



HOW TO PAY FOR IT

MAT for Hospitalized Patients

California has made significant investments to address the nationwide opioid epidemic. These efforts include a broad range of activities under the umbrella of the state's State Opioid Response grant, also known as the [Medication Assisted Treatment Expansion Project](#).¹ While efforts are multifaceted, improving access to medications for addiction treatment (MAT) for patients with opioid use disorder (OUD) is a major focus.² FDA-approved medications for the treatment of OUD consist of various formulations of methadone, buprenorphine, and naltrexone. Improving patient access to MAT is being accomplished through projects to enhance education, training, and mentoring for providers; conduct information and media campaigns; and expand the numbers of programs and providers in primary care, inpatient, residential, jail, and other care settings.

As one component of the state's opioid work, the [California Bridge program](#) received more than \$12 million to support expansion of MAT in emergency departments and acute inpatient hospital settings. As of March 2019, 31 hospitals received California Bridge grants and joined a learning collaborative to expand access to treatment through the design and implementation of MAT programs. Many

[California Bridge resources](#) are available to any hospital in the country, regardless of participation in the collaborative.³

Expanding access to treatment for MAT in hospitals is timely, given how often hospitals treat patients with OUD. The rate of opioid-related hospital admissions in California increased by more than 50% between 2008 and 2017 (from 122 to 215 per 100,000 population).⁴ Opioid-related hospital admissions typically include a primary medical, surgical, or psychiatric diagnosis with a secondary diagnosis of OUD. The primary diagnosis may be a consequence of OUD (e.g., endocarditis, osteomyelitis) or may be unrelated to the underlying OUD.

While hospitalized patients often have medical and surgical complications of substance use disorder, few hospitals have systems in place to treat the underlying addiction.⁵ Buprenorphine and methadone — the most common OUD medications — are considered the gold standard for evidence-based treatment and can be easily started and maintained in inpatient settings by either hospitalists or hospital-based addiction medicine consultation services.

This paper describes how MAT is reimbursed in acute inpatient settings, addressing three areas for payment:

- ▶ Professional services — how clinicians are reimbursed
- ▶ Hospital costs
- ▶ Pharmacy costs associated with the medication

The paper assumes that patients begin these medications while hospitalized, but it does not address ongoing community-based care once patients are discharged. Providers who offer MAT in inpatient settings should have systems in place to arrange for such ongoing care. Options for community linkages can include community health centers, substance use disorder treatment clinics, specialized hospital discharge MAT clinics (also known as Bridge clinics), Opioid Treatment Programs (formerly called methadone clinics), and telemedicine. Information on reimbursement for MAT provided in other settings can be found in [How to Pay for It: MAT in Community Health Centers](#) and [How to Pay for It: MAT in the Emergency Department](#).

Professional Services

Inpatient MAT uses the same set of Current Procedural Terminology (CPT) codes that are used for other inpatient admissions, whether provided by a hospitalist or as a consult. The CPT codes include:⁶

- ▶ **99221–99223:** New or established patient initial hospital inpatient care services
- ▶ **99231–99232:** Subsequent hospital care

- ▶ **99251–99255:** New or established patient initial inpatient consultation service
- ▶ **99356:** Prolonged consultation, inpatient setting, first hour
- ▶ **99357:** Each additional 30 minutes beyond the first hour
- ▶ **99238–99239:** Hospital discharge day management, 30 minutes or less; hospital discharge day management, more than 30 minutes

In their documentation, providers would add OUD to the list of diagnoses; this addition could trigger higher payment by increasing acuity or by documenting the increased time it takes to manage the patient. Whether the acuity increases depends on the individual patient’s medical condition and insurance coverage.

Some hospitals supplement MAT in inpatient settings by including counseling and support services provided by social workers, peer counselors, substance use navigators, and related providers. Such services may include Screening, Brief Intervention, and Referral to Treatment (SBIRT), which is a common approach to understand the severity of a substance use disorder, increase patient awareness, and connect patients to treatment.⁷ Costs associated with SBIRT and other counseling activities are not typically billable as a separate professional service during hospitalization. However, if physician services include prolonged face-to-face counseling, the CPT codes listed above can also be used for time-based billing.⁸ And while these behavioral health and social support services could be helpful during an inpatient stay, they are not required for hospitals offering MAT.

Hospital Costs

Hospitals are reimbursed for facility costs separately from professional services. In California, these costs are typically reimbursed on a per diem basis or through a diagnosis-related group (DRG) methodology.⁹ MAT-related services — such as counseling provided by a social worker — would be included in the DRG payment.

As with professional services, adding OUD as a diagnosis may increase the patient’s acuity and, as a result, the case mix index (CMI). A higher CMI indicates a more complex and resource-intensive caseload¹⁰ and may increase reimbursement accordingly. As with professional services, the potential for increased reimbursement would depend on the patient’s medical condition and insurance coverage.

Pharmacy Costs

In an inpatient setting, MAT is paid for in the same manner as all other medications. The pharmacy purchases medications, often through wholesale drug contracts. Once purchased, medications are typically reimbursed by health plans using a per diem payment. This per diem is essentially a case rate that covers any medication that a patient may need over the course of admission, regardless of cost. Upon discharge, a patient would use an outpatient pharmacy to fill subsequent prescriptions. Increasingly, commercial and Medi-Cal health plans allow buprenorphine prescriptions for addiction diagnoses without prior authorization.¹¹ For patients requiring ongoing methadone treatment, access to this medication would be obtained through an opioid treatment program.

Buprenorphine is relatively inexpensive. One commonly available out-of-pocket cost estimator showed that an eight-milligram sublingual tablet was \$1.16 as of April 2019.¹² In contrast, Vivitrol (naltrexone injectable for extended release) was around \$1,500.

Conclusion

Although there may not be additional payment associated with providing MAT (i.e., the acuity did not increase), there are other benefits to offering MAT in inpatient settings. First, patients admitted for a primary issue related to their addiction (e.g., septic arthritis) may begin to experience withdrawal during the admission. Left untreated, patients may decompensate or leave against medical advice, or may become agitated, requiring sitters or security, which can add costs to the admission. Second, starting treatment for underlying OUD could reduce the length of stay. In turn, reducing length of stay saves hospitals money because of the method by which many are reimbursed.¹³ The associated savings are likely greater than the costs associated with delivering MAT. Further, the likelihood of readmission may also be reduced, which can lessen penalties for hospitals in some value-based payment arrangements. For example, recent research demonstrated that 30-day and 90-day readmissions were reduced significantly for patients taking buprenorphine at the time of hospital admission.¹⁴ Finally, stabilizing a patient's addiction can facilitate treatment of the patient's other diagnoses and prevent recurrence of preventable conditions (e.g., infection from IV drug use), improving provider and patient experience and potentially improving clinical outcomes.

Looking Ahead: Alternative Payment Models

Case rates or bundled payments are typically used for surgical procedures (e.g., knee replacement) and could be applied to MAT. This rate would include all costs associated with inpatient medical and addiction treatment and for an established period of time postdischarge. This case rate may better reflect the intensity of counseling and peer support services — provided by either the buprenorphine prescriber or by ancillary providers — that would facilitate starting patients on MAT and encouraging them to seek care postdischarge.

The other option to improve payment for hospital-based MAT would be to establish new codes, similar to those for advance care planning (e.g., CPT 99497, 99498).¹⁵ These codes enable time-based payment for communication between providers and the patient and family. Creating new CPT codes and ensuring these codes are reimbursed would require policy changes at the federal level; however, the change would serve to recognize the time that MAT-related communication and counseling could take.

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About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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About This Series

The California Health Care Foundation commissioned *How to Pay for It*, a series of short papers that focuses on reimbursement mechanisms for strategies that advance integration of behavioral health and medical care.

Endnotes

1. California MAT Expansion Project, accessed May 29, 2019, www.californiamat.org.
2. Medications for addiction treatment (MAT) may also be referred to as medications for opioid use disorder, or MOUD.
3. Resources are available on the California Bridge website, www.ed-bridge.org.
4. HCUP Fast Stats (Oct. 2018), Agency for Healthcare Research and Quality, accessed December 12, 2018, www.hcup-us.ahrq.gov.
5. Honora Englander et al., "Tools to Support Hospital-Based Addiction Care: Core Components, Values, and Activities of the Improving Addiction Care Team," *Journal of Addiction Medicine* 13, no. 2 (Mar. 2019): 85–89, doi:10.1097/ADM.0000000000000487.
6. "Hospital Inpatient Care Services CPT Code Range 99221-99223," AAPC Coder, accessed March 1, 2019, coder.aapc.com; Time-based billing can be used for these codes. For more information, see Carol Pohlig, "Bill by Time Spent on Case," *The Hospitalist* 2008, no. 7 (July 2008), www.the-hospitalist.org.
7. "Screening, Brief Intervention, and Referral to Treatment (SBIRT)," Substance Abuse and Mental Health Services Administration, last modified September 15, 2017, www.samhsa.gov.
8. Pohlig, "Bill by Time."
9. "Diagnosis Related Group (DRG)," HMSA Provider Resource Center, last modified July 13, 2018, hmsa.com.
10. "Open Data Portal: Case Mix Index," California Health and Human Services, accessed March 8, 2019, data.chhs.ca.gov.
11. For more information on coverage of medications for addiction treatment in California, see *Medicaid Coverage of Medications for the Treatment of Opioid Use Disorder: California*, American Society of Addiction Medicine, accessed April 30, 2019, www.asam.org (PDF).
12. This price was based on a 60-day supply estimate using GoodRx, calculated on April 30, 2019.
13. Many hospitals are paid by DRG, a methodology that calculates payments based on a bundle of services, regardless of length of stay.
14. Jessica L. Moreno et al., "Predictors for 30-Day and 90-Day Hospital Readmission Among Patients with Opioid Use Disorder," *Journal of Addiction Medicine* (forthcoming), accessed March 8, 2019, doi:10.1097/ADM.0000000000000499.
15. *Frequently Asked Questions About Billing the Physician Fee Schedule for Advance Care Planning Services*, Centers for Medicare & Medicaid Services, July 14, 2016, www.cms.gov (PDF).