

## COLLABORATIVE MODELS FOR MEDICATION ASSISTED TREATMENT *Key Elements of the Massachusetts Collaborative Care Model*

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### **Origin and Articulated Goals**

Originally funded by the Department of Public Health (DPH), Bureau of Substance Abuse Services (BSAS), the Massachusetts Collaborative Care Model (MCCM) began as a pilot at the Boston Medical Center to increase access to medication-assisted treatment (MAT). In 2007, the model was expanded to 14 Community Health Centers/Federally Qualified Health Centers (CHCs/FQHCs) through grants from BSAS for CHC/FQHC capacity development and an accompanying statewide technical assistance program. More than 30 CHCs/FQHCs now deliver Medicaid-financed MCCM services, with annual admissions totaling 3,309.

Intended to address high rates of opioid use and overdose, long waits for MAT, and increases in opioid-related hospitalizations, the model provides wide geographic treatment availability, increases engagement of high-need patients, and integrates clinical aspects of care. MAT is incorporated into primary care in CHCs/FQHCs through the hiring nurse care managers (NCMs) to provide Drug Addiction Treatment Act (DATA)-waivered providers with the clinical support required to treat patients with opioid use disorder (OUD). Through this integrated approach, the state sought to increase the number of DATA-waivered providers as well the number of individuals treated for OUD.

### **Delivery System**

Massachusetts contracts with a variety of health care settings to provide services, including MAT. Settings include acute care outpatient hospitals, medical group practices, community health centers, community mental health centers, and opioid treatment programs. A subset of these MAT providers receive additional funding from DPH to facilitate the MCCM. Additionally, the state currently is implementing a system of 17 accountable care organizations (ACOs) responsible for the total cost of care for all Medicaid-covered services for a specific group of enrollees. In Massachusetts, ACOs are responsible for ensuring that their members have access to MAT.

### **Medicaid Authority**

The MCCM operates under provisions of the Massachusetts Medicaid state plan and the Section 1115 demonstration waiver that allow reimbursement for providers, pharmacy services, and FQHCs for covered Medicaid services.

### **Clinical Model**

Key to the MCCM are the NCMs who are fully dedicated to care management of the office-based opioid treatment (OBOT) patients, support to DATA-waivered providers, and the provision of urgent care drop-in hours.

The MCCM follows four stages of treatment:

- 1) Screening and assessment of the patient's appropriateness for office-based treatment
- 2) Medication induction under the NCM's supervision
- 3) Stabilization
- 4) Maintenance

NCMs use the Clinical Opioid Withdrawal Scale to assess withdrawal symptoms and determine patient appropriateness for OBOT.

Although the NCM performs the initial screening, the DATA-waivered provider confirms the OUD diagnosis and the patient's appropriateness for office-based treatment and provides a prescription for induction to be filled by the patient. The NCM then schedules a medication induction visit, and the patient returns with his or her prescription in hand for the first observed dose of medication. A second dose is administered 30–60 minutes later, if necessary, with a reassessment conducted 1–2 hours later and agreement on a follow-up plan. A check-in by phone or visit occurs on Day 2. The stabilization stage involves weekly visits, whereas maintenance can require less frequent visits on an as needed or monthly schedule. Provider visits occur at least every 6 months.

Many MCCM patients served by the CHC/FQHCs are high-risk individuals because of social determinants of health addressing the issues of housing and food insecurities, employment, insurance, and co-occurring physical or mental disorders.

Flagship components of the NCM model include the provision of care management and frequent follow-up; the ability to address challenging issues experienced by patients (e.g., positive urine tests, insurance challenges, prescription/pharmacy issues, family reunifications) as well as co-occurring medical issues (e.g., pregnancy, acute pain, surgery, injury); attention to concrete service support (e.g., legal/social issues, housing); and the provision of brief counseling, social support, and patient navigation. With the NCM performing these functions, waived providers can devote their time to the medical aspects of care.

### **Required Infrastructure**

Surrounding the waived providers, the MCCM requires an NCM in an integrated setting, the availability of counseling, and, for some clinics, an optional pharmacist as a member of the team. In addition, the NCM must be able to either bill for “individual medical visits” or finance the model through medical cost offsets. (See the section on Financing).

### **Special Features**

The state contracts with Boston Medical Center for a robust menu of technical assistance activities managed by a program director, with core training consisting of a mandatory 8-hour training for the NCMs, based on the waived provider training. This core course is supplemented by quarterly sessions for the NCMs that address current and emerging management issues in OBAT and create a community of practice that provides NCM-NCM peer support and reduces practitioner isolation. On-site training is provided to clerical, administrative, and other support staff on OBAT support functions and the stigma of addiction. CHCs also have access to the technical assistance staff through telephone, email, in-person site visits, and in-person or team-based shadowing as needed. The program also facilitates an electronic mailing list for addiction providers.

### **Financing**

CHC/FQHC capacity initially was supported through state grants that supported one full-time equivalent (FTE) NCM in each clinic with an expected caseload of 100 patients. In Year 4 of grant funding, the nursing staff ratio grew to 1:125 through the addition of one FTE medical assistant. Recently the state converted the capacity grants to unit reimbursement dependent on the number of patients managed by

each Center. Although MassHealth provides base service reimbursement, DPH provides this supplemental funding.

Because all CHCs are FQHCs, payment is provided through the Prospective Payment System; NCMs bill at the same rate as physicians for an individual medical visit. The CHC/FQHC encounter rates and patient load generate sufficient revenue to cover nursing salaries and other program costs. [The Department of Public Health/Bureau of Substance Abuse Services cost modeling analysis](#) (see Slide 40) of the MCCM shows that it takes approximately 40 patients per year, at 27 visits per patient, to fund a full-time NCM, adjusting for efficiency and administrative costs. That is less than half the required NCM caseload. Consistent with this analysis, seven of the centers have been able to expand beyond grant funding and add an additional NCM.

### **Achievements**

- At the initial CHCs, the number of waived physicians increased from 24 to 144 in 3 years (375 percent increase).<sup>1</sup>
- Annual admission of OBOT patients increased from 178 to 3,309.<sup>2</sup>
- 67 percent of patients enrolled in 2017 remained in treatment 12 months or longer.<sup>3</sup>
- Mortality rates were 75 percent higher among beneficiaries receiving drug-free treatment and more than twice as high among those receiving no treatment, compared with patients receiving buprenorphine.<sup>4</sup>
- Average emergency department visits per enrollee decreased from 1.24 before OBOT to 0.61 after OBOT, and the average number of hospitalization per enrollee decreased from 0.26 to 0.08.<sup>5</sup>

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<sup>1</sup> Centers for Medicare & Medicaid Services. *Clinical Pathways & Payment Bundles for Medication Assisted Treatment*. Medication Innovation Accelerator Program (IAP) National Webinar Series, January 17, 2017. LaBelle Presentation: State Experience: Massachusetts, Slides 30–45. <https://www.medicaid.gov/state-resource-center/innovation-accelerator-program/iap-downloads/reducing-substance-use-disorders/nds5mat-webinar.pdf>

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Clark RE, Samnaliev M, Baxter JD, Leung GY. The evidence doesn't justify steps by Medicaid programs to restrict opioid addiction treatment with buprenorphine. *Health Affairs*, 30(8):1425-1433.

<sup>5</sup> Centers for Medicare & Medicaid Services, 2017. Op. cit.