Concept Paper: Delaware Medicaid Office-Based Opioid Treatment (OBOT) Model

High rates of opioid use disorder (OUD) and associated adverse outcomes continue to disproportionately impact the Delaware Medicaid population. In calendar year 2021 (the most recent data available), Delaware had the third highest rate of OUD-related deaths in the country.[1] This concept paper provides the framework for a new Delaware Division of Medicaid and Medical Assistance (DMMA) office-based opioid treatment (OBOT) program, which is focused on building a comprehensive network of outpatient medical providers to serve patients with OUD by incorporating buprenorphine treatment into their standard care. Buprenorphine is the gold standard treatment for OUD. Over the past decade, five state Medicaid agencies have implemented statewide initiatives, through the design of programmatic requirements and enhanced reimbursement structures, to spur the adoption of buprenorphine treatment into primary care and other outpatient medical settings. DMMA intends to design and administer a similar OBOT program in Delaware.

In this concept paper, DMMA has proposed basic elements of the OBOT model, including eligible provider types, eligible patients, service delivery approaches, performance measures, payment model, staffing requirements, the provider enrollment process, among other initial program components. This straw proposal is intended to start an important bidirectional dialogue with stakeholders to design a program that works for Delawareans with OUD and fits into our Delaware-specific healthcare ecosystem and provider base. DMMA will implement a robust stakeholder engagement effort to obtain input and feedback, refine/change these initial design recommendations, and create an operational plan to ensure effective and efficient implementation. Key stakeholders include Medicaid managed care organizations, outpatient medical providers, beneficiaries, family members, and many others.

Proposed Design Elements

In February and March of 2023, DMMA conducted a national best practice scan to identify best practices in statewide OBOT initiatives. Based on that research, DMMA is proposing the design elements that follow.

A. Eligible Provider Types

All state Medicaid OBOT programs studied by DMMA included primary care practices in their models, with some states including other specialty medical and behavioral health practices. To align with eligibility of DMMA's OBOT Fellowship and to expand reach to high need/underserved populations in Delaware, DMMA proposes to include primary care practices (including Federally Qualified Health Centers) and any interested

[1] https://www.kff.org/other/state-indicator/opioid-overdose-death-rates/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Opioid%20Overdose%20Death%20Rate%20(Age-Adjusted)%22,%22sort%22:%22desc%22%7D

specialists with the ability to prescribe medications for opioid use disorder, such as obstetrics, gynecology, or other outpatient medical practices focused on women's health; infectious disease clinics; and outpatient psychiatry clinics.

B. Service Array and Delivery Approach

All states interviewed by DMMA endorsed low-threshold, trauma-informed service delivery models that underscore rapid access to medications for OUD with availability of other psychosocial services (e.g., counseling, case management). As such, DMMA proposes that OBOTs deliver low-threshold buprenorphine treatment, including buprenorphine initiation (if the provider is willing and able) and stabilization services, guided by the ten tenets aligned with the highly effective medication-first model[2] displayed in Exhibit 1.

DMMA will consider developing OBOT initiation sites open 24 hours a day, 7 days a week (tentatively called Buprenorphine Access Centers)—targeting at least one in each county—that could assist patients with medication inductions as needed. During the stakeholder engagement process, DMMA will query outpatient medical practices about the feasibility and implications of addressing other substance use conditions, such as stimulant use and alcohol use disorders, through this or related initiatives.

Exhibit 1. Ten Tenets of Delaware's Proposed OBOT Service Delivery Approach
1. Screening protocols to identify patients in need of buprenorphine treatment.
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.
3. Rapid access to medications prior to lengthy assessments or treatment planning sessions.
4. Ability to provide flexible buprenorphine initiation approaches, including capacity for at-home and telehealth (observed and unobserved) medication initiations.
5. Convenient access to care options, such as drop-in hours, extended hours, telehealth, colocation, and mobile units.
6. No counseling or other non-medication service engagement mandates (but individualized services should be offered).
7. Polysubstance use should not exclude patients' participation in care within the OBOT program.
8. No arbitrary tapering or time limits, with discontinuation only if it is worsening the patient's condition.
9. Strategies to effectively retain patients in care, including higher doses (up to 24 mg), contingency management (limited to specific populations per pending 1115 waiver), and staffing models that support assertive engagement.
10. Harm reduction and sustained engagement protocols to address lapses and/or continued use to promote patient safety, engagement, and retention, including using drug screening as a therapeutic tool that does not result in discharge based on lapses and/or positive test results.

Many states require OBOTs to complete a comprehensive assessment and/or treatment plan for each patient. DMMA will engage providers and other experts on how to balance the collection of essential information needed to deliver effective care with the need to provide rapid-access, convenient, and low-barrier care.

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

C. Eligible Patients

DMMA proposes that this service is delivered to Medicaid beneficiaries with OUD with or without other co-occurring mental health or substance use disorder (SUD) challenges. DMMA acknowledges that certain populations bear a disproportionately high burden of OUD and its impacts. For this initiative, DMMA will consider how to create expectations and requirements for OBOT providers to increase MOUD access for at least three vulnerable populations: pregnant and parenting people, justice-involved individuals, and persons with prior non-fatal overdoses. To better reach and serve these populations, DMMA will: align with existing initiatives (e.g., SUD 1115 waiver programs, Overdose System of Care); develop specialized content on outreach and engagement of these populations; provide access to clinical experts and guidance (e.g., buprenorphine initiation in pregnancy) to support stronger clinical practice; and consider requirements and financial incentives to serve these populations.

D. Payment Model and Reimbursement Approach

As shown in Exhibit 2, DMMA plans to provide enhanced reimbursement to OBOT providers through increased Evaluation and Monitoring (E&M) reimbursement rates for buprenorphine initiation and stabilization and availability of a new billing code to cover care coordination services. Given the potential complexity and time requirements of buprenorphine initiation, the payment rate for initiation will be higher. If feasible, like other states, DMMA will design a care coordination code that is billed on a per person per month basis.

Exhibit 2. Proposed Payment Model for Medicaid OBOT Program

- **Enhanced payment for medications for opioid use disorder (MOUD) intake, assessment, and initiation** (potential billing code: 90792 with "HF" modifier, payment rate TBD)
- **Enhanced payment for evaluation & management (E&M) for MOUD continuation** (potential billing codes: 99212 – 99215, with "HF" modifier, payment rates TBD)
- **Creation of a new monthly care coordination code** (potential code: G9012, payment rate TBD) *[Note: This code would only be open to the 'prescriber-plus' OBOTs.]*

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 OBOT program.

DMMA may require OBOT providers to contract with MCOs. MCOs may be required to participate in the program, to contract with all Medicaid-certified OBOTs, and pay specific rates via a directed payment. DMMA will consider whether it is also necessary to reimburse for OBOT services in the fee-for-service program.

E. Staffing Requirements

Most statewide OBOT initiatives require a prescriber and at least one clinician (e.g., nurse care manager, licensed behavioral health clinician). While all other states have relatively prescriptive staffing approaches, DMMA acknowledges that each OBOT

provider may have different staffing needs to effectively incorporate buprenorphine treatment into its unique practice setting. Some programs may prefer a prescriber-only model, while other programs may wish to add behavioral health clinicians, nurse care managers, care coordinators, peer specialists, or patient navigators to their programs. 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). Through stakeholder engagement, DMMA will assess whether prescribers are interested in option 1 and whether a special enrollment/designation process for option 1 providers is necessary.

Exhibit 3. Proposed Staffing Models

Option 1. Prescriber-Only Model	*Option 2. Prescriber Plus Model*
● Prescriber provides buprenorphine initiation, stabilization, and light care coordination services without additional staffing. ● Prescriber has access to increased E&M and existing behavioral health integration code. ● Prescriber has access to training, technical assistance, and practice support from addiction specialists. ● Prescriber is required to offer psychosocial services and have resources in place (through referral relationships) to provide linkage to such services. ● Prescriber and staff must offer Naloxone kits or make it available through other means (e.g., co-prescribing).	● Prescriber leads/oversees buprenorphine initiation and stabilization but other staff conduct care coordination. ○ If a nurse care manager model (NCM) is used, NCM can support key elements of initiation and stabilization clinical workflow with prescriber support. ● Prescriber has access to increased E&M and care coordination codes. ● Can use care coordination reimbursement and existing billing options to cover additional staff roles (e.g., nurse care managers, navigators). ● Team members have access to training, technical assistance, and practice support from addiction specialists. ● Team members are required to offer psychosocial services and have resources in place (direct staffing or referral relationships) to provide such services. ● Team members must offer Naloxone kits or make it available through other means (e.g., co-prescribing).

F. Performance Measures

States largely use process measures to monitor OBOTs. DMMA is proposing a set of claims-based measures to reduce provider reporting burden. For each OBOT provider and across the cohort, DMMA (or its MCOs) will assess the utilization of relevant procedure codes (e.g., enhanced E&M code, care coordination 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.

G. Application and Enrollment Process

States typically require Medicaid and managed care organization (MCO) enrollment for OBOTs, providing a special designation that allows them to receive enhanced reimbursement. **DMMA will utilize a simple application and enrollment process that includes:**

- Prospective OBOT provider submits application that includes practice-level information (e.g., business name, NPI number, location), 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 issues designation letter to OBOT provider.
- OBOT provider contracts with each Medicaid MCO.
- Medicaid MCOs activate special codes with enhanced rates.
- OBOT provider begins service delivery and reporting.

OBOTs 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. Available Technical Assistance and Support

While research demonstrates that OUD 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 buprenorphine treatment. Further, providers may want or need real-time advice/consultation or even wish to directly collaborate with an addiction specialist around a patient's care.

Pending funding availability, DMMA plans to contract with a local entity or entities to provide group and individual technical assistance and practice guidance on buprenorphine treatment in outpatient medical settings; offer real-time clinical advice and consults to providers via a hotline/warmline; and receive direct referrals from OBOT providers to consult around or directly deliver care (via telehealth or in-person) to patients who may need a higher level of care. This entity must have specialized expertise in serving the special populations referenced above, and may also serve in the "Buprenorphine Access Center" role described in "Section B" above.

I. Alignment with Other Delaware Initiatives

Existing initiatives have created a helpful foundation for DMMA's OBOT work. For example, in its 1115 demonstration waiver extension request,[3] DMMA proposed adding Medicaid coverage for contingency management (also known as motivational incentives) for individuals with a stimulant use disorder and/or for pregnant or postpartum people with an opioid use disorder. DMMA has developed coordination and collaboration plans with each of the relevant projects, primarily focused on leveraging existing convenings for stakeholder engagement deepening the engagement of and financial sustainability of existing Office-Based Opioid Treatment programs.

If you have any questions or comments on this concept paper, please contact SUPPORTAct@delaware.gov.

[3] https://dhss.delaware.gov/dmma/files/de_proposed_dshp_1115_waiver_ext_req_pub_notice_nov_2022.pdf