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Preferred Office-Based Addiction Treatment (OBAT) Manual Updates
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The History of the Preferred OBOT (2017) to the new Preferred OBAT (2022)

- **Effective April 1, 2017** the Virginia Department of Medical Assistance Services (DMAS) **launched the ARTS** (Addiction and Recovery Treatment Services) benefit
- The **Preferred Office-Based Opioid Treatment (OBOT) model was also implemented within the ARTS benefit**, providing reimbursement for care coordination (G9012) for the first time within Medicaid for primary care practices, as well as improving reimbursement rates for addiction (opioid use disorder) treatment services and removing the service authorization requirements for preferred products for Medications for Opioid Use Disorder (MOUD).
- The initial Preferred OBOT application and policies were developed in 2017 and **DMAS is making revisions to strengthen the benefit as well as continuing to learn areas that need further clarification through feedback received from providers and managed care**. DMAS has made several updates to the policies as well as the forms to strengthen the model, with the latest revision to expand the model to allow for other primary substance use disorder (SUD).

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The History of the Preferred OBOT (2017) to the new Preferred OBAT (2022) cont.

- The Governor and the General Assembly approved Section ZZZ of the 2020 Appropriations Act, which **required DMAS to expand the OBOT model effective March 1, 2022, to allow for other primary SUDs, referred to herein as Preferred Office-Based Addiction Treatment or Preferred OBAT**.
  - WHY? More patients die from alcoholism each year than any other form of substance use disorder. Methamphetamine misuse and cocaine use disorders are on the rise and Preferred OBOTs were not able to get reimbursed for services not related to OUD.
- This required a state plan amendment approval from the Centers for Medicare and Medicaid Services (CMS), a revision to the Virginia Administrative Code and a policy manual update – all which required input from the public.
  - Thank you for your review and feedback to help DMAS strengthen and expand this benefit!
- **Note:** Opioid Treatment Programs (OTPs) continue to require primary OUD to serve members.

What is a Preferred OBAT?

Frequently Asked Question: *"The preferred model for treating the opioid use disorder in Virginia and now expanding to be used for other forms of SUD. How are the Preferred OBOT and OBAT similar?"*

Health care team who drives treatment planning and care delivery:

- **Providers (physicians, NPs, PAs)** within your program, who prescribe the medications, and other providers across programs/departments to achieve the medical management of the substance use disorder and management of co-morbidities: conducting medical evaluation and order, review lab tests, refer for or manage treatment of Hep C, HIV
- **Therapists:** counseling/relapse prevention services, starting with psychosocial/ASAM assessment by a licensed clinician
- **Care administration supports:** Health Administrative Assistants (HAAs)/practice manager, nurses, pharmacies/labs
- **Peer recovery specialists (billable service)**
- **Care coordinators:** document the multidimensional interdisciplinary plan of care with input from the team (IPOC) and progress/changes**;** help patients navigate how to access the care/services included on the IPOC; convene team meetings for monthly reviews
- **Patients** (and some family members)

Comprehensive interdisciplinary care can now be provided for other substance use disorders.

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Key Preferred OBAT Model Policies

- DMAS encourages same day access and initiation of MOUD for individuals with OUD.
- Patients must be diagnosed with a primary SUD per DSM-5 criteria, with the exception of tobacco-related disorders and non-substance-related addictive disorders
- While medications can be an important part of the treatment, patients can be served in the OBAT, if **NOT** on any medication for their SUD.
- Medications covered by Medicaid that do not require prior authorization include:
  - Buprenorphine/naloxone Suboxone films or generic tablets,
  - Naltrexone both Vivitrol and the generic tablets for either alcoholism (AUD) or opioid use disorder (OUD),
  - Disulfiram and acamprosate for treatment of AUD.

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Key Preferred OBAT Model Policies cont.

- Medication alone is not usually sufficient; **same day billing for medical and behavioral health services is strongly encouraged**.
- DMAS requires **co-prescribing naloxone when prescribing buprenorphine**. DMAS **recommends prescribing naloxone for individuals with any SUD as the risks of polysubstance use**, whether intentional opioid use or unintentional use where drugs are contaminated with synthetic opioids, increases risk factors for overdose. This is important due to the increasing presence of fentanyl in non-opioid illicit drugs, such as cocaine and methamphetamine.
- DMAS **supports home inductions** "when clinically appropriate."

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Key Preferred OBAT Model Policies cont.

- Telemedicine and the Preferred OBAT
  - The foundation of the Preferred OBAT model is to provide the **medical and behavioral health services within the same locat**ion, have **in-person interactions with the member** and provide the **high-touch care coordination** to support the member in their recovery.
  - DMAS recognizes that there may be situations that telemedicine is necessary to engage the member in treatment and recovery, especially if the member makes this request. Thus Preferred OBAT services **may be provided via telemedicine based on the individualized needs of the member** and reasons why the in-person interactions are not able to meet the member's specific needs must be documented.

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What Primary Diagnoses are Covered within the OBAT?

Public Comment: *"Under Medical Necessity Criteria section, it indicates that the patient must have a primary diagnosis of OUD. That means that patients who are being treated here for other substance use disorders, other than Opioids, don't get reimbursed for ARTS covered services, such as Care Coordination G9012. We perform the care coordination services on patients with Opioid Use Disorders as well as other Substance Use Disorders and this diagnosis should be expanded to cover services for providers who treat a variety of drug abuse."*

- To be eligible for services, the member must be enrolled in Virginia Medicaid and meet the following medical necessity criteria for Preferred OBAT services:
  - Must have a primary diagnosis of SUD as defined by the most current version of the DSM, with the exception of tobacco-related disorders and non-substance-related addictive disorders.
    - Opioid Use Disorder
    - Alcohol Use Disorder
    - Other SUD (i.e. cannabis, hallucinogens, stimulants, inhalants, sedative/hypnotics, polysubstance)

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Care Coordination Activities

Public Comment: *Supplement p.38 "Substance Use Care Coordination does not include maintaining service waiting lists, scheduling transportation rides or periodically contacting or tracking members to determine potential service needs that do not meet the requirements for the monthly billing. Care Coordination should absolutely include assisting patients with Medicaid transportation because the service is horrible. Patients are stranded for hours and unable to get anyone to help them despite repeated calls from the patient and our staff."*

DMAS Response:

- Substance Use Care Coordination must include supporting the member's medical, behavioral health, and other health care needs through facilitation of necessary referrals to help meet the overall biopsychosocial needs to the member.
- Substance Use Care Coordination must include the appropriate use of and facilitation of referral to a variety of community based support modalities, including a variety of different recovery and wellness pathways, peer recovery services, social service agencies, community based resources appropriate to the member's needs, mutual-aid supports and other evidence based best practices.

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Care Coordination Activities cont.

- Substance Use Care Coordination should include addressing needs beyond the member's medical status and include issues such as unstable housing, food insecurity, child care, transportation and other social determinants of health.

- Face-to-face Substance Use Care Coordination is encouraged and should be documented. If for some reason the member is unable to meet face-to-face and other forms of communication are conducted, such as telehealth or telephonic mode of delivery, this too must be documented. If member is unavailable for face to face Substance Use Care Coordination, re-evaluation should occur to see if the service is appropriate for the member currently with their treatment process.

- All contacts with the member regarding the overall care plan should be documented, as well as efforts to educate the member regarding treatment planning, the importance of treatment plan adherence and timely reporting of all updates and concerns should be documented.

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Clarifications: Comprehensive Individual Service Plan

Public Comment: *"Preferred OBOTs and OTPs are required to develop an Individual Service Plan (ISP) within 24 hours from intake…"Does the comprehensive ISP that is built in the coexistent counseling program, with the input of the OBOT staff, sufficiently meet this requirement?"*

DMAS Response:

- The Comprehensive ISP shall be developed to address needs specific to the member's unique treatment as identified in the multidimensional assessment as applicable to the respective ASAM Level of Care.
- The Comprehensive ISP shall be developed and documented within 30 calendar days of the initial ISP to address needs specific to the member's unique treatment as identified in the multidimensional assessment.
- The Comprehensive ISP must be reviewed every 90 calendar days and documented within the member's medical record no later than seven calendar days from the date of the review and signed off within 24 hours.
- The Comprehensive ISP shall be contemporaneously signed and dated by the CATP(s) and the physician and/or physician extender, as necessary. A Credentialed Addiction Treatment Professional must sign off on the comprehensive ISP if developed by a CSAC or CSAC-Supervisee.

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What Should be Included within the Comprehensive ISP?

- The formatting of the Comprehensive ISP may be at the discretion of the provider but must include all required components as stated below:
  - The member's treatment or training needs,
  - The member's measurable goals,
  - Measurable objectives and recovery strategies to meet the identified needs and goals,
  - Services to be provided with the recommended frequency to accomplish the measurable goals and objectives,
  - The estimated timetable for achieving the goals and objectives;
  - An individualized discharge plan that describes transition to other appropriate services; and
  - Be based on the ASAM Multidimensional Assessment.

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Clarifications: Interdisciplinary Plan of Care (IPOC)

- The IPOC must be **developed and documented within 30 calendar days** from the initial assessment date prior to billing for Care Coordination services by a Credentialed Addiction Treatment Professional (CATP).
- The IPOC is an essential documentation and planning tool to use during the interdisciplinary treatment team meetings and is required to bill for SUD Care Coordination.
- The CATP must sign off on the IPOC if developed by a CSAC or CSAC-Supervisee.
- While the IPOC must be reviewed monthly during interdisciplinary treatment meetings, the minimum requirement to update the IPOC is at least every 90 calendar days or whenever there is a significant change in the member's treatment goals and objectives.
- If the provider is providing **Substance Use Care Coordination services, the IPOC is considered meeting the Comprehensive ISP documentation requirements** if it is reviewed and updated at a minimum of every 90 calendar days.

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What Should be Included within the IPOC?

- The IPOC is **person-centered, recovery oriented, includes all planned interventions, aligns with the member's identified needs (including care coordination needs and recovery goals), is regularly updated as the member's needs and progress change, and shows progress and or regression throughout the course of treatment**.
- The documentation contains, but is not limited to:
  - The member's treatment or training needs,
  - The member's measurable goals,
  - Measurable objectives and recovery strategies to meet the identified needs and goals,
  - Services to be provided with the recommended frequency to accomplish the measurable goals and objectives,
  - The estimated timetable for achieving the goals and objectives,
  - An individualized discharge plan that describes transition to other appropriate services, and
  - Be based on the ASAM Multidimensional Assessment.

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CSAC & CSAC-Supervisee Scope of Practice

Public Comment: *"We are seeking clarification regarding the stated on page 17, "The CSACs and CSAC-Supervisees may not practice autonomously…" Please operationally define "practice autonomously" as the guidance regarding supervision from the Board of Counseling is not sufficient."*

DMAS Response:

- The scope of practice for a Certified Substance Abuse Counselor is defined in § 54.1-3507.1, which states that:
  - "A certified substance abuse counselor shall be (i) qualified to perform, under appropriate supervision or direction, the substance abuse treatment functions of screening, intake, orientation, the administration of substance abuse assessment instruments, relapse prevention planning, substance abuse treatment, case management, substance abuse or dependence crisis intervention, client education, referral activities, record keeping, and consultation with other professionals; (ii) qualified to be responsible for client care of persons with a primary diagnosis of substance abuse or dependence; and (iii) qualified to supervise, direct and instruct certified substance abuse counseling assistants. Certified substance abuse counselors **shall not engage in independent or autonomous practice**. " Facilitation or participation in "planned interventions" by Certified Substance Abuse Counselors is within the scope of their practice as long as they are practicing under supervision as required by law and regulation.
- By definition, autonomously means: **with the freedom to act independently.**

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CSAC & CSAC-Supervisee Scope of Practice

- DMAS' requirements are based off of scope of practice requirements from the DHP to provide substance use disorder counseling, psychoeducational services.
- CSACs and CSAC-Supervisees are not allowed to do a diagnostic assessment, but are allowed to do the multidimensional assessment to make recommendations for a level of care. It must be signed off/ approved by a licensed professional who is supervising the CSAC or CSAC-Supervisee.

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Updates: Preferred OBAT Application

OBAT Attestation Highlights

- As of April 4, 2022, DMAS will accept **one OBAT provider application at a time** unless stipulated otherwise.
- Providers submitting multiple applications for various sites using a copy and paste method for the application **will not** be accepted by DMAS.
  - All applications will be reviewed within 30 calendar days and updates will be shared as needed.

Updates: Preferred OBAT Application

Required Documents for Formal Review

- ARTS Preferred OBAT Provider Attestation and Application;
- Preferred OBAT Provider Credentialing Checklist;
- Preferred OBAT Staff Roster indicating the licensed practitioners are credentialed as an in-network provider with the Virginia Medicaid Network Contractor or at least one of the Medicaid Managed Care Organizations (MCOs);
- A screen print showing license or certification with current dates for licensed medical and clinical staff (including proof of autonomous practice or a practice agreement for NPs and PAs as indicated); and
- Staff and scheduling plan including a description of how you will handle emergencies and/or on-call services, as well addressing individuals needing to start on buprenorphine outside the prescriber's office hours.

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Updates: Preferred OBAT Application

OBAT Attestation Form

- The following revisions have been added:
  - Preferred Contact Information including name, phone number, and email address

PREFERRED OBAT CONTACT INFORMATION			
Name:			
Direct Phone Number:		Email Address:	

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Updates: Preferred OBAT Application

OBAT Attestation Form Model of Care

- DMAS is requesting that all applications be completed in a **site specific framework**, meaning the application should reflect a day-to-day narrative of operations within the individual facility.
  - **Note: The foundation of the Preferred OBAT model is to provide the medical and behavioral health services within the same location, have in-person interactions with the member and care coordination to support the member in their recovery.**
  - **Preferred OBAT services may be provided via telehealth based on the individualized needs of the member and must have supporting documentation detailing the exception of telehealth (transportation, childcare, employment, co-morbidities) that impede their access to treatment.**

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Updates: Preferred OBAT Application

OBAT Attestation Form Model of Care

- The following revisions have been added:
  - Description of the contractual relationship between the Credentialed Addiction Treatment Professionals and buprenorphine-waivered practitioner or the organization employing the practitioner (i.e. independent contractor, full-time, part-time, etc.)
  - Description of additional medical and behavioral health needs and emergency protocols including hospitalization as a last resort,
  - Addition of the Peer Recovery Support role in the interdisciplinary team **(as needed)**,
  - Description of comprehensive treatment and integration for other physical and mental health conditions on-site or through collaboration with other providers within reasonable access geographically to the member.

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Updates: Preferred OBAT Application

OBAT Attestation Daily Staff Schedule

- The following revisions have been added:
  - Include the method of service delivery with staff name and credentials (includes Residents and Supervisees)
    - **Note:** list staff by those providing services on-site followed by those providing services via telemedicine
  - Updated MAT induction to state **Medication Induction** since OBAT expansion includes medications for opioid (OUD) and alcohol use disorder (AUD)
    - **Note:** Please indicate days of week for MDs, NPs, and PAs only
  - Added Peer Recovery Support Services to the list of responsibilities

	Hours per Day of Week							Responsibilities											
Practitioner Name and Credentials Please list and indicate the method of service delivery with staff name and credentials; also, list staff providing services on-site followed by those providing services via telemedicine.	M	T	W	Th	F	S	Su	**Medication Induction** *(please indicate days of week for MDs, NPs, and PAs only)*	Psychotherapy Individual or Group	Psychotherapy Family	Substance Use Disorder Counseling Individual/Group	Prescribing/ Medication Management	Behavioral Health Intake/ Evaluation	Medical Intake Evaluation	Care Coordination	Peer Recovery Support Services	Labs	Urine/Saliva drug testing	Infectious Disease Screening
Example: John Smith, MD (on-site)		*4*		*4*	*8*			*T, Th*						*X*					*X*
Example: Jane Doe, LCSW (telemedicine)		*4*	*4*	*4*	*8*	*2*			*X*	*X*	*X*		*X*						

Updates: Preferred OBAT Application

OBAT Attestation Organizational Staff Roster

- The following revisions have been added:
  - Service Delivery column to state which staff will be on-site vs. telemedicine and ensure alignment with the daily staff schedule

Provider Change of Status (List: Add, Term, Update)	Provider Name	Degree (e.g., MA, MSW, Ph.D., MD)	Professional Licensure or Credential	License Number	Service Delivery (i.e. On-Site, Telemedicine)	Billing NPI	Individual/ Servicing NPI	DEA / DEA-X #	
								DEA#	DEA-X#
Ex: Add	*John Smith*	*Ph.D*	*MD*	*0101652368*	*On-site*	*6521585234*	*8963254147*	*FT234567*	*XT234567*

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OBAT Sites

As of April 20, 2022, there are **196** approved OBAT sites in the Commonwealth.

- 61 in Southwest VA & Tennessee region
- 32 in Northern VA region
- 29 in Tidewater region
- 26 in Central VA region

Preferred Office-Based Addiction Treatment (OBAT) Providers by Managed Care Regions
Last updated April 20, 2022 | 196 Sites

Preferred Office-Based Addiction Treatment Programs, also called Preferred OBATs, are a type of outpatient addiction treatment designed for people with opioid use disorder (OUD). Preferred OBATs provide high quality Medication-Assisted Treatment (MAT), for treating people with OUD as well as other primary substance use disorders (SUD).

This list includes Medicaid enrolled Preferred OBATs along with their contact information.

Central Region: 26 OBATs

OBAT	Address	Intake Phone Number	Type
Chesterfield CSB	6801 Lucy Corr Court Chesterfield, VA 23832	804-768-7318	Community Services Board
Henrico Area Mental Health and Developmental Services (multiple locations)	10299 Woodman Road Glen Allen, VA 23060	804-727-8515	Community Services Board
	3908 East Nine Mile Road Henrico, VA 23223	804-727-8515	Community Services Board
	9403-A Pocahontas Trail Providence Forge, VA 23140	804-727-8515	Community Services Board
	2010 Bremo Road, Suite 122 Henrico, VA 23226	804-727-8515	Community Services Board
Fredericksburg Medical Center (Kaiser Permanente facility)	1201 Hospital Drive Fredericksburg, VA 22401	301-816-6148	Medical Clinic
MCV – MOTIVATE Clinic (multiple locations)	501 North 2nd Street Richmond, VA 23219	804-628-6777	Medical Clinic
	401 N. 11th Street Richmond, VA 23219	804-828-4409	Medical Clinic
Richmond Behavioral Health Authority	107 N. 5th Street Richmond, VA 23219	804-819-4000	Community Services Board
BrightView Health, LLC	5001 West Village Green Drive, Suite 205 Midlothian, VA 23112	804-292-2402	Outpatient Clinic
Daily Planet Health Services	517 W. Grace Street Richmond, VA 23220	804-783-0678	Federally Qualified Health Center

https://www.dmas.virginia.gov/media/4566/preferred-office-based-addiction-treatment-obat-providers-by-managed-care-region-04-20-2022.pdf

ARTS 4 Year Evaluation

Prevalence of SUD Diagnoses

- **Just over 100,000 Medicaid members had a diagnosed SUD in SFY 2020**, an increase of almost 30% from SFY 2019.
- As in prior years, **OUD was the most frequently diagnosed SUD in SFY 2020** (40,465 members) **followed by AUD** (37,647 members), **cannabis** (27,290 members), **and stimulants**, which includes the use of **methamphetamines** (22,493 members).
- **Stimulant use is especially concerning given the almost 50% increase** in Medicaid members with this diagnosis between SFY 2019 and 2020.
- During the same period, **OUD prevalence increased by 33.2%** , **AUD by 34%, and cannabis use by 38%.** There was also a **58.4% increase in diagnoses related to hallucinogens, although overall prevalence of hallucinogens is still very low** (only 822 members with diagnoses in SFY 2020).

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Questions or Feedback?

Contact Us

Call the ARTS Helpline at (804) 593-2453

Email: SUD@dmas.virginia.gov

ARTS Webpage:
https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/

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