Delaware Division of Medicaid and Medical Assistance's Management of Addictions in Routine Care Model *(updated 9/11/24)*

High rates of substance use disorders (SUD) and associated adverse outcomes continue to disproportionately impact the Delaware Medicaid population. In the calendar year 2022, per claims analysis, 12.1 percent of the Delaware Medicaid population had any SUD. The most represented SUDs in the Delaware Medicaid population were opioid use disorders (OUD) at 7.6 percent and alcohol use disorders (AUD) at 3 percent. Data from the U.S. Centers for Disease Control and Prevention demonstrates that Delaware had the fourth highest rate of drug overdose mortality in the country in 2022. Further, Delaware was tied for the second highest rate of polysubstance use among Medicaid beneficiaries in the country in 2020 (most recently available data) per the Centers for Medicare and Medicaid Services Databook.

This concept paper provides the framework for a new Delaware Division of Medicaid and Medical Assistance (DMMA) Management of Addictions in Routine Care (MARC) program, which is focused on building a comprehensive network of outpatient medical practices to serve clients with SUD by incorporating buprenorphine and other addiction medications, as well as other strategies to address SUD, into their standard care. In this concept paper, DMMA identifies key elements of the MARC model, including eligible provider types, eligible clients, service delivery approaches, performance measures, payment model, staffing requirements, the provider enrollment process, among other initial program components.

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DMMA's MARC program is based on national best practices research associated with the Office-Based Opioid Treatment (OBOT) model. Over the past decade, numerous Medicaid agencies have implemented statewide initiatives, through the design of programmatic requirements and enhanced reimbursement structures, to spur the adoption of OBOT, primarily focused on incorporating buprenorphine treatment into primary care and other outpatient medical settings. DMMA's model, however, is designed to serve clients with other SUDs that can be effectively addressed through medications in outpatient medical settings, including AUD. For this reason, DMMA has elected to not use OBOT terminology and is using MARC instead; this both reflects DMMA's commitment to addressing SUDs beyond OUD in our model and our intent to normalize medications and other tools for addiction treatment in outpatient medical settings versus viewing it as the establishment of a new specialty program.

After a national best practice scan and interviews with other states, in March 2024, DMMA implemented a robust stakeholder engagement effort to obtain input and feedback initial design recommendations for this model. Through structured survey tools, DMMA received feedback from 18 prospective MARC programs and nine collaborating entities, such as Medicaid managed care organizations, hospital systems, and other healthcare entities. DMMA is currently in the process of interviewing consumers who have received medications for addiction to gather additional input on the model. DMMA plans to continue an important bidirectional dialogue with stakeholders to design a program that works for Delawareans with SUD and fits into the Delaware-specific healthcare ecosystem and provider base.

Program Specifications

A. Eligible Provider Types

DMMA will include primary care practices (including Federally Qualified Health Centers) and any interested specialists with the ability to prescribe medications for addiction, such as obstetrics, gynecology, or other outpatient medical practices focused on women's health, infectious disease, and pediatric care. Other specialties will be considered by DMMA through the provider application, attestation, and readiness review processes, described in Section G below, by assessing the specialty type, medication prescribing patterns, performance on Medicaid quality measures, and other factors to assess appropriateness of participation in the program.

Specialty SUD programs – such as outpatient, intensive outpatient, and opioid treatment programs – are vital partners to the MARC program as inbound and outbound referral partners and collaborators but are not eligible to enroll in the MARC program. Further, primary care services embedded in specialty SUD programs are ineligible. Pharmacists will not be eligible to participate in the MARC program through direct prescribing of medications in early implementation but will be integral to ensuring that medications are readily available, and if appropriate, stored and administered (i.e., Sublocade injections) to MARC clients within pharmacies and other medical settings.

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B. Service Array and Delivery Approach

DMMA endorses a low-threshold, trauma-informed service delivery model that underscores rapid access to medications for addictions with availability of other psychosocial services (e.g., counseling, case management). Further, most Delaware stakeholders endorsed DMMA's preference to broaden the focus of MARC beyond opioids, given that there are effective medications that can be incorporated into routine medical care that address other SUD types, around which the Delaware Medicaid population has concerning prevalence rates. As such, DMMA proposes that MARCs deliver low-threshold medication treatment, including initiation and continuation services, guided by the ten tenets aligned with the medication-first model[1] displayed in Exhibit 1.

Exhibit 1. Ten Tenets of Delaware's Proposed MARC Service Delivery Approach
1. Screening protocols to identify clients in need of medications for addiction.
2. Partnerships with other systems (e.g., hospital emergency departments, justice settings, emergency medical services) to create smooth and rapid access to care for individuals with elevated overdose risk and/or who are underserved (i.e., pregnant and parenting people with SUD).
3. Rapid access to medications prior to lengthy assessments or treatment planning sessions, and convenient access to care options for initiation and continuation of medications to the extent practicable, such as drop-in hours, extended hours, telehealth, colocation, and mobile units.
4. Ability to provide flexible medication initiation approaches, including capacity for at-home and telehealth (observed and unobserved) medication initiations.
5. No counseling or other non-medication service engagement mandates (but individualized services should be offered).
6. Ability to identify and support clients to engage in higher levels of care, if appropriate.
7. No exclusions for polysubstance use or continued use, leveraging harm reduction and sustained engagement protocols to address lapses and/or continued use to promote client safety, engagement, and retention in care.
8. No arbitrary tapering or time limits, with discontinuation only if it is worsening the client's condition.

[1] https://www.jsatjournal.com/action/showPdf?pii=S0740-5472%2819%2930120-5

9. Strategies to effectively retain clients in care, including higher buprenorphine doses (up to 24 mg), contingency management (limited to specific populations per approved 1115 waiver), and staffing models that support assertive engagement.
10. Use of drug screening as a therapeutic tool that does not result in discharge based on lapses and/or positive test results.

C. Payment Model and Reimbursement Approach

As shown in Exhibit 2, DMMA plans to provide enhanced reimbursement to MARC providers. While the provision of medications for addiction fits within routine medical care, DMMA is providing enhanced payment for the services identified in Exhibit 2.

Exhibit 2. Proposed Payment Model for DMMA's MARC Program

Service	*Description*	*Code*	*Payment Rate*	*Limitations*
Comprehensive Assessment and Care Planning	Screening and identification of SUD, incorporating SUD into problem list, establishing care goals, and developing plans to address in future visits	TBD with HF modifier	TBD	Can be billed once per year per beneficiary; all SUDs except tobacco
Ongoing Care Planning	Providing support around care goals, facilitating harm reduction, refining care goals	99212-99215 with HF modifier	TBD	Initial visit must occur within 4 weeks of Comprehensive Assessment and Care Planning visit; all SUDs except tobacco; will be limited in number of times it can be billed per year (TBD)
Principal Illness Navigation	Helping clients understand their medical condition or diagnosis, guiding clients through the health care system (more here)	G0023, G0024 with HF modifier	TBD	Only open to prescriber-plus MARCs; all SUDs except tobacco.

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Further, DMMA will provide guidance on how to optimize other available billing and coding options, including for screening, urine drug screening, ancillary psychosocial services, consultation with addiction specialists, and other services and procedures that may occur within the MARC program. Most of these services and billing codes are already opened and priced according to the Delaware 2024 Physician Fee Schedule and include:

- Behavioral health integration (99484)
- Interprofessional consultation codes (99446-99449, 99451, 99452)
- Screening, brief intervention, and referral to treatment (SBIRT) codes (99408, 99409)

- Behavioral health screening codes (96127, G0444)
- Established patient E&M without physician (e.g., nurse services) (99211)
- Urine drug screening (80305, 80306, 80307)
- Initiation of medications for addiction treatment in emergency departments (G2213)
- Tobacco cessation counseling (99406, 99407)

DMMA intends to enroll MARCs directly and then refer them for MCO contracting. MCOs will be required to pay enhanced rates via a directed payment. DMMA, to the extent allowable and feasible, in partnership with MCOs, will ensure that MARC services delivered via telehealth and in the community (i.e., mobile services) are fully reimbursed.

D. Staffing Requirements

DMMA acknowledges that each MARC provider may have different staffing needs to effectively incorporate medications for addictions into its unique practice setting, including consideration of what staffing models best support their client populations. In lieu of a prescriptive approach, as shown in Exhibit 3, DMMA currently plans to allow a prescriber-only (option 1) and prescriber-plus model (option 2). Option 2 enables the practice to add a Principal Illness Navigator.

Through their stakeholder survey responses, most prospective MARC providers expressed interest in the prescriber-plus model. While most respondents preferred either nurses or social workers as ancillary staff, they acknowledged that a wide array of staff could perform required Principal Illness Navigator functions, including community health workers, medical assistants, peer specialists, and licensed professional nurses. DMMA's use of the Principal Illness Navigation model for care coordination allows for flexible staffing.

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Exhibit 3. Proposed Staffing Models	
Option 1. Prescriber-Only Model	*Option 2. Prescriber Plus Model*
● Prescriber provides medication initiation, continuation, and light care coordination services without additional staffing. ● Prescriber has access to increased E&M reimbursements. ● Prescriber has access to other open and priced codes at their standard reimbursement levels, such as the behavioral health integration code. ● Prescriber has access to training, technical assistance, and practice support from addiction specialists. ● Prescriber offers psychosocial services and have resources in place (through referral relationships) to provide linkage to such services. ● Prescriber and staff offers Naloxone kits or makes available through other means (e.g., co-prescribing).	● Prescriber provides medication initiation and continuation. Principal Illness Navigator (PIN) provides navigation services. ○ If a nurse care manager model (NCM) is used, NCM can support key elements of initiation and continuation clinical workflow with prescriber support. ● Prescriber has access to increased E&M and practice can bill PIN code, using existing billing options to cover additional staff roles (e.g., nurse care managers). ● Team members have access to training, technical assistance, and practice support from addiction specialists. ● Team members offer psychosocial services and have resources in place (direct staffing or referral relationships) to provide such services. ● Team members offer Naloxone kits or make it available through other means (e.g., co-prescribing).

To the extent that navigation services are delivered by staff who are already reimbursable within that staff's standard scope of practice (e.g., nursing services), Principal Illness Navigation should only be billed when services and activities are 'above and beyond' that standard scope.

E. Eligible Clients and Client Recruitment

DMMA proposes that this service is delivered to Medicaid beneficiaries, served through MCOs, with SUDs (excluding tobacco) with or without other co-occurring mental health challenges. Given that MARC providers are not specialty SUD programs and provide whole-person care (including primary care), clients should be recruited to participate in their full array of services. Solely marketing the SUD medication component of services may trigger regulatory requirements, such as 42CFR Part 2, as the MARC program would then "set itself out" as an SUD program. However, other internal and external strategies can be used to engage individuals with SUD and primary care needs, by (1) implementing universal SUD screening protocols among clients; (2) identifying current clients with SUD diagnoses who have not been engaged around their SUD within the practice; (3) forging partnerships and care pathways with other systems (e.g., emergency departments, criminal justice settings) to reach underserved populations with SUD; (4) partnering with Medicaid Managed Care Organizations to receive referrals; and (5) partnering with the specialty SUD system to receive referrals.

F. Performance Measures

DMMA is proposing a set of claims-based measures to reduce provider reporting burden. For each MARC provider and across the cohort, DMMA (or its MCOs) will assess the utilization of relevant procedure codes (e.g., enhanced E&M code, Principal Illness Navigation code) and the National Quality Forum (NQF) #3175 measure that calculates the percentage of people receiving MOUD who use it for at least six months. Further, DMMA will include diversity and equity metrics in the MARC program to track access, utilization, and outcomes among different demographic groups, including racial/ethnic minorities, pregnant and parenting people, justice-involved populations, and persons with prior non-fatal overdoses.

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G. Application and Designation Process

DMMA will provide a special MARC designation that allows them to receive enhanced reimbursement. DMMA will utilize a simple application and designation process that includes:

- Prospective MARC provider submits application that includes practice-level information (e.g., business name, NPI number, location, taxonomy), service delivery location(s), prescriber/other staffing details (e.g., chosen staffing model, staff names and credentials), and target number of patients served each quarter.
- DMMA conducts desk review of provider applications and advances selected providers to a second phase of review, in partnership with MCOs, involving a more granular eligibility and readiness review.
- DMMA, in partnership with MCOs, approves selected MARC providers and issues designation letters.
- MARC provider requests contracts with Medicaid MCOs.
- MCOs select MARC providers for contracting.
- Medicaid MCOs and DMMA activate special codes with enhanced payment rates for Medicaid beneficiaries enrolled with managed care programs.
- MARC provider begins service delivery.

Submitting an attestation and receiving approval from DMMA will not guarantee an MCO contract; MCOs will have discretion to select providers through their readiness review process, based on factors such as network adequacy and past provider performance. The readiness review process is expected to be implemented in early 2025. MARCs that do not directly employ licensed behavioral health practitioners to provide SUD counseling would not be subject to licensure under current and proposed Delaware Division of Substance Abuse and Mental Health (DSAMH) regulations.

H. Alignment with Other Delaware Initiatives and Services

Existing initiatives have created a helpful foundation for DMMA's MARC work. These include:

- *1115 SUD Demonstration Waiver.* In this waiver,[2] DMMA added Medicaid coverage for contingency management (also known as motivational incentives) for individuals with a stimulant use disorder and/or for pregnant or postpartum people (PPP) with an opioid use disorder. MARC programs that serve PPP can apply to participate in both initiatives, providing motivational incentives to PPP who receive medications for opioid use disorder.
- *Partnership with the Division of Substance Abuse and Mental Health (DSAMH) and Specialty SUD Programs.* DMMA will collaborate with DSAMH to ensure bi-directional relationships between MARC and specialty SUD programs, and also encourage MARC programs to participate in the Delaware Treatment and Referral Network.
- *Medicaid Managed Care Organization Partnerships.* DMMA will also partner with its MCOs to conduct quarterly claims analysis of MARC clients, link eligible MCO beneficiaries to MARC services, facilitate training and technical assistance, and coordinate linkages between providers and programs within the MCO network.

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I. Available Technical Assistance

While research demonstrates that SUD can be treated in outpatient medical care with minimal practice adaptation, DMMA acknowledges that specialized technical assistance may be needed to help providers gain the skills, expertise, and comfort level to implement medications in routine care. Further, providers may want or need real-time advice/consultation or even wish to directly collaborate with an addiction specialist around a client's care.

In early 2025, DMMA will provide MARC Early Adopter Grants to select practices to help them become champions of the model and position themselves as a resource for other providers to overcome barriers to treating addiction as part of the normal course of business. Examples of how early adopters may use the funds include conducting community needs assessments, designing and implementing staff training plans including anti-stigma/discrimination strategies, form partnerships to allow for bi-directional referrals with SUD specialty care providers, and create evaluation plans. Early adopters will be expected to forge operational partnerships to reach high-need populations, such as individuals with criminal justice involvement, pregnant and parenting people, and individuals who have experienced non-fatal overdoses.

If you have any questions or comments on this concept paper, please contact Dr. Sherry Nykiel, DMMA Behavioral Health Medical Director, at Sherry.Nykiel@delaware.gov.

[2] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/de-dshp-dmntn-appvl-05172024.pdf