NATIONAL COUNCIL for Mental Wellbeing

CENTER OF EXCELLENCE
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INTEGRATED CARE FINANCING SERIES

MODULE 1

MEDICATION FOR OPIOID USE DISORDER

NOVEMBER 2022

Background

This brief is part of a series that aims to accelerate the ease of implementation of evidence-based integrated care interventions across a myriad of organization settings. It also serves a contextual complement to the Integrated Care Financing Decision Support Tool, which provides billing, reimbursement and aggregate financial modeling insights to support implementation. Like all its counterparts, this Medication for Opioid Use Disorder (MOUD) module is mutually inclusive and can be used independently or in conjunction with the other modules. Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

Please note this module is accurate as of publication date (November 2022).

Introduction

For decades, the integrated care movement has emphasized the integral role of mental health and substance use treatment services in improving health outcomes and service delivery across the American health care system. Ensuring that evidence-based integrated care approaches are permanent, widespread and accessible to all consumers hinges on health care organization and health system adoption of sustainable financing strategies. The need for integrated primary care and mental health and substance use treatment services is more pressing than ever amid an opioid epidemic that has claimed the lives of more than 750,000[1] Americans over the past two decades. MOUD is the most effective intervention to treat individuals living with opioid use disorder (OUD), yet financing strategies for such approaches can be complex and confounding to provider organizations. Deployment of sustainable MOUD financing strategies incurs the dual benefits of meeting an urgent public health imperative while also strengthening the broader integrated care movement. This brief will provide practical guidance on MOUD financing strategies, including:

- Coverage landscape
- Core MOUD services
- Revenue cycle considerations
- Optimizing staff to maximize reimbursement
- Building sustainable partnerships, care coordination and care transitions
- Preparing for value-based payment

Application and Limitations

The national health care financing landscape is complex and variable, often informed by local factors, such as state policy decisions, allocation of categorical grant-based funding, health insurance coverage and payer priorities. This brief and series will primarily focus on fee-for-service (FFS) financing considerations for MOUD. Despite this FFS lens, the insights that follow are universally applicable to organization settings that are financed through alternative payment mechanisms such as cost-based, prospective and value-based payment arrangements, acknowledging that FFS costing considerations are often the financial benchmark to structure alternative payment mechanisms. In short, the information herein is as specific as possible while acknowledging variations in local payment and delivery landscape and operational diversity across organization settings. Guidance on how to adapt this information to your local landscape is highlighted throughout this brief in the *Implementation Considerations* subsections.

Please note that payers and/or local policies and regulations may mandate specific documentation standards to authorize and/or substantiate patient eligibility for MOUD services and complementing clinical services. Practices are encouraged to review their payer contracts and local regulations for additional guidance.

MOUD Coverage Landscape

MOUD Definitions

The Food and Drug Administration (FDA) recognizes[2] three prescription medications for the treatment of OUD:

1. Buprenorphine
2. Methadone
3. Naltrexone

Each medication has multiple modalities for administration to the patient. For example, naltrexone and buprenorphine are manufactured in pill and long-acting injectable formulations. The administration modality is noteworthy through a financing lens as it may impact health insurance coverage, the frequency and type of billable encounter and clinical workflow of an organization.

Coverage Considerations

This brief reviews coverage and financing considerations salient to qualified health plans (QHPs), Medicaid and Medicare. Collectively, these coverage options provide health insurance to more than 89% of Americans.[3] Organizations seeking to implement MOUD should consider the health insurance coverage of their target population – or "payer mix" – as it has clinical workflow and financing implications. For example, payment rates, billing and reimbursement procedures and utilization management can vary widely by payer, which holds implications for the staff needed to manage administrative burdens and revenue opportunities, which may also vary by professional discipline.

The Mental Health Parity and Addiction Equity Act (MHPAEA) mandates coverage of substance use disorder (SUD) services, including medication, in most health insurance plans in a manner that is equitable to physical health benefits. However, payers have great latitude on the services and treatment that are covered and prioritized. For example, payers can choose to prioritize generic over name brand medications or place prior authorization requirements on the long-acting injectable version of a medication and no prior authorization on the tablet version of the same medication. Table 1 notes considerations by major health insurance categories below.

Table 1. MOUD Mandatory Coverage by Type

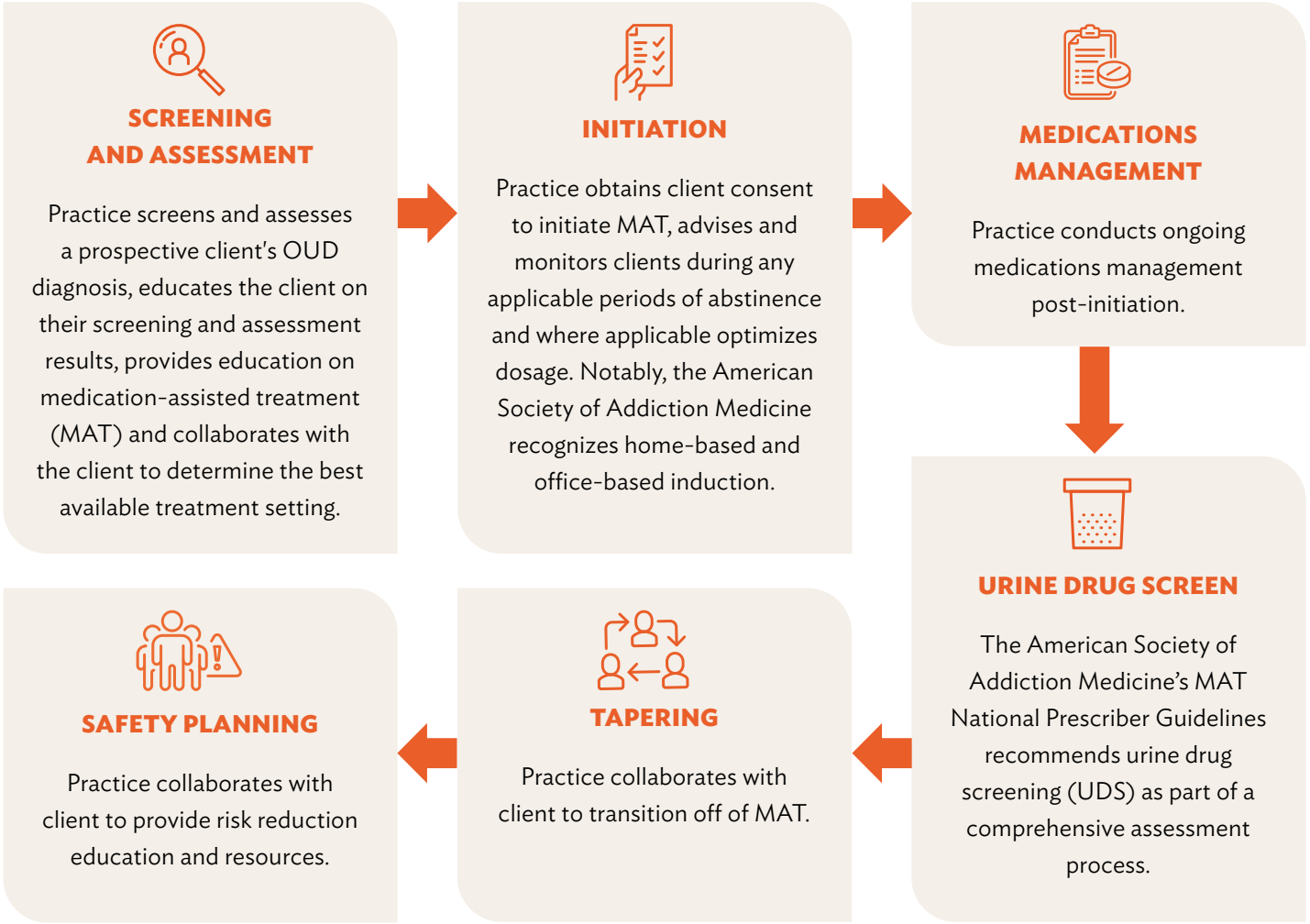
QUALIFIED HEALTH PLANS	MEDICAID	MEDICARE
QHPs are required to cover at least one prescription medication in every category and class of the U.S. Pharmacopeia – National Formulary,[4] or as many prescription medications, in class and category, as the state essential health benefit (EHB) plan. Recently, an independent study[5] noted that all state essential health benefit plans covered at least one form of buprenorphine. This suggests that buprenorphine is widely available across most QHPs. Organizations are encouraged to review the prescription drug coverage of their state's EHB[6] plan to ascertain an approximation of coverage of MOUD in their states and jurisdictions.	Every state Medicaid agency has elected to cover prescription drugs. While this choice means that state Medicaid agencies are functionally required to cover all prescription drugs, utilization management techniques are used to restrict and accelerate access to specific medications. The SUPPORT Act requires state Medicaid to cover MOUD. This includes all FDA-approved drugs and behavioral health therapy from October 2020 through September 2025. The only exception is if a state certifies that statewide implementation is infeasible due to provider shortages.	Collectively, Medicare Parts A, B and D offer uniform coverage of most MOUD. Part C Medicare Advantage plans must meet minimum coverage requirements but may also prioritize and restrict access to specific drugs through utilization management. Until January 1, 2020, coverage of methadone for OUD treatment was prohibited in standard Medicare.[7] Opioid treatment programs (OTPs)[8] may now apply to be included in the Medicare program.

Core MOUD Services

The comparative effectiveness of MOUD's ability to support long-term recovery and reduce overdose mortality risk for people living with OUD is well documented. Organizations may also choose to offer substance use treatment and recovery support services (RSS) alongside or in coordination with MOUD prescription drugs. Complementary services may be required by your jurisdiction and/or care setting. Implementing MOUD services that are patient centered, effective and financially sustainable requires careful consideration of your organization's desired services array and staffing model. Billing, coding and coverage nuances across a generalized MOUD clinical workflow are detailed below. Approximate Medicare FFS reimbursement rates, billing codes and applicable professional disciplines are noted in the Decision Support Tool.

MOUD Prescribing

All prescribers who are licensed to practice and have a valid Drug Enforcement Agency registration can prescribe all forms of methadone and naltrexone. Buprenorphine-prescribing authority requires training and a registration process.[9] General MOUD prescribing phases are noted below. Comprehensive MOUD national prescriber guidelines are available through the American Society of Addictions Medicine.[10]



Mental Health and Substance Use Services

Mental health and substance use treatment services are broadly reimbursable across QHPs,[11] Medicaid[12] and Medicare Parts A,[13] B[14] and C. While this coverage is largely mandatory, organizations should assess the licensed and credentialed professionals who are eligible to provide specific services under their payer contracts. This assessment should consider utilization management and differentiate the extent to which services can be reimbursed via *direct provision* by a licensed and credentialed professional versus those that are reimbursable *under the supervision* of a professional with a license. For example, a payer may require that individual therapy be provided by a licensed psychologist, social worker, marriage and family therapist and/or counselor, yet allow nonlicensed providers, such as certified recovery specialists, to provide group therapy under the supervision of a licensed professional. The nuance of *direct provision* versus *under supervision* applies to Medicaid and QHPs and will have implications on an organization's staffing model that are discussed later in this brief, including assurance that:

- Staff is acting within their licensure's scope of practice.
- Patients receive services that are responsive to their needs.
- Staff is performing to the top of their licenses.
- The financing and delivery model is aligned to maximize sustainability.

Conversely, eligibility for reimbursement by professional discipline is consistent across all parts and published by CMS.[15]

Recovery Support Services

The Substance Abuse and Mental Health Services Administration (SAMHSA) defines RSS as [services that support] a process of change through which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.[16] Compared to MOUD and Behavioral Health Therapy, RSS are less uniformly defined across QHPs, Medicaid and Medicare. While it is possible for all professional disciplines to provide recovery services, models of care often prioritize RSS to be delivered by nonlicensed professionals. In the past decade,[17] state policy decisions have determined the extent to which nonlicensed professionals, such as community health workers, peers and peer recovery support specialists are able to seek direct reimbursement for services rendered. The lack of national coverage standards and guidelines has defaulted to a patchwork landscape[18] of health insurance financing opportunities for RSS. Coverage guidance is detailed in Table 2.

Table 2. Coverage Considerations of Recovery Support Services

COVERAGE TYPE	COVERAGE GUIDANCE
Qualified Health Plans	QHPs are not required to cover RSS. Despite a lack of a mandate, some QHPs have elected to include coverage of peer services through value-based and alternative payment mechanisms.
Medicaid	RSS are not a mandatory Medicaid benefit. States can elect to reimburse for services through a state plan amendment or waiver process. If a state chooses to cover RSS, utilization management such as copayment, prior authorization and quantity limits may apply.[19]
Medicare	Medicare does not cover RSS provided by nonlicensed professionals in Parts A, B and D. The CMS encourages[20] Part C (Medicare Advantage) plans to cover peer services, but it is not required.

Implementation Considerations

The aforementioned considerations provide general guidelines regarding mandatory MOUD coverage. This information should be paired with research on how these parameters manifest in local payer landscapes. Coverage by billing codes is also highlighted in the Decision Support Tool. To this end, salient action items include:

- ☐ Conduct a payer mix assessment to determine the aggregate health insurance coverage status of your target patient population.
- ☐ Identify coverage of all three MOUD prescription drugs and their modalities in your state's EHB benchmark plan.21 Use these insights as a general approximation of coverage for QHPs and the private health insurance market.
- ☐ Examine your state/jurisdiction Medicaid preferred drug list to determine coverage of MAT.
- ☐ Review payer contracts to ensure that your care setting is credentialed to offer MAT services.
- ☐ Investigate the extent to which your state/jurisdiction mandates substance use treatment health and/or recovery support services to be delivered in conjunction with MAT.
- ☐ Review additional utilization management techniques across all payers. Consider the estimated time burden of negotiating prior authorization and other payer engagement in your staffing model. Prevalent utilization management includes:
  - » Copayment and coinsurance
  - » Prior authorization
  - » Quantity limits
  - » Step therapy
- ☐ Review your state's prescribing guidelines to determine what services must be concurrent with MAT prescribing.
- ☐ Determine MOUD services staffing model, noting staff who are directly reimbursable, reimbursable under supervision and not reimbursable.
- ☐ Identify and support patients with accessing pharmacy assistance program to pay for MOUD.
- ☐ Build partnerships with organizations such as federally qualified and rural health centers (RHC) to support individuals without insurance.

Revenue Cycle and Quality Management

Revenue cycle management refers to the clinical and operational processes that capture, manage and collect patient services revenue. An efficient revenue cycle is accurate, precise and expedient and supports the overall financial sustainability of clinical services. These processes must be buttressed with timely and accurate coding or "charge capture." Thus, the provision of patient-centered MOUD services should be paired with assertive revenue cycle and clinical quality management processes.

For example, retention in MOUD services in a manner that is clinically appropriate and responsive to patient needs results in positive aggregate clinical outcomes and predictable and sustainable revenue opportunities. Similarly, consistent and predictable patient volume and revenue allows organizations to efficiently allocate staff in a manner that mitigates the risks of underutilization and unnecessary staffing expenses. Organizations are encouraged to develop and monitor key performance indicators (KPI) that can provide insight into the quality and sustainability of services. It is also important to note that payers may require specific service sequences or workflows to maximize reimbursement.

While KPIs should vary based on setting of care, staffing model and coverage of services, sample clinical and revenue cycle KPIs for MAT services may include:

- Clinical
  - Rolling 1-, 3- and 6-month MOUD program retention rates.
  - Number of new monthly MOUD patients.
  - Percentage of patients on MOUD with an opioid negative UDS.
  - For buprenorphine prescribers:
    - Aggregate provider prescribing capacity.
    - Percentage of aggregate provider prescribing capacity occupied.
- Revenue Cycle
  - Days in accounts receivable – The average length of time that it takes for an insurance claim to be paid.
  - First-pass ratio – Also known as a clean claims ratio. Defined as the percentage of claims paid upon first submission rate.
  - Denial rate – Total percentage of claims denied.
  - Bad debt rate – Percentage of claims written off relative to collected expenses.
  - Net collections ratio – Percentage of total revenue collected compared to allowable charges.
  - Attributable staffing expenses – Cost of staff directly attributed to MAT services.
  - Attributable plant and equipment/indirect rate – Cost of facilities and expenses directly attributable to MAT services.

The chart below provides tips and tricks to streamlining reimbursement of MOUD services across the standard phases of a revenue cycle.

Table 1. Revenue Cycle Tips and Tricks

REVENUE CYCLE PHASE	DEFINITION	TIPS AND TRICKS
Registration	Collecting client contact and health information. Validate client insurance and service coverage.	• MOUD screening and assessment tools that are validated to be completed by client during the registration process can be used to accelerate the comprehensive assessment process. • This phase of the process is the best time to confirm utilization management that may be applied to MAT services.
Coding and Charge Capture	Translating clinical services into billable charges.	• Payers may have specific services that must occur prior to, concurrently with or subsequently to MOUD services. Ensuring that your coding aligns with these requirements, a process known as "code sequencing," mitigates claim denial risks.
Utilization Review	Payer reviews a request for services to determine clinical appropriateness.	• Ensuring that validated screening and assessment tools have been administered that confirm OUD diagnosis and that your organization is the appropriate care setting that can reduce adverse actions during the utilization review process.
Claim Submission	Organization submits claim to payers for payment.	• The number of claims submitted at one time (known as claims batching) has liquidity implication. Submitting claims frequently expedites revenue and liquidity yet can increase administrative burden.
Denial Management	Organization reviews claims denial and resubmits where appropriate.	• Organizations should work to assess and address trends related to claims denial to support an efficient revenue cycle.
Client Collections	Organization seeks applicable out-of-pocket costs from client.	• Payers may require organizations to make a good faith effort to collect applicable out-of-pocket costs.

Implementation Considerations

Organizations interested in MOUD are encouraged to consider the clinical and operational processes salient to efficient revenue cycle. Salient considerations include:

- Creating and monitor KPIs for clinical and financial sustainability.
- Establishing an iterative process to respond to negative trends in KPI performance.

Optimizing Staffing to Maximize Reimbursement

Staff compensation and benefits are a prominent expense in all health services budgets. Simultaneously, a confluence of factors can shape an individual provider's scope of practice and ability to seek payer reimbursement for services rendered. These factors include education, licensure, payer and/or facility credentialing, state policy decisions, organization setting prerogatives and federal regulatory considerations. Given the magnitude of the impact of staffing on service delivery budgets, organizations should consider intentional alignment of staff roles with reimbursement opportunities in a manner that prioritizes patient need. Thus, optimizing staffing to maximize reimbursement ensures MOUD services delivery sustainability and can enhance capacity to service patients in need.

Top of License Concept

The top of license concept is a management technique that encourages organizations to ensure that staff involved in service delivery are operating at the highest level of their licensure as much as possible. For example, the cost of a physician's time22 is different than that of a community health worker23 (CHW). Additionally, physicians provide services that a CHW cannot provide and vice versa. A staffing model that aligns capability with reimbursement potential can maximize revenue and reduce underutilization staffing expenses.

Implementation Considerations

Implementation considerations for optimizing staff to maximize reimbursement include:

- Crosswalk-covered services to reimbursable tasks by professional discipline.
- Accounting for expenses associated with nonreimbursable staff and tasks.
- Prioritizing billable staff time to reimbursable tasks and nonbillable staff time toward nonreimbursable staff tasks.
- Examining payer contracts for staffing, workflow and/or service sequencing considerations.

Building Sustainable Partnerships, Care Coordination and Care Transitions

While the direct provision of any or all MOUD services may be appealing to some organizations, others may be interested in delivering specific services or extending their existing capacity to service individuals living with OUD through partnership. The breadth and depth of the opioid epidemic's negative impact on public health means that there is enough patient need for most organizations to step up and offer any degree of intensity of MOUD services. The following are reimbursement mechanisms and considerations that may support collaboration for MAT services.

Collaborative Care Codes

In 2017, the CMS approved Medicare payment for clients living with mental health and substance use challenges who are participating in psychiatric collaborative care management programs. This interdisciplinary care model allows for attending physicians to receive reimbursement for care coordination with a client's psychiatrist. Within the context of MOUD services, a primary care physician can consult with a psychiatrist or board-certified addictions specialist (where applicable) to prescribe medication where both parties have a reimbursement mechanism. Collaborative care codes also allow for initial and subsequent care management visits. Applicable services include:

- Tracking patient follow-up and progress using the registry with appropriate documentation; participation in weekly caseload consultation with the psychiatric consultant.
- Ongoing collaboration with and coordination of the patient's mental health care with the treating physician or other QHP and any other treating mental health organizations.
- Additional review of progress and recommendations for changes in treatment, as indicated, including medications, based on recommendations provided by the psychiatric consultant.
- Provision of brief interventions using evidence-based techniques such as behavioral activation, motivational interviewing and other focused treatment strategies.
- Monitoring of patient outcomes using validated rating scales.
- Relapse-prevention planning with patients as they achieve remission of symptoms and/or other treatment goals and are prepared for discharge from active treatment.

Chronic Condition Management Codes

Under Medicare, chronic care management services provide reimbursement for providers to care for clients with two or more chronic conditions that are expected to last 12 or more months. For eligible Medicare beneficiaries, MOUD organizations can receive reimbursement for clinical coordination with other providers. Similarly, non-MOUD providers can seek reimbursement for care coordination with MAT providers.

Transitional Care Management Codes

Transitional case management codes are used to coordinate services that transition Medicare beneficiaries from inpatient and residential care settings to outpatient and community-based care. The codes can be used within 14 days of discharge from an inpatient or residential facility. States can authorize nonphysicians to bill under these codes.

Functional Reporting Codes (G-Codes)

Functional reporting codes (G-Codes) are used by Medicare[24] to convey information regarding a beneficiary's functional ability and/or medical complexity and severity. Complexity and severity codes can be used to indicate current, projected or actual complexity at the time of discharge. Organizations who leverage G-Codes are documenting their clinical necessity in the patient's medical record. Providers should also include a rationale for use of the G-Codes for each date of service.

Addressing Social Determinants of Health

Addressing the social determinants of health is an evidence-based practice to promote MOUD adherence and retention,[25] however, traditional FFS mechanisms rarely reimburse expenses incurred addressing the social determinants. While direct provision of basic needs may not be reimbursable, it is possible that coordination and case management with external

community-based resources that address these needs are billable. These opportunities are laid out in greater detail in the care coordination module. Additionally, organizations can choose to reinvest excess revenues from MOUD services into addressing social determinant barriers, such as food, transportation, childcare and housing stability. Reinvestment may have the opportunity to support patients and promote program sustainability. For example, if a patient misses a MOUD management appointment due to a transportation barrier, the patient is at risk of falling out of care and the organization incurs a missed revenue opportunity. Low-cost opportunities to address transportation barriers, such as transit passes and car share reimbursement, may pay for themselves by mitigating lost revenue.

Implementation Considerations

All organizations should consider starting, augmenting or refining their MOUD services array. Key considerations include:

- Seeking partnership opportunities to expand patient access to the full array of services through partnership.
- Exploring the extent to which mental health and substance use integration, collaborative care, chronic condition management and transitional care management codes are available in your payer contracts.
- Weighing the costs and benefits of reinvestment in addressing social determinant barriers for patients receiving MAT services.

Preparing for Value-based Payment

While this brief primarily focused on FFS reimbursement for MOUD services, it is important to note that the prevalence of value-based payment (VBP) is growing exponentially. In 2008, only one state Medicaid agency offered a VBP mechanism. As of 2018, 48 states offered value-based payment. While VBP is likely the future of most payment arrangements, organizations providing MOUD services in a FFS environment have an opportunity to garner insight, refine processes and analyze data that will be crucial when negotiating informed VBP arrangements with payers. Emerging and prevalent VBP models for MAT financing[26] include:

- **Pay-for-Performance**. Payers can offer incentive payment above FFS rates for specific clinical process or outcomes data.
- **Per Member Per Month**. Payers may offer organizations an all-in monthly rate for all MOUD services provided, instead of individual reimbursement per service.
- **Shared Savings**. Providers offer organizations the opportunity revenue share for overall reductions in cost associated with providing MAT services.

Delivering MOUD in FFS environments can serve as a proving ground for organizations to hone clinical and operational processes and collect data to discern the alignment or dissonance with VBP mechanisms that are available in the local payer landscape.

Closing

Please contact the Center of Excellence for Integrated Health Solutions through their website if you have any questions or concerns.

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