

National Dissemination Webinar #5:
Clinical Pathways and Payment Bundles for Medication
Assisted Treatment

Audio Transcript

Hannah Dorr: Good afternoon, everyone. I am Hannah from NASHP and welcome to today's webinars on the Clinical Pathways and Payment Bundles for Medicaid Assisted Treatment.

Before we get started, I will like to go over just a few logistics. We ask that you please mute your line and do not put your line on hold. If you'd like to ask a question or leave a comment, please use the chat box on the lower left hand side of your screen. The chat box will not be seen in you are on full screen mode, so make sure you exit out of full screen mode if you'd like to ask a question or leave a comment. You will also need to exit out of full screen mode to participant in polling questions

Please, know that during today's webinar, one of our presenters will sharing their screen and during that time we recommend that your maximum your screen in order to see the information that is being presented. Our moderator will notify you of this went the change happens.

After the meeting is over, please complete the evaluation that will pop up after you exit the webinar. This will allow us to continue to improve your experience. And with that, I will hand it over to Tyler Sadwith from CMS.

Tyler Sadwith: Thanks Hannah and welcome to everyone joining us today. My name is Tyler Sadwith. I am a project lead in the Substance Use Disorder Track of the Medicaid Innovation Accelerator Program. I am a Health Insurance specialist at CMS. We're glad that you could join us for this national webinar on designing clinical pathways and payment bundles for medication assisted treatment. I would like to provide a brief overview and introduce our speakers for today's session.

Today's webinar is part of our national effort to highlight what we have learned through the Medicaid Innovation Accelerator Program, or IAP for short. Under the IAP, we've offered various activities related to substance use disorder, including a High Intensity Learning Collaborative with a small cohort of states, a number of Targeted Learning Opportunities provided to a broader set of states, and technical assistance opportunities to support states in their efforts to introduce programs, policy and payment reforms to improve the care for Medicaid beneficiaries with substance use disorder.

During today's webinar, we will talk about different approaches for designing episodes of care and payment bundles for medication assisted treatment for opioid dependence. Specifically, we will hear from several states about MAT models currently in use in their Medicaid programs, and discuss key clinical elements and planning strategies for implementation. Then we will explore the fundamentals of developing bundled rates models for purchasing the services provided by those programs. The IAP has developed several tools and resources related to this work, and we hope to share those resources and make them available on our website soon. We know there is a pressing need to deliver these critical services to individuals with opioid use disorder, and our hope is that this discussion will really serve as a starting point/resource for states interested in value-based purchasing for MAT.

Turning to the agenda, we invited several state partners to discuss their experience with designing and implementing the MAT models, and we invited members from our IAP team to discuss how those models can be represented within an episode of care and within a bundled frame work.

First our IAP speakers we introduce this work as it originated as a request for technical support from one of our IAP states. Then we will hear from Vermont and from Massachusetts regarding their experience

with planning and implementing MAT models that serve the Medicaid population. And then, we will take a look at some of the resources that were developed under IAP as part of this effort, which are based on the Vermont and Massachusetts models.

Before we get started, I want to make a quick note that we are highlighting these states, and providing these resources for informational purposes. The services and payment methodologies are not approved or endorsed by CMS and any Medicaid service covered under Medicaid state plan must meet state plan requirements, and the type of bundled payments that we are referencing today can only be developed if the services are covered in the state plan or another Medicaid authority. These resources are not considered templates for developing state plan amendment and just to be clear this is not a different path for approving SPAs.

With that, I would like to quickly introduce our speakers and then we can get started. Mady Chalk is the Senior Adviser at the Policy Center at the Treatment Research Institute. Dr. Chalk has more than 30 years' experience in addiction and mental health treatment, policy and research including in the federal government, where she was a Director of the Division for Services Improvement in the Center for Substance Use Treatment in SAMSA and she was also the Director in their Office of Managed Care.

John Brooklyn is board certified in family medicine and addiction medicine. He is also an Associate Clinical Professor in family medicine and psychiatry at the University of Vermont, College of Medicine. He is a Medical Director of the UVM Substance Abuse Treatment Center and of several Opioid Treatment programs in Vermont. Dr. Brooklyn worked to develop the Hub and Spoke Model in Vermont and is a national consultant for doctors for methadone and buprenorphine treatment.

Anthony Folland is a Clinical Services Manager and State Opioid Treatment Authority for Vermont, where is he responsible for the regularity oversight for the OTP Hub programs. Prior to his five years in state government, Mr. Folland held direct service and management positions in community mental health and addiction programs for roughly 20 years in Vermont and North Carolina.

Colleen Labelle is a Program Director at the State Office-Based Addiction Treatment Program in Massachusetts, and is a Nurse Manager at the Boston Medical Center's Office-Based Addiction Treatment Program. She is board certified in Addiction Nursing and Pain Management and has over 30 years of clinical experience in HIV and addiction care. She serves as faculty for the ASAM Buprenorphine Certification Course and she is a clinical expert for the Association for Medical Education, Research and Substance Abuse.

Susan Parker is the Executive Vice President and founder of Parker Dennison and Associates. Miss Parker has significant experience with fiscal and operational aspects of publicly funded community behavioral health systems, having worked with providers, state and local funding authorities and managed care organizations in more than 40 states.

Last but certainly not least, Colette Croze will serve as out moderator for this webinar. Miss Croze is a private consultant specializing in public resource management, and she is focused on purchasing and design options for managed systems of care and integrated health strategies. She has worked with state

mental health systems, federal Medicaid waivers and Medicaid state plan amendments, recovery oriented service systems, and behavioral health homes for individuals with chronic conditions.

With that I will turn it over to Dr. Chalk to get us started.

Mady Chalk: During the last 10 years, medications have become increasingly important though underutilized in treatment of opioid use disorder. In the last year as Tyler mentioned, in the interest of aligning clinical services with waived physicians delivering medication, and to improve quality and accountability, one the IAP states requested a system to developing bundled services and rates for medication assistance treatment. Critical to this effort, a description of the service component and the clinical pathway necessary to implement the medication assistance treatment was developed. Colette?

Colette Croze: We looked around, trying to focus on the clinical box before we looked at rates. And we looked at three jurisdictions to states and city actually, who had consciously developed a clinical model for the delivery of MAT. Not just open up a Medicaid reimbursement code, but actually had a model. And that's Massachusetts Collaborative Care Model, Maryland – it was the Baltimore Buprenorphine Initiative and, Vermont, of course, the Hub and Spoke. And in our case we put the emphasis on the Spoke.

Why did we choose these models? Well, each of the models has been sustained jurisdiction wise for a significant period of time. There was a track record for the clinical services, as well as you will see in the presentation, the emerging, terrific data on the effectiveness and to changes in the quality.

Each model had clear roles for primary care and the specialty system. So that was one piece of it, and secondly, a clear division of labor for waived physicians, nurses, licensed behavioral health clinicians. And finally within the clinical framework, each model had specific objectives for the state or city. In the Baltimore case, we are trying to effect through the use of medication assisted treatment, delivery in a very conscious way. So we have today with us, Vermont and Massachusetts. And then we will have the description of the clinical pathways and the rate model. And without further ado, I am going to throw is over to Tony.

Anthony Folland: Hi. Thank you so much. Tony Folland. Thank you for having me on. We'll try to run through this, Dr. Brooklyn and myself, and kind of walk through the Vermont experience so far. When we originally looked at the Hub and Spoke, the primary policy goals that we were really looking at were around offering beneficiaries with opioid risk/opioid use disorders who also were either experiencing or at risk of developing another chronic condition. And really being able to try to primarily expand access to addictions treatment. We knew that we had a waitlist in the state, we knew that we were underutilizing medication assisted treatment, and we really wanted to bring to scale and capacity our state offerings.

At the same time, we looked at this as an opportunity to really integrate both primary health care and addictions healthcare into kind of the health home framework. We wanted to make sure that we were maximizing the use of our specialty addictions programs, our opioid treatment programs, or for Vermont lingo they are called "Hubs". As well as the general medical settings; or in most cases "Spoke" providers in Vermont lingo. As well as, needless to say, we wanted to improve health outcomes and we wanted to make sure folks had access to stable recovery.

The next slide really is just kind of a schematic to look at how the system was originally conceptualized, where we had the Hub or the OTP in the middle. The Spokes as a continuing care option for folks that particularly were on buprenorphine or naltrexone based products. For the folks who might start in the Spoke who had less severe needs, that the Hub then could become the de-facto if that person destabilized, and really develop medical transitions of care. On the outside you can see the variety of providers and programs that we thought might feed into this system. Whether that was the criminal justice services, or the child welfare services, or providers that might feed into the system, as well as providers that we would need to access on the outside of the system.

Just to kind of give context, a Spoke in Vermont is really an office-based opioid treatment program that has imbedded support services. And it's really the clinical support system around a person. So it's the collaborating health and addiction professionals who are monitoring adherence, coordinating care, providing access to recovery support, offering psychotherapy or counseling services, and providing case management and referrals to social programming. As well as providing contingency management. And when we thought of Spokes, we wanted to do this as conceptually as wide as we could. We wanted to make sure that there were primary healthcare providers. We wanted to make sure that independent providers, independent psychiatrists. The thought was that "any willing provider" - and that we would figure out how to develop an infrastructure to support any willing provider.

And kind of where we started; so flashback to January of 2013 when we started the service system. All existing buprenorphine prescribers were eligible. And at that point we had about 120 buprenorphine prescribers seeing Medicaid beneficiaries on any monthly basis. And all of those were initially designated as Spoke providers. And conceptually when we looked at it, we wanted to make sure, because we had heard from physicians that the primary barrier for them either becoming buprenorphine prescribers, or increasing the number of patients that they saw; was around their ability around having enough time to see folks and to have the skills necessary to coordinate that care that folks might need. So our concept was to embed one FTE Registered Nurse and one FTE licensed behavioral health clinician into any provider office at a two folks for every hundred (rate). So in a health service area; we had 14 Vermont health service areas; for any health service area that was treating 100 folks, we would then embed one FTE of each service into that. And that could be in a singular office; it could be as Dr. Brooklyn may describe later in his federally qualified health center, they treat 350 people. So it could be deployment of the FTEs into that service array. And this was really to provide an infrastructure for those physicians so they could continue to provide good quality medical care, and to coordinate these folks' medical and their social services care at a magnitude and a structure that would support them.

We originally said that folks could be provided through consultations, in collaborations with regional contractors. If folks had a FQHC type model that they could direct-hire the FTEs themselves. Or we encouraged if they wanted to work with their local healthcare systems, if they were mental health center they might not have access to a lot of nursing staff. They might want to subcontract the nursing through the hospital. So we encouraged folks to do that based on what their regions offered. And at the end, the payment model; really what we did, it worked out to be \$163.75 per member per month as a payment. But the way this worked, was we really looked at this and said New England-wide healthcare costs for a registered nurse is \$85,000 a year. Fifty-five thousand dollars a year was the average salary of a licensed

behavioral health clinician. You add in all their fees, their fringe benefits, and we came up with about \$196,000 a year. We divide that by 100 people because that was the expectation that they would be embedded for a 100, and when we came down to it, it works out to \$163.75 per member per month. And the payments were funneled through the Blueprint for Health and their Community Health Team. So every health service area has the Blueprint for Health Community Health Team. We funneled through there and they would then deploy within their regional services.

So from here I think it's time we were going to move on to the clinical processes and I will pass this over to my friend, Dr. Brooklyn.

John Brooklyn: Thank you, Tony and welcome everyone. Next slide please.

So one of the things that I wanted to be sure about as a doctor was that we trained physicians to prescribe buprenorphine but they are not trained in addiction medicine. So it was very important to me that if we were going to have a system like this, that we gave additional tools to the community doctors to decide if the patient that they were seeing was appropriate for their level of care, or whether they need to be referred to a higher level of care, i.e. the Hub. So we developed this Treatment Need Questionnaire, which was a 21 item checklist, kind of loosely based on Addiction Severity Index, which may be familiar to many of you. And it encompasses a variety of areas and we took a few items from each one. And thought that we would develop a scoring system whereby if people scored relatively low that they would be much more likely to do well in an office-based treatment. For instance, on the Treatment Need Questionnaire there are questions about IV drug use, there are questions about cocaine, benzodiazepines, alcohol use, questions about mental health and medical health, then things like transpiration, employment, whether they had children in the home. And it was not designed to be completely predictive, but to give a doctor a quick gestalt as to whether the complexity of this individual was going to be too great for them. In which case the recommendation is they would refer this person to the Hub, where the person would become stabilized and hopefully this person would be able to return to the Spoke. Or if they felt that the score was such that they could handle the individual, they would take the person to treatment. And if the person destabilized, they continued to use perhaps, or weren't compliant with the rules of the clinic, then they would be referred to the Hub.

The scoring system here indicates levels. I will mention that when you look at a score over ten, what we thought was that if someone was board certified in addiction medicine and perhaps they had a structured program where they had onsite counseling and they could really provide a high level of service, then they were probably going to be okay in the Spoke. But if the person did not have that comfort level, they should be comfortable referring that person to a Hub. And anybody with a score of 16 which is actually quite high would almost universally be considered a Hub client.

So from there we also – next slide – developed at Dartmouth, developed an Office-Based Opioid Treatment Stability Index. It's not listed here, but it has eight items. This essentially was designed for the MAT team, the licensed clinical social worker, or the RN that's working with the physician to kind of look to see if people are remaining stable. And that was designed at office visits to reassess whether the person is doing well. And it had items such as urine drug screens, if the person is using any benzodiazepines or alcohol, if they are having lots of cravings. If in checking the prescription monitoring

system, which we would do periodically, if there was any unadmitted prescription, is there any lost or stolen prescriptions, have they run out of their medications. It was really designed to look at stability, so a physician could decide whether or not they wanted to continue to work with the person or refer to a higher level.

Next slide. And this was really all designed to be very supportive of the physicians in the community so it was in a way a bit of a universality. We know that we have things for diabetes, we have clinical pathways for hypertension and asthma, we felt that we should have something similar for opiate use disorder which would be designated as a chronic disorder. And then in terms of some of the challenges these are some of the challenges we had looked at in determining whether or not to go forward with the teams that Tony spoke about. This slide probably should have come a little earlier. Essentially you can see these Community Health Teams were modeled after any other Community Health Team, say for diabetes, asthma, depression, and so that there would continue to be support for the physicians. And the funding was for eight quarters and since that time we have continued to support it in the state. The first eight quarters were Affordable Care Act Section 2703 funding.

Next slide please. So what we were hoping to see was an increase in the number of physicians who were waived, an increase in the number of patients that the physicians were caring for and were trying to practice up to their waiver. And so when we looked at it we were trying to look at how can we increase the number of doctors who can become waived for a 100 because at the time that was the cap. And that the feedback for the infrastructure support we wanted it to be very positive.

Next slide. So you can see on this timeline that in March 2012 we had a real disproportionate number of people who were in OTP or the methadone programs, and only 650 patients. While in the office space treatments we had almost three times as many people. We thought that was marketplace driven, that there weren't as many methadone programs from the state. And so with the adoption of the Hub/Spoke two years later, you can see the number of people in the Hub actually exceeded the number of people in the Spokes. And that by 2016 we had actually increased even more so to the point where you now have about 3,400 people; almost double the number of people who were on office based buprenorphine, and five times the number of people in the Hub who were there in 2012. You can also see that the increase in the number of doctors who were waived and the cap. We had 169 physicians in 2012 that had 30 patients. That rose to 269, so went up by 100. And those with 100 patient waiver went from 37 to 73. So significant increases in both categories.

Next slide please. And then last but not least, for my slides, the most important about this overall deployment of MAT in the state of Vermont is our percentage of change in death per 100 thousand. These are in New England states, and you can see in 2014 that our rate actually went down by almost 8% because we estimate that approximately, I'm trying to think of the number, there is 10.1 people per thousand who are currently in MAT in the state or approximately 1% of individuals. And except for one site, there is virtually no waiting list to get into treatment anywhere in the state. We believe that the increase in access has had a significant effect on that. I'm going to turn it back over to Tony.

Anthony Folland: Thanks, John. So I think part of what we wanted to look at is as well is what are the financial impacts, because part of the system development was really around financing. So we did a study

that predates the Hub and Spoke. And what we found was when we looked at Medicaid beneficiaries who were receiving MAT versus those folks who were we believe had opioid use disorders, but who were not receiving care, we found that the MAT costs were really offset by the lower non-opioid medical costs. That MAT was associated with lower utilization of non-opioid medical services and we found it to be cost effective even if just looking at general medical processes and medical costs per patient. And then we predicted that an initial savings of \$6.7 million in Medicaid that we reinvested back into case load expansion. We are in the process of doing a wider analysis where we are going to look at all the costs of individuals including correctional costs, and we're going to assign a cost base. We are using the folks at On Point for Health to work with us, who will be coming out with as wide a scale study as we can come up with. And that is in systems development as we speak.

Challenges and opportunities. So needless to say in order for this occur one of the first challenges we needed to figure out how could we offer buprenorphine within the opioid treatment programs. In order to be able to have this system work where you could have bidirectional flow between the Hubs and the Spokes. We needed to make sure that we could do that at cost neutral to our treatment providers. The costs differential between buprenorphine and methadone is significant, so we needed to figure out how to do a reimbursement directly to the providers, the Hub providers, and we were able to accomplish that. In fact, at this point, of all the people in the OTPs, the 3,100 plus that John mentioned, almost a 1,000 of those folks are on buprenorphine, which allows for that bidirectional access. The OTPs are able to take folks in on buprenorphine seamlessly and as folks stabilize they are able to transition out to Spoke providers. The other thing we had to really do, and John spoke to this, was the defining stabilization and blending cultures. As John mentioned again, we were teaching buprenorphine prescribers historically had to prescribe buprenorphine but not teaching them addiction medicine, and figuring out what stability looked like was inherently different. So that was part of our discussion, and how do we do that. And that was part of the rationale for the tools development. And last but not least, we needed to figure out how do we provide ongoing support both to our prescriber physicians, but also to their embedded MAT teams. So we have a lot of work that we are doing with the Dartmouth folks around learning collaboratives. Doing separate learning collaboratives for new prescribers, what we refer to as 'OBOT 101'. And we are doing regional collaboratives, where we take one region of the state and have all of the major players in that area, including the Hub, work together and finalize their processes and come up with really good clinical pathways across each other. And then we had a separate learning collaborative where we offer that directly to the Spoke providers, the embedded health team providers, to make sure that we are in enhancing their skills across the arc. And I think with that, that would be it.

Colette Croze: Great thanks so much Tony and John and as usual the Vermont folks have given us a wealth of information, some that's new, some that's from the original program. Now we have questions for the audience. We've got a polling question. Which of the following represents the greatest challenge to your states' ability to increase access to medication assisted treatment? Select your answer and click submit directly on your computer screen...Still having people register...

Here we see the results. Financing and reimbursements - must be the reason for the popularity of this webinar, infrastructure, the number of waived physicians. So mostly it is financing and waived physicians. So hopefully through the course of the webinar and the discussion you'll get some ideas about

how to address that. Alright let's move on to Colleen who's going to tell us about Massachusetts's program. Here we go.

Colleen Labelle: Good afternoon. It's a pleasure to be here. I'm going to speak to you about our model in Massachusetts, being developed as an office-based... We used to call it OBOT- office-based opioid treatment program. But it was switched to OBAT standing for office-based addiction treatment so that we're all inclusive because we do treat both opioid and alcohol, because injectable naltrexone can be used for both venues.

So why did we start doing this? Similar to what Vermont has spoken about is, you know, the need. We've been struggling with addiction in the northeast corridor for a longer period of time, I think, than some other regions have and that we saw this increase in overdose and substance abuse that was going on way back and with that we finally came across this new medication that came out through DATA 2000, the Drug Addiction and Treatment Act. But, however it was not getting the uptake that all of us had hoped for. Not enough physicians were waived, or were going after the waiver, and only physicians at that point could do this. In Massachusetts, at 2005, there were only about 1% of our physician base that was waived at that time, and many of those that were waived were not prescribing and if they were prescribing were only prescribing maybe in small amounts or to a few patients, or only to their patient population. We saw this increase in overdoses, with hospitalizations and medical comorbidities related to this - endocarditis, soft tissue infections and all the cardiac complications that we are all struggling with now. That was what we were seeing and what we're still struggling with today.

So with that, we looked at doing this expansion of treatment using the office-based addiction treatment model on a state level. Our State Authority, which back then was Michael Botticelli who is the White House Office ONDCP Director was vested in piloting this alongside myself at Boston Medical Center. So we, also Alex Wally went ahead and he spearheaded this research study and we went ahead and sent out surveys to all the prescribers within the state through our State Authority asking them a questionnaire about whether they were prescribing, whether they had their waiver, how often were they prescribing, and if they weren't, why weren't they not prescribing. And with that there was really no surprise to what we learned. And that was clearly this lack of resources, this lack of nursing support which came up a lot and the office support, the administrative support, and the payment component of it. Like, how do I do this? How do I pay for it? How do I support it? And providers really feeling like they didn't have the knowledge, they just didn't have those tools in their toolbox. It wasn't something that they learned in medical school and they didn't know how they could float this into their busy medical practices. So most of those that we surveyed, 55% of those had expressed more than one barrier to the reason why they weren't prescribing or were prescribing in small numbers. So, what the Boston Medical Center Model went ahead, and did and it's now being dubbed the "Mass Model" by SAMSHA, is put this collaborative care approach together using the nurse care manager.

And so went I went to Michael Botticelli back in 2003 and spoke to him about this and was like, 'We have this great medication in Boston that we know works, and we have patients that have this complex disease, but how do we do this in a medical practice where providers are already tapped? They don't have the time and this is going to be really complicated to do. So, would you fund a nurse care manager to support these physicians, that would have the support to be waived to provide this treatment within their

busy primary care practices? So, he agreed to that and so in piloting this he put it into a primary care practice and then from their further expanded it into community health centers across the state which many of them were federally qualified health centers, FQHC's. So this nurse care manager model supported the physicians and worked collaboratively with the physicians, with the pharmacists, and it really decreased the burden on the doctor since they were dealing with all the complex needs of the patients on a day-to-day basis, and also it's more cost effective.

So, what we did with the nurse care manager model is that we developed a training and we took the training. And I had done the ASAM training back in the day when providers were getting waived even though I wasn't a physician so I learned from that. I worked with amazing mentors here to learn a lot about buprenorphine, addiction really early on. So we took and tweaked that training to something that was more concrete, more day-to-day for nurses that would be doing this in a case management type role in these community health centers and these primary care practices. And so we provide a training similar to that to new nurses and to support staff to educate them and to instruct them about our policies and procedures and help them to then take those policies and procedures and treatments agreements, and tweak them to their centers and their needs so that they're not reinventing wheels and starting over and help them to learn how to do this in their practices alongside with their primary care providers.

Also using pharmacists. Pharmacists are an amazing tool that I think a lot of us don't use enough. They're our eyes and ears out there when we don't know what's really going on and what's happening on the other side. Patients coming in early, showing up, looking for early refills having all of these complex issues and seeing many different providers. So they're a really good team player and we've been using them really well for a long period of time. Also, setting up counsel services, so collaborating with counseling services. Some of the health centers, some of the facilities, had counseling and support services on-site. Others had to contract out and get those services elsewhere and then some had patients that were coming from afar such as Vermont, so to speak so needing to come to one site for their care but then having to come there for the counseling could be a burden. It could be a challenge to setting up transportation. So setting up counselling close to where someone lives can sometimes be more appropriate if you really want them to show up. And we set up drop-in hours, the ability to be more flexible, especially in the early stages of recovery when our patients really struggle with following the rules and getting things done the way that people typically do in society. So really trying to be more flexible, and to address the insurance issues. Insurance, as we all know, can be a really challenging process especially with prior authorizations, different formulas. What payers pay for which drug? Which payers pay for which claim? How much are they paying for? And how often do you have to give other information to the payer?

So this Collaborative Care Model, is similar to me to – I just think of it, I did HIV before this and it just seems much like that model, where you have patients with complex diseases and you build your team around your patients and you are able to meet their concrete needs, their medical needs, their support services, so that physicians are not getting taxed with that and are still able to manage their practice. And you know we can develop a problem list with our patients. It can be 15 things long and put their disease of addiction, or the disease of HIV, or their diabetes at the top of the list. But in reality to the patient, at the top of the list is, where am I going to sleep tonight? How am I going to get my food? How am I going

to pay for the copay? How am I going to get to my appointment? So making sure that we're dealing with those things as well as educating them on their disease, so that we get better outcomes.

So the nurse becomes that great person that communicates between and provides support services and helps provide answers and our patients can very often when they have something that they need, they want and need it then so being able to answer that call and being able to be there. So we actually have a setup on our phones in our clinical offices that they actually ring in everybody's office so when the patient gets impatient and keeps calling and calling, someone can see that that line is lit and they'll pick it up and try and help that person in real time so that we can decrease the anxiety of what is going on for them to help them out.

So expanding the model, we've taken this model and we've expanded it out into community health centers. This started in 2007. We started the model at BMC we then saw that it was really effective and so Michael Botticelli and the Bureau of Substance Abuse Services in Massachusetts went ahead and put an RFR out and put it out to the community health centers and then funded the community health centers to put this model in play if they were willing to cover the salary of the nurse care manager. In addition, they put another RFR out for someone to apply to the training and technical support for the community health centers. So at the time that this model had first come out, 14 health centers had been funded and now we're up to over 30 health centers are funded by our Bureau of Substance Abuse Services with the Nurse Care Manager Model.

The training and technical support piece we actually applied for at that point and had had it since 2007. So we continue to support these community health centers and with that we've seen this increase in the number of providers that have become waived. We've seen more patients come into treatment and we've seen this real integration of addiction treatment into the primary care setting and with that we're seeing the patients coming in to care and we're seeing them getting treatment for their diseases and were seeing integrated behavioral health alongside that because that's a model that were all moving towards.

So the model has been very sustainable in Massachusetts because the community health centers in Mass. are able to bill for skilled nursing visits, not just NP visits, but skilled nursing visits, as well as the fact that the state has supported it. So we've done some cost modeling to show that this is a pretty effective model of care because it does get reimbursed, because patients do show up, and then they come in for their other medical issues too. So even if it was not a reimbursed model in other settings, it's going to be something that would be and feasible because of the fact that they're now getting their diabetes care, they're now doing more prevention, they're not ending up in emergency rooms, so just something to keep in mind.

The training and technical support that we provide is pretty intense in that we provide onsite training for all of the sites here at Boston Medical. We then go out to sites to do trainings specific to their needs for themselves as well as to their support staff. They may need training on de-escalation or on addiction 101 or how to engage the staff or how to get people on board. So if we don't have people at the front door who are actually engaged and understanding this, and working with the patients then things don't work so well. So it's really important to get the whole team. We need to work from the top down and so we work through that. We do quarterly educational sessions we bring them together. We have listservs so that

they're connected through these listservs where I see the information on different levels, addiction conferences, information on things that are happening in the state, reimbursements, and also a place for them to get feedback from me if they need that. So we provide relevant articles and literature and reimbursement information as well.

So the success in the community health centers and so again we've implemented this again into over 30 sites now. The increase in number of providers that have waivers has increased up to 375 percent so when started we had 24 providers out of all the health centers and then had 114, and that number still continues to grow. And the health center alone has served more than 10,000 patients from 2007 until 2013. So patients are getting their treatments in their communities, in their community health centers, by their providers. They're now getting care for all their other medical issues as well so we're doing prevention and keeping them out of the hospital, integrating care in community health centers and patients are getting best practice levels of care. The retention and this has been very impressive as well. So patients are being retained in care. So we published on this looking at the health centers, across all the health centers it showed that greater than 65 percent of patients were still in care and it's actually greater than 12 months at this point. And there was a decrease in mortality. Our center alone we've serviced over than 1,500 people just at Boston Medical Center. We've only had one person die in care and that was from an overdose. We're not talking about medical care. The patients in care don't tend to die. It's the patients, when they leave care, that they don't do so well.

We've seen lower cost for Medicaid for patients that are in treatment with medication and UMASS published a study in Health Affairs looking at this as well. But you can see from this, when you look at the first six months prior to one of our patients starting in one of these OBAT settings, they were showing up in the emergency room at a greater number, and over time in that first six months of care that decreased them somewhat, and then seven to twelve months later it was a further decrease in the emergency room. As well as hospitalization, so patients, not ending up in the emergency room as often. They're not ending up hospitalized, they're not engaging in risky, unsafe behavior if they're getting treatment for their disease. They're not ending up incarcerated. Some of them may be cleaning up old warrants and things but there has definitely been a decrease in those events as well.

So this funding that happened with this program that we've seen has been that the state funded \$270,000 dollars at the start of this for its training and technical support which provides the training to each site. In addition, they funded each community health center up to \$100,000 just to cover the nurse care manager. That nurse care manager, similar to the Vermont model, was supposed to manage a case load of 100 patients, granted they'd be a rolling admission increasing over time. We then, increase that number to 125 patients for that nurse care manager, with the addition of a medical assistant. But that didn't happen until year four. So we figured if we could add the medical assistant on to the model, we could have the medical assistant do more of the concrete services, and have the nurse do more of the medical. Nurses do a lot as far as the induction, the stabilization, the maintenance, the medical issues, the surgeries, the accidents, the pregnancies, so they are dealing with a lot of those things on a day-to-day basis when you have a large case load of patients on opioid treatment.

So this increased access to patient care. It was able to address concerns and things that are going on with patients in real time instead of weeks later, so hopefully you can address something before it was a

problem. It dealt with prescriptions and pharmacy issues that were going on, and again, the medical commodities that I spoke about. And there was an ability to intensify and deal with other issues on this level. The nurse was central, and this was their job; this is what they were doing in their day-to-day. The nurses, also, most of them are trained in addiction. A lot of them are certified in addiction and some can provide grief counseling and support for patients, and again, are able to deal with large cases.

Colette Croze: Thanks so much colleen.

Colleen Labelle: Thank you.

Colette Croze: An action pack presentation as usual. We really appreciate you doing that for us. You heard about Vermont and Massachusetts, how the states made it available to waived physicians in terms of support. We would like to ask you about what your Medicaid program may provide support services for MAT providers. You can see the poll on the screen. Hmm – people are responding.

Ok, let's see the results – learning collaborative is the biggest winner, then training programs and technical assistance. We had a comment from an attendee that we need to have a 'none of the above' category for the answers, so maybe we will make that improvement for next time. Alright, thanks and let's move on. We have time for some questions for Vermont and Massachusetts. I don't think we have any in our chat box now, but we did receive some with registration. I want to ask the question that I think I know the answer to. So one person who registered wanted to know from Vermont and Massachusetts, what strategies do you recommend to states who are really, really struggling to improve the number of waived physicians. I think we know what the answer is but why don't I ask Tony first and then Colleen.

Anthony Folland: So I think I may defer to John on this one given that he is the prescriber. I think in our case it was really building the communication with our prescribing partners and reaching out to them and asking them what is was that they needed. Then as a state trying to build that to their needs. What they identified in most cases was really infrastructure support, but it wasn't exclusive to that. It was really building the bridge of partnerships. We were fortunate in that Vermont was already, even before this model, number one per capita in the country for the number of prescribers and buprenorphine amounts per capita. But it still was not sufficient. John, I would love your opinion.

John Brooklyn: I think one point that is lost in all of this, is that when we talk about Hubs, the medical director of the OTP, or the HUB, is consider to be an addition expert at that center. I think if you're talking about a network of doctors, primary doctors and specialty physicians... People in the community who are taking care of diabetes, they know of a diabetes specialist or cardiologist that they can communicate with. So I think part of it is identifying at these methadone programs or these large programs, who are your addiction experts in the community and is there a way to establish linkages with community providers so that if they are interested in it, they have a knowledgeable person that they can consult with and refer to. I think that's in many ways, I know at Boston Medical Center, that's a model that would build upon people's comfort level in taking on prescribing of buprenorphine. So I think that's where I would try to focus my energy, to identify a couple physician champions in the community that could begin to communicate, maybe to some grand rounds, or just maybe spread the word around that this is something they are there to help and support the other doctors with.

Colette Croze: Great. Colleen, would you have anything new to add?

Colleen Labelle: No, I think would probably support what the others have said. And in addition to that, I think leadership is key here. And in our states being on board, and our states really, our governor, our state authority have been very vested and very loud about the fact that this is a big problem, and so has Vermont. And that we need to do something more. And I think that speaks volumes and that really does energize people to get involved and to do more. So I think that's huge. And then vesting the supports, and having those physician champions such as you spoke about. In addition to that, we are looking at a whole new world right now, where we're having NPs and PAs coming to the table. And I think that they are an amazing resource that we need to have, and we need to engage, but we also need to support and mentor and help them.

Colette Croze: Great, thanks Colleen.

I'm going to turn this back over to Mady and Susan who are going to actually describe the interworkings of the clinical pathway and the payment bundles. So, Mady?

Mady Chalk: Let's talk in a little bit more detail about the clinical pathways which really are the service components that are needed if one's going to develop bundled services or for that matter implement any kind of medication assisted treatment program. In order to do this, we not only looked at the three models we just discussed, but we also consulted a number of physicians and other clinicians that who were working with MAT currently. And when you boil it down here's what, here are the services that you begin to see. That initially you need some kind of assessment and to follow, if appropriate, if you need to refer a patient just like Vermont was talking about the Hub and Spoke, and some treatment planning. You need somebody to offer the medication, and you need a service component that includes induction with withdrawal management, otherwise known to some as detoxification. And then you need stabilization services in early treatment. And I think Tony mentioned in his presentation, that as your developing these clinical pathways, you need to think about how you help clinicians understand what a stabilized patient looks like and stabilization doesn't look the same for every patient. But it needs to be well understood before you move along the clinical pathway to maintenance and then ultimately after a significant period of time probably, discontinuation with medical withdrawal at the request and in consultation between a patient and a clinician. So, after we worked on the three models in this project, we began to think about what purpose does the models serve? They serve a number of purposes. The models are guides that states can use and adapt to develop similar clinical pathways and services with corresponding rates. The models also identify factors that can be adjusted to develop the rates. The factors that can be adjusted on a state-by-state basis to include the composition of the staff and the costs of those staff, the time required for each intervention or service component, and other costs that we all know about that are both direct and indirect.

The bundles in our examples have in the tool, that you will hear Susan talk about, have included lab costs for urinalysis but have not included the cost of the medications themselves. So as Colette mentioned early on in the beginning, let's just review there were three models of delivery that we looked at the first model was the Baltimore Buprenorphine Initiative, which later became adopted by the state of Maryland, which used specialty providers to offer the medication and to get patients stabilized, and then transferred those

patients with assistance from a care manager to primary care for continued maintenance and continuing care, ultimately discontinuation if the patient so desired. The second model you heard Colleen talk about the Massachusetts Primary Care Model, didn't begin in specialty care. It began in primary care practices and clinics with nurses to support prescribers. In the Baltimore model the all of the support staff was housed in specialty, the initially in the specialty provider. In the third model, the Spokes within Vermont Hub and Spoke used primary care practices enhanced with nurses and clinical care managers as you've heard Tony and John talk about.

So what are the resources that are required in all of the models regardless of whether they started in specialty care or in primary care? Staffing obviously, waived physicians and soon to be nurse practitioners and physician's assistants added to that. Support staff including registered nurses, nurse care managers and substance use disorders counselors. And you need sites in which the services are going to be delivered. So you need specialty outpatient treatment programs if you're going to need patients that have later needs to go back and forth between primary care and specialty care. You need your outpatient primary care practices and your primary care clinics as sites. And with that I am going to turn this over to Susan Parker.

Susan Parker: Thanks, Mady. I am going to now walk you through the construction of the tools that support the rate models that we are going to be talking about. There are two tools for each of the three models. The first one is a clinical pathway that describes each step along with the composition of the types of professionals, their credentials. And the second tool is a rate model that actually calculates the provider costs. The rate model calculates a bundled rate for a group of related activities. It follows the six major activities that Mady went through in a prior slide. And the Excel model matches up to the steps in the clinical pathway.

The rate model calculates total cost for provider services – all of the professional services that are included- and it includes the cost of the urinalysis. The model does not include pharmacy costs- the actual costs for the medications. And the model is constructed to allow users to tailor the costs, the assumptions around all of the costs to a specific state or area. That is how the model is constructed- the rate model. The rate model crosswalks to each step in the clinical pathway and the assumptions in the clinical pathway as far as how long an activity takes and whether an activity is done by the physician or a nurse or an LCSW. The time span that is included in each bundle ties again to the underlying steps in the clinical pathway. Sometimes the step covers several weeks. For example, in the Vermont Spoke model that we're going to be talking through in just a moment, the time span for the clinical assessment through the induction is eight weeks. The time span for stabilization is eight weeks. Other spans are monthly and these are pretty much intended to be activities that may carry on for some length of time or even indefinitely depending upon client needs or client choices. An example of a monthly timespan is maintenance.

The Excel model has two sheets. One sheet is to allow states to enter their specific costs. The second sheet shows the actual rate model calculations for every step in the clinical pathways and all of the assumptions. They're designed for user input in all of the grey shaded areas. The rate models, as they will be put up on the CMS website shortly, has numbers in there as assumptions around salaries and benefit rates and those sorts of things. Those are not specific to Vermont but are really intended to be 'Anywhere,

USA' so that we can have somewhat reasonable numbers in there that allow the models to calculate, and function and come up with something that kind of makes sense on its face, but is not tied to any specific state.

The assumptions for state-specific costs touch on several areas. The first one builds personnel costs per billable hour. And that calculation is based on salaries and productivity rates by type of professional, by their credentials. It includes the average number of weeks worked after paid time off. In the example that I've got, I assumed there would be 45 weeks of work and then obviously seven weeks of paid time off. So the average weeks of work is 45. And the assumption...it needs an assumption around a combined rate for payroll tax and fringe benefits. Obviously those are things like employer FICA, and health insurance costs, and those sorts of things. And in the model the assumption that I used was 35 percent on top of salaries for payroll and fringe combined. There are two additional percentages that need to be entered. These calculate off of personnel. The first one is 'other direct program costs' and then the next one is 'general administrative and overhead rate' (G and A). And that one calculates off as a percentage of total personnel plus the preceding item, 'other direct program costs.' In the model that we are going to go through in just a second, you'll see that I've got an assumption of 30 percent for other direct program costs and 20 percent for G and A and overhead costs. You will also need to enter a cost per urinalysis in the assumptions page and then we use that to calculate the total cost of urinalysis based on however many are normally done for a person. And then the average group size per staff member. So what this does is calculate the amount of staff time per client, per hour of group. So if you have nine people in a group then you would have 0.11 hours of staff time per person in the group. Obviously if you had a group that was co-led then you divide the clients equally across those two to come up with the same number. That allows calculation of what your cost is for running that group.

Now when we move to the actual rate calculate rate part of the model, you're going to see it is structured into two sections. The top section summarizes the rates and lengths of time for each phase in the clinical pathway. So that summarizes the rate for each. The lower section goes through all of the detail calculations for each of those rates in some level of details. It includes the percentage of clients each step applies to - typically it applies to 100 percent of clients, the staff time required for each step, etcetera. So it goes through all of the calculations that are necessary to come up with all of the activities and staff time that are included in each step in the clinical pathway.

At this point I am going to walk you through the two tools so that you can actually see what those tools look like and how they are constructed. I am going to start with the actual clinical pathway for what we call 'Model Number Three,' the Vermont Spoke. What you can see is that it is organized into three columns. The first column on the left hand side is each step. The middle column describes where it is being done and what type of staff is doing it. The right column is the assumptions that were underlying the financial model. For example, if you look at step 1A, that is the multidimensional clinical assessment. There is a brief description there of what that is for Vermont. In the right column it says 'okay this multidimensional clinical assessment is going to take a half hour, 30 minutes, from the physician. Then it is going to take another 60 minutes from a licensed behavioral health professional. We assumed that is going to be split 50-50 between a CAC and an LCSW or other licensed professional. So you will see when we walk over to the actual Excel model where those numbers are carried into that model. So you

can see in this description, the Word document for the clinical pathway, all of the steps are in the right-hand column. Steps one through six which will then tie into the rate model.

So now I am going to move into the rate model itself, the Excel spread sheet and I'm going to start with the second sheet, which you'll see at the bottom, the tab is labeled 'Assumptions.' What you can see there is that I have by type of professional what their annual salary is as well as what their productivity rate is for that professional. So you can see that I've got that the physician earns \$200,000 a year and is productive at 75 percent of their time. So their cost per billable hour based on all of the calculations down below, in terms of weeks worked and payroll taxes is \$200 per hour. The cost similarly for a nurse practitioner is \$100 per hour and you'll see that that is going to carry into my actual rate calculations. And then you can see that in the grey cells, that is where you want to enter your data, whatever your assumptions are. And if it's not a grey cell it means it's a calculated cell and you shouldn't enter any information into that.

You'll notice that I've got here in row eleven I've got an 'other.' I've got their salary at one dollar and a productivity rate of one percent. That is to allow flexibility so if there is another type of professional that a state wants to enter, for example like a licensed professional counselor that has a different salary level and we want that in the mix of professionals that are performing services, we can enter that in here and it will automatically flip through. I thought it gave states a good amount of flexibility in terms of how they construct their professionals. You can see on down in the grey cells, I've got all of those things that I talked about before that are going to drive your costs – weeks worked after PTO, your payroll and fringe rate, other direct program costs, G and A and overhead costs, your cost per urinalysis. If you look on down, there are notes that are at the bottom. There are eight notes. Those are definitions that will help you determine what needs to be entered in the grey cells above. So that is the assumptions page for the Vermont Spoke.

I also just briefly wanted to show you another assumptions page and this is from the Massachusetts Primary Care Model. You'll see that I've got, instead of a single type of prescriber, which is what I have in the Vermont model, I've got three different types of potential prescribers: a physician, a physician's assistant, and a nurse practitioner. Then based on percentages of who performs services, for example if the physician is going to perform half of the services, the physician's assistant is going to do 30 percent and the nurse practitioner is going to do 20 percent. So based on their salaries and productivity levels my average cost per billable hour for a prescriber is \$147. So I just wanted you to know that that other alternative is out there to allow you to use different credentials for your prescribers.

So now I am going to walk through the actual rate calculations. Now you'll see in a manner similar to what I described, you've got the top half of the screen that is showing a summary of what the rates are for each phase. For example, for a clinical assessment through induction it is an eight-week period and the rate for that is \$1,962.18. For stabilization, another eight-week episode, we've got \$912.51. Then maintenance is a monthly rate and it's \$351.26 and discontinuation and medical withdrawal, if that is selected at the client's option, that is \$395.66. And then the details for each of the calculations are down below the summary that is in rows two through six.

In the left column you'll see numbered steps, one through three, 1A. Those tie out to the steps in the clinical pathway. So that is how it crosswalks. If we walk through the example that we saw in the clinical pathway, if we look under 1A starting in row 13, we see that the physician takes a half hour, and that's a 100 percent physician. The behavioral health professional took an hour and that is split 50-50 between the LCSW and the CAC, and the cost for that then is \$60.58. So that means that the total cost for the multidimensional clinical assessment is \$160.58. You'll see that the personnel cost per billable hour carries over and that is in row 11 right under the appropriate professional. You'll also see that in column M, I put in some check totals that allow you to ensure that you have 100 percent entered in for the staff. So you can make sure that you didn't accidentally leave a staff off as you were entering staff for each of the specific activities.

So as we walk down through the clinical assessment through induction you can see the time that is required for each activity. We went through the clinical assessment. If we drop down for example to row twenty-one and we tie that out to the induction step on the clinical pathway, we can see that there is four hours of individual counseling, which I've got entered in there, and it is split again 50-50 between the LCSW and the CAC. When we tally that up, we've got a subtotal for direct personnel of \$1,257.81 and then we are adding on the two additional costs – the direct program costs based on the 30 percent from the assumptions page, and the G and A and overhead again from the assumptions page at 20 percent which gives us a total in row 27 of \$1,962.18, which ties into the summary up above. So that is an overview of how the Excel model operates.

So now moving back to the PowerPoint we went through all of those details off of the Vermont model, so with that I am going to turn it back to Colette.

Mady Chalk: Okay. The implantation principles underline the bundled rate that Susan was talking about and the clinical pathways that we discussed earlier, are terribly important. Developing weight setting methods requires that the clinical services, the pathway that underlie them, in providing MAT, be describe as fully as you can describe them. We describe them as best as we thought we could in the clinical pathways that we discussed earlier. The clinical infrastructure needed to support physicians or any other prescribers, needs to be identified. The nurses, the care managers that are going to be needed, for the site and across your state in different sites needs to be assessed and you need to know whether you have sufficient resources available. Where the waived physicians, and soon to be nurse practitioners, and physician assistants are. To what extent they are accessible, and do they have integrated clinical staff or to what extent will those have to be provided externally? What referral networks are available and who has MOUs or formal affiliations, agreements, between specialty and primary care providers? We also need to keep in mind that implementing any of these models needs to be evaluated on a regular basis to assess whether they are meeting the objectives to which they were set up. The purposes, objective, whether they are enhancing quality for patients, and improving patient's healthcare staff. Colette?

Colette Croze: Yes. Now what haven't we haven't we addressed in the...well the takeaway points. Key elements clearly described by Mady and Susan. The rates are created for the stages of treatment, so there's a pathway obviously and there's discrete sections. Flexibility in provider types, when Susan talked about the sections in the rate methodology the Excel spreadsheets that you would input yourself based on your salaries, provider types, etc. We presented, we had Vermont and Massachusetts present and we

focused on the pathways for those two models but the third pathway, which you will get to see when CMS has posted it, will also show you the pathways in relationship to the Baltimore project where the treatment initiates in the specialty system and then you have an additional step for handoff to primary care.

So what haven't we told you about bundled rates? Well states would have to make a decision about what activity, action, or intervention actually triggers a bundled payment, which practitioner or organization would receive the bundled reimbursement, what documentation of service provision is required if you're paying for a bundle of something, and what metrics would be used to evaluate improvements in quality resulting from the use of the bundled payments rather than unit of service reimbursement. So those are questions that the purchaser would need to answer to in trying to apply the bundled rate methodology and those will be left to the state decisions.

We have time for questions. We have none that have come in from chat box, but we did receive some in advance. Mady, I'm going to ask you to take a shot at this one – we had a question about what kind of issues might states anticipate in regard to carving services out in the bundled rates?

Mady Chalk: Yes, well it seems to me that if states consider carving out some of the services by definition, they are... The whole point of clinical integration is to have physicians linked with the clinical services they need to support them and the rest of the team they need gets the defused. It also diffuses clinical accountability. If a state wants to hold a group of providers and their support staff accountable for delivering MAT, if you unbundle or pull-out cost of services out of the bundle, they are no longer a part of the accountability and no longer accountable for the services they are providing because they are outside of the bundle. Putting the services back together then, putting them back in to maintain the integrity of the clinical pathways, clinical models that we described or that you would describe, would be pretty difficult, and it seems to me that you end up right back where we're starting frankly, in many areas of this country, which is that we have a practitioner siloed treatment and reimbursement approach with no whole clinical pathway or clinical model. I think there are some real issues in carving services out of bundled rates.

Colette Croze: Thanks, Mady. I want to remind the audience that you have to take your screen out of the full screen shot in order to see the chat function. We don't have any questions coming in so I want to move to another one that we received. I'm going to ask Susan if she can give us some thoughts about this one. We had a question about whether the models that presented represented more cost efficient or cost savings model that still encourages best practices for treatment provision.

Susan Parker: Sure, Colette. As you heard from Vermont and Massachusetts, none of them use the bundled payments in exactly the way that we put them together based on their models, but they did talk a fair amount about the benefits that they accrued from their clinical models including increases in the waiver physicians and increases in retention in treatment and lower healthcare costs overall for those who are in treatment. I think many of us understand that much of the savings from effective behavioral health services may accrue out of medical cost savings and not just comparisons to behavioral health. Vermont was also able to reduce, over time, deaths when neighboring states were experiencing dramatic increases. Vermont does use a PMPM which is a type of a bundle, but is a little different than what we have put

together here. We haven't done a comparison between fee-for-service rates and our bundled model nor was it our purpose to save money over fee-for-service. It was really to put together a rate that supported the treatment model that we're trying to put together and encourage adherence to that treatment model by fully supporting the cost of developing that service. That's really what our bundled models were designed to do.

Colette Croze: Thanks, Susan. We also had a question about how the states could take the information presented here to create a competitive rate to incentivize provider participation. I'm going to take a shot at that one. I'd have to take us back first. You hear us repeatedly talking about the clinical model and the support infrastructure for the physician. So I think that, for me, the first step on the path about incentivizing provider participation is that the model that provides support that the physician needs in order to be able to carry out his or her role with the right kind of infrastructure. But once you articulated a model that supports the waived physician then I guess we would talk about honest pricing. If you created a staff at a fully loaded rate, that's based on appropriate personnel costs, the necessary overhead, build in time for the tasks that allowed in good clinical practice, that if you look back at the concerns that the physicians responded raised in Vermont and Massachusetts, it goes right back to the infrastructure so I guess we could point you there before you talked about trying to figure out incentivizing the rate.

Question about confirming whether the medications were not included in the bundled rate because they go through the pharmacy instead. That is correct, these are the clinical services and the one non-clinical service, as I think Susan and Mady pointed out, urinalysis costs are included as part of the rate.

Colette Croze: We had a question, and this I'll pawn over to Mady. Can you describe the requirements of MAT providers who wish to bill one of these model bundled rates? For example, licensure, setting type, etcetera.

Mady Chalk: Sure. Some of the states have developed certification and training programs, by the way, for, leaving aside the training required for waived physicians, regardless of site, although I need to remind everybody, I guess, that DATA 2000 said that this was an office-based treatment service, and not in based in hospitals, and not based in other inpatient settings. Yes, waived physicians, there are training requirements for them, and there are actually free trainings available for those physicians through ASAM and other organizations. In order for a physician to receive a waiver they have to be certified as having had the training. But some states have created certification programs for counselors, they have MAT. And it seems to me that this becomes an initial step in developing implementation plan – identifying what kinds of training. Colleen talked about training nurses and nurse care managers. Tony and John talked about training physicians and providing clinical supervision to them and clinical availability of other physicians. All of that needs to be considered as you are developing an implementation plan for any of these spots. Colette?

Colette Croze: Great. Thanks, Mady. I have a question that I'm going to send back to Massachusetts and Vermont, we had a state asking what HIPAA compliance issues might states need to think about regarding billing and information sharing when you're bundling rates like this? Tony, John start, and then Colleen?

Anthony Folland: I think that we didn't really have HIPAA compliance issues. I think one of the things we did experience, that we needed to figure out was using both specialty care providers and non-specialty providers. The link of when somebody was using a 42 CFR Part 2 facility and when they were not, and figuring out how to get universal releases in place so that that information could be corresponded across providers.

Mady Chalk: Did you succeed?

Colleen Labelle: This is Massachusetts. I would say the same thing, that we use 42 CFR when we need to in those facilities. As well as, within our own facilities we have patients sign and consent at the start of treatment that says we will be sharing their information within the organization and that can be a big organization such as Boston Medical or Partners, but for the purposes of medical care only, so that they know the information will be shared in that respect. We also develop memorandum for agreement and what have you, such that Vermont spoke about, so that we are able to collaborate and coordinate in order to provide better care.

Colette Croze: Okay. I'm seeing a question in the chat box—so we have a question about are there specific codes for bundled services and payments? We have not dropped into the coding zone yet, so I'm going to ask you to hold on to that question and as we proceed to that with this work in that next phase we'll try to move back to that one.

One of the attendees would like to know if it's possible to get a copy of the releases and MOU and that would be a question for Vermont and Massachusetts.

And then I finally wanted to remind you that, both Mady and Susan have referenced it, but the clinical pathways and rate models will be available on Medicaid.gov soon, so you will be able to dig into the details of those. So I want to call your attention to the resources that are available and that are referenced in the material here, as well as speaker contact information, and remind you that there will be an evaluation reminder that will pop up as you close the webinar. Thank you for your time and attention today. Hopefully we will be speaking with you about the bundled payments and clinical pathways additionally in the future. Thanks.

[End of recording]