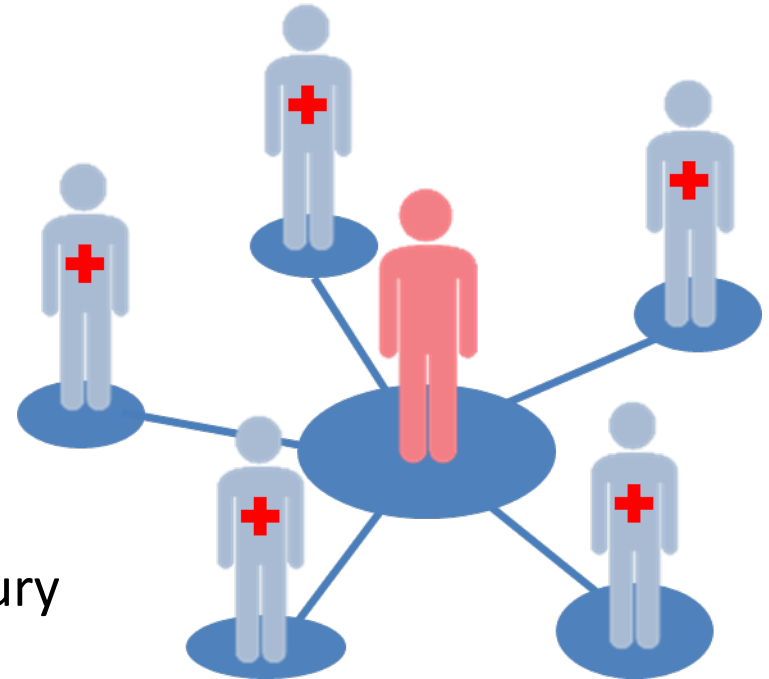


Program Funding

- \$270,000 per year for State Technical Assistance
 - Training, booster sessions, quarterly state educational sessions, conference calls, site visits, support staff and admin assistance, support to statewide providers in nonprofits, accountability of grant deliverables
- \$100,000 per community health center for Nurse Care Manager
 - 1 full time RN
 - 1:100 staff to patient ratio
 - Rolling admission of new patients each week to reach 100
 - 1:125 with addition of Medical Assistant in year 4 of the grant

Why the Nurse Care Model Works

- Increased patient access
 - Frequent follow-ups
 - Case management
 - Able to address
 - positive urines
 - insurance issues
 - prescription/pharmacy issues
 - Pregnancy, acute pain, surgery, injury
 - Concrete service support
 - Intensive treatment needs, legal/social issues, safety, housing
 - Brief counseling, social support, patient navigation
 - Support providers with large case load



Polling Question (2/2)

- Does your state Medicaid program provide any of the following services to support MAT providers? Select all that apply.
 - Training programs
 - 1:1 technical assistance
 - Comprehensive MAT benefit design
 - Learning collaboratives
 - Infrastructure funding
 - Other

Discussion & Questions (1/2)



In-Depth Look at Clinical Pathway & Payment Bundle Models

Mady Chalk, PhD, MSW, Senior Policy Advisor,
Treatment Research Institute

Susan Parker, Executive Vice President and Founder,
Parker Dennison & Associates

Colette Croze, MSW, Private Consultant, Croze
Consulting

Clinical Pathways/Services Common to All Models

- Step 1
 - Assessment, referral (if appropriate), & treatment planning
- Step 2
 - Offer of medication
- Step 3
 - Induction with withdrawal management
- Step 4
 - Stabilization
- Step 5
 - Maintenance
- Step 6
 - Discontinuation with medical withdrawal

Utility of State Models

Three strong examples of MAT models currently in use in state Medicaid programs were selected as a basis for developing the bundled payment methodology.

- Models act as guides
 - They are designed to give states tools to develop similar pathways & corresponding bundled average rates
- Models allow states to adjust factors to reflect local practices & costs
 - Composition of professional staff, staff costs
 - Time required for each clinical service
 - Other direct & indirect costs
- Bundle inclusions & exclusions
 - Included: Laboratory costs of urinalysis
 - Excluded: Medication costs

Three Models for Delivery

Model 1: Baltimore Buprenorphine Initiative

- Adopted by Maryland
- Uses specialty providers to offer medications, clinical services & transfers patients to primary care practices for maintenance/continuing care

Model 2: Massachusetts Primary Care

- Uses primary care practices and clinics with nurses to support prescribers

Model 3: “Spokes” within Vermont’s Hub & Spoke Delivery System

- Uses primary care practices enhanced with nurses & clinical care managers

Resources Required in All Models

- Staffing
 - DATA 2000-waivered physicians
 - Nurses: registered nurses, nurse care managers
 - Substance use disorder counselors
- Sites
 - Specialty outpatient treatment programs for substance use disorders
 - Outpatient primary care practices
 - Primary care practices or clinics

Rate Model: Overview

- Model calculates total cost for provider services, including urinalysis
 - Model excludes pharmacy costs
 - Allows users to tailor to local provider costs & required professionals
- Model crosswalks to the steps & assumptions in the clinical pathway:
 - The time span included in rate for each bundle is tied to underlying steps in the pathway
 - Monthly rates allow some phases to continue indefinitely depending on client choices & needs (i.e. maintenance)
- Overview of Excel model:
 - Designed for user input in gray shaded cells
 - Estimates used to populate model to yield approximate rates
 - **Two sheets:**
 - Assumptions for state specific costs
 - Rate for Clinical Model calculates rate based on clinical pathway and assumptions

Rate Model:

Assumptions for State-Specific Costs

- Calculates personnel costs per billable hour based on:
 - Salaries and productivity rates by type of professional
 - Average weeks of work after paid time off
 - Payroll tax and fringe benefit rate (combined)
- Other direct program costs (as % of personnel)
- General administrative and overhead rate (as % of total personnel & other direct program costs)
- Urinalysis
- Average group size per staff
 - Formula in cell below calculates the average amount of staff time per client per hour of group (e.g. $1/9=0.1111$ or .1111 hour of staff time per client per group)

Rate Model: Clinical Model Sheet

Top Section - Summarizes the rates & length of time for each phase in the clinical pathway

Lower Section - Follows the clinical pathway & details:

- Percentage of clients each step applies to (typically 100% of clients)
- Staff time required for each step (in hours)
- Composition of professionals for each activity (average % by type of credential)
- Brings staff costs/billable hour from Assumptions sheet
- Applies the other direct program percentage to the subtotal of personnel costs
- Applies general administration and overhead percentage to total direct costs
- Yields total cost for each step in clinical pathway
- Average hourly costs (column K in VT model) shows the cost for the corresponding activity with the percentages of each type staff
 - Allows reasonableness check
- Staff check totals is a review tool to ensure staff %s total 100% (column M in VT model)

Logistics Check

We are now going to walk through a state model.

Please reference the clinical pathway and rate model resource document relative Vermont to follow along with the audio recording.

Walk Through Vermont Model

Vermont Model

Calculated rates shown in rows 3 – 6

Hourly rate per billable hour from Assumptions sheet in row 11 (MD/DO \$200, etc)

Physician component of clinical assessment in row 14—0.5 hours and 100% MD/DO

BH professional component of clinical assessment in row 15—1.0 hours and 50% of MD/DO
LCSW and CAC or \$60.58 for activity

Other direct costs (row 25) applies 30% from Assumptions to total personnel costs

G&A/OH applies 20% from Assumptions to total direct costs

Rate for Clinical Assessment through Induction is \$1,962.18 for the eight week period

Repeats for remaining three phases of treatment

Implementation Principles for Using Clinical Pathways & Bundled Rate

Principle 1

- Development of rate-setting methodologies must start with an articulation of the clinical pathways that underlay them

Principle 2

- Analysis of these successful OBOT models underscores the need for a clinical infrastructure to support physicians

Principle 3

- Sufficient resources must be available, i.e. waived physicians with integrated clinical staff, referral networks, & formal affiliations between specialty & primary care providers

Principle 4

- Bundled rate approaches must be periodically evaluated to determine whether they are enhancing quality, improving patients' health status, & meeting the purchaser's goals

Implementation Questions to Consider

- What triggers the bundled payment?
- Which practitioner/organization receives the bundled reimbursement?
- What documentation of service provision is required?
- What metrics will be used to evaluate improvements in quality resulting from the use of the bundled payments?

Webinar Summary:

Key Take Away Points

- Most of the key elements of each model are similar
- Rates are created for stages of treatment within the clinical pathway
- There is flexibility in provider types for assessment & maintenance
- Initiation of MAT in the specialty system requires an additional step in the clinical pathway

Discussion & Questions (2/2)



Resources

- American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction Involving Opioid Use, ASAM
 - <http://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf?sfvrsn=24>
- Informational Bulletin: Medication Assisted Treatment for Substance Use Disorders, Centers for Medicaid and CHIP Services
 - <https://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-07-11-2014.pdf>

Resources CONT'D

- Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings, AHRQ
 - <https://www.effectivehealthcare.ahrq.gov/ehc/products/636/2350/opioid-use-disorder-report-161123.pdf>
- Treatment Needs Questionnaire.
 - Developed by Sigmon, SC & Brooklyn JR (2015) for Vermont
 - Included as a PDF in the reminder email yesterday
- Office-Based Opioid Treatment Stability Index.
 - Tool utilized by Vermont
 - Included as a PDF in the reminder email yesterday

State Speaker Contact Information

- John Brooklyn, MD, University of Vermont
 - johnr.brooklyn@gmail.com, 802-864-6309
- Anthony Folland, VT Department of Health
 - anthony.folland@vermont.gov, 802-652-4141
- Colleen Labelle, MSN, RN-BC CARN, Boston Medical Center
 - colleen.labelle@bmc.org, 617-797-6712

Speaker Contact Information

- Colette Croze, MSW, Croze Consulting
 - crozec@aol.com, 302-378-7555
- Mady Chalk, PhD, MSW, Treatment Research Institute
 - mchalk@tresearch.org, 202-425-0433
- Susan Parker, CPA, MT, Parker Dennison & Associates
 - susanp@parkerdennison.com, 480-419-4147

Thank You!

**Thank you for joining us for this
National Dissemination Webinar!**

Please complete the evaluation form
following this presentation.