

SUD Workgroup Feedback

Meeting Date	Requires Further Action?	Issue	Responsible Party	Discussion	Decision/Resolution
3/24/2016	No	2.1: Is 24/7 availability for facilities within close proximity ok?	N/A	Yes, and access by phone is needed when not able to reach a facility.	N/A
3/24/2016	No	2.1: Is there a distinction between co-occurring and enhanced programs?	N/A	Yes, as discussed in detail in the ASAM Manual	N/A
3/24/2016	No	2.1: Will we be discussing level of care for adults only?	N/A	During this meeting, the discussion focuses on adults however services will be available for adolescents also; see the ASAM manual for additional information.	N/A
3/24/2016	No	2.1: Under the Medallion 3.0, occupational services are not paid for. There is a need to specify/outline this.	N/A	Yes, as is outlined in the ASAM manual.	N/A
3/24/2016	No	2.1: DMAS standards need to be revised to align with ASAM criteria	N/A		N/A
3/24/2016	No	2.1: Are there clear pathways as to determine which level of care is recommended for the member?	N/A	Yes, as is outlined in the ASAM manual.	N/A
3/24/2016	No	2.1: Most IOPs don't have physicians on site	N/A	Optional but helpful to have. Definitely needed on higher levels of care such as 3.5/3.7	N/A
3/24/2016	No	2.1: For facilities without physicians on staff, who will write the prescriptions?	N/A	Facilities should have referrals close in proximity to assist. Localities are also expected to work closely with members PCPs.	N/A
3/24/2016	Yes	2.1: Are there enough CSACs? There is a need to better define credentialing, as this is different from being licensed.	N/A	as of 6/21/2016 the workgroup is discussing credentialing options to use in the various service evels within the ASAM model	Ongoing
3/24/2016	No	2.5: The term "day treatment" is generally not used in this field. Not all of the physicians are "addiction docs"- they may have psychiatrists who have experience however, do not have credentialed physicians; this could be due to the low reimbursement rates. Most are doing ambulatory detox under partial hospitalization to get the 6 hours of time with the member. Hard to keep the program full- not the same has IOP where the member is in care for about 6 months. Challenging to fill the program due to the number of hours. Billing in 3hr blocks- 1hr=1unit. Does transportation play a role in this?	N/A	as of 6/21/2016 the workgroup is discussing credentialing options to use in the various service evels within the ASAM model, service requirements must adhere to the ASAM guidance.	N/A

3/24/2016	No	3.1: Regarding assessments-This is usually a step-down- never “first line” of treatment, which one would imply that an assessment has already been completed. This level of care doesn’t typically have a physician attached. Higher/lower levels need to document why this level of care is needed when submitting the transfer.	N/A	The MCO's and Magellan will provide an ASAM assessment, the provider must coordinate to ensure a clinical assessment occurs in line with their licensing requirements.	See item 14:
3/24/2016	No	3.1: How does ASAM define addiction physician?	N/A	Our MCOs and providers are very concerned about the requirement for ASAM Level 3.1 that “an addiction physician should review admission decisions to confirm clinical necessity of services (page 225)” because Level 3.1 programs are not required to have a physician on staff. Also Level 3.1 is typically a step-down service and many members were already assessed by a physician at a higher level of care who recommended they be transferred. Of note, physician review of admission decisions is not required for ASAM Level 3.5. Could Virginia require the physician at the previous level of care to review and recommend the admission to Level 3.1? Since our MCOs and Magellan will have SUD Care Coordinators who will be assessing all members to confirm clinical necessity of services for residential treatment, can this requirement for an addiction physician be waived by Virginia for ASAM Level 3.1 and be replaced by the MCO or Magellan SUD Care Coordinator as part of the UM process? ASAM manual has definitions however, there is an exception in VA- with regard to administering assessments, psychiatrists with experience and training in addiction medicine for facilities that do not have physicians on site. Will follow up with CMS.	CMS clarified that this requirement could be meet if: 1) A physician at the previous level of care has reviewed the admission and confirmed that admission to Level 3.1 is clinically necessary AND 2) A behavioral health professional has performed a multidimensional assessment based on ASAM criteria to confirm that ASAM Level 3.1 is an appropriate placement (this could be a LPC or LCSW at the previous level of care or a MCO or Magellan SUD Care Coordinator).
3/24/2016	No	3.1: Payer should not have say in how services are delivered to patients who are not in their care.	N/A	This disussion will resume with the review of utilization and benefit management	N/A
3/24/2016	Yes	3.5: Approval by physician is not listed on worksheet as mentioned in 3.1 and 3.3 in ASAM Manual- needs clarification	Team	Will follow up with ASAM and also with CMS if needed.	
3/24/2016	No	3.7: Assessment would be required here, rather than the lower levels of care since there are physicians on site	N/A	N/A	N/A

3/24/2016	No	3.7: Can LPNs satisfy the requirements to monitor medication administration and daily care of the member in place of the RN, as long as under RN supervision? RN still needs to administer the nursing assessments- needs clarification	Kate Neuhausen/DHP/ CMS	Level 3.7 states that necessary support services include that “a registered nurse conducts an alcohol or other drug-focused nursing assessment at the time of admission. An appropriately credentialed and licensed nurse is responsible for monitoring the patient’s progress and for medication administration (pages 266-7).” Will follow up to confirm credentialing standards in line with the practice act. This issue will require further clarification from a physician who has administered the withdrawal management service and who can discuss staff needs in various ASAM levels, will follow up with ASAM consult as needed.	CMS said that Virginia’s state practice act should guide our decisions about nursing but that it would be consistent with ASAM to allow a RN or higher to conduct the initial nursing assessment and a LPN to monitor the patient’s progress and administer medications as long as this aligns with the state practice act. DMAS has contacted the Virginia Board of Nursing to obtain an answer to this question.
3/24/2016	Yes	3.7: What is a credentialed RN?	Kate Neuhausen/DHP	Will follow up with DHP to confirm ASAM terminology in state practice act	
3/24/2016	No	3.7: Availability of psychiatric services is limited- needs specifying, access to level 4 when member needs higher level of care. Doesn’t specify whether a psychiatric NP or psychiatrist is available to assist member	Kate Neuhausen/CMS	Level 3.7 states that necessary support services require that “psychiatric services are available on-site, through consultation or referral when a presenting issue could be attended to at a later time. Such services are available within 8 hours by telephone or 24 hours in person (page 267).” Will follow up with CMS	CMS said they would be happy for Virginia to require that psychiatric services be provided by a psychiatrist or psychiatric NP given the complexity of patients’ mental health conditions at Level 3.7 as long as the providers can staff it and the providers, plans, and Magellan can pay for it.
3/24/2016	Yes	3.7: Can tele psychiatry be used?	N/A		
3/24/2016	No	4.0: Can there be exceptions for medical necessity for very complex patients who will need stays of longer than 15 days inpatient or 30 days in residential treatment that would allow Virginia Medicaid to reimburse for longer stays and draw down a federal match (if a MCO or Magellan makes a compelling case for medical necessity and that the member will be harmed if they are transferred to a lower level of care)?	Kate Neuhausen/CMS	Will follow up with CMS	CMS clarified that the 15 day limit for inpatient detox is a hard limit. However, the 30 days for residential treatment is an average length of stay not a maximum length of stay. CMS encourages short-term stays in residential treatments and would like the health plans and Magellan to actively manage the length of stay through the SUD Care Coordinators and other utilization management strategies. However, CMS recognizes that some Medicaid members may need longer lengths of stay than 30 days in residential treatment because of their complex medical and behavioral conditions and social needs.
3/24/2016	No	Is the DSM-V diagnostic criteria being used?	N/A	The DSM criteria will be used for diagnostic standards, ICD-10 will be used for claims processing	N/A
3/24/2016	No	How will EPSDT be incorporated into this?	N/A	EPSDT aged SUD cases will simply follow ASAM placement criteria for placement decisions	Individualized cases will require an EPSDT review to determine an appropriate level of care if an ASAM standard is not warranted to meet the individuals needs.

3/24/2016	No	What is the role of SA Coordinator in this plan?		Virginia's plan is that the MCOs and Magellan (BHSA) will hire SUD Care Coordinators who will use the ASAM Criteria to perform an independent, multidimensional assessment of all members, place members at appropriate levels of care, and make recommendations for length of service for all residential treatment services. Our health plans and Magellan would like to know what qualifications CMS will expect the SUD Care Coordinators to have in order to perform these assessments using ASAM Criteria. Can the MCOs and Magellan hire licensed Masters-level behavioral health providers (LPCs or LCSWs) with substance abuse experience instead of CSACs to perform the independent assessments for residential treatment using ASAM?	CMS clarified that they are okay with the health plans and Magellan hiring licensed Masters-level behavioral health providers with substance abuse experience to serve as SUD Care Coordinators and perform the independent, multidimensional assessment using ASAM criteria for residential treatment services as long as this aligns with Virginia's state practice act on which providers can perform assessments. DMAS has contacted the Virginia Department of Health Professions to confirm that this would align with Virginia's state practice act. CMS clarified that they are okay with the health plans and Magellan hiring licensed Masters-level behavioral health providers with substance abuse experience to serve as SUD Care Coordinators and perform the independent, multidimensional assessment using ASAM criteria for residential treatment services as long as this aligns with Virginia's state practice act on which providers can perform assessments.
3/24/2016	No	3.7/4.0: Virginia does not have an adequate workforce of addiction specialist physicians and addiction psychiatrists. Psychiatrists, internists, or family physicians with addiction experience but no formal certification serve in these roles in many programs.	Kate Neuhausen/CMS	Many of the ASAM Levels mention a certified addiction medicine physician or addiction psychiatrist, including Level 3.7 which says that "many states require that the physician serving as medical director for a Level 3.7 treatment program be a certified addiction medicine physician or addiction psychiatrist with specialty training and/or experience in addiction medicine (page 268)" and Level 4.0 which says "If Level 4 is a specialty addiction service, the physician staffing a Level 4 service is frequently an addiction specialist physician. If Level 4 is an acute psychiatric facility, the physician is ideally an addiction specialist psychiatrist (page 282)." Will follow up with CMS	CMS recognizes that Virginia has workforce shortages and may not be able to meet the high bar of an addiction psychiatrist for Levels 3.7 and 4.0 in many regions. They agreed that it would meet the spirit of ASAM if a psychiatrist or other physician (such as an internist or family physician) with substance abuse treatment experience serves as the medical director of and/or staffs a Level 3.7 Residential or Level 4.0 Inpatient setting. CMS encourages providers, health plans, and Magellan to develop consultation systems so physicians who are not addiction specialists can serve on the front lines providing direct patient care but will be able to consult an addiction psychiatrist or certified addiction medicine physician about challenging cases.

3/31/2016	Yes	Ambulatory Withdrawal Management without Extended on-site Monitoring (ASAM1-WM): Typically this would not be compared to the 2.1 service but to the partial hospital program since there is a physician and nurse associated. There are medical practices that do this through office visits rather than hospital site.	Kate Neuhausen	Does the current practice align with ASAM? Seems like it would be flexible. This would be for low-risk patients. This program would be paid for through E and M codes for physician visits. This is not limited to suboxone only, there are other medications that apply to this program as well. Will review further.	TBD by 7/12/2016
3/31/2016	Yes	Ambulatory Withdrawal Management with Extended on-site Monitoring (ASAM2-WM): Sounds the same as ASAM1-WM-- could be paying in office setting without knowledge; not aware however mostly occurs in partial hospital setting due to the 6 hrs spent with patient. This is part of the per diem, not a separate rate. Are there any suboxone induction codes? Would there be a need for a modifier?	Kate Neuhausen/Debbie Sikes	Inductions without a physician would not be feasible. Should have it available for flexibility. Will be considered for the reimbursement discussion/workgroup meeting. DMAS will look into paying through current reimbursement method. Debbie Sikes will reievew current suboxone induction codes	TBD by next meeting
3/31/2016	No	Would a psych clinic be able to bill if they have the medical staff available?	N/A	This would apply more to level 4.0	N/A
3/31/2016	No	Clinically Monitored Residential Withdrawal Mangement (ASAM3.2-WM): Does this currently exist and is being paid for?	N/A	Les- yes, on the commercial side. Not many available	N/A
3/31/2016	Yes	Clinically Monitored Residential Withdrawal Mangement (ASAM3.2-WM): This is comparable 3.3/3.5? Could this be a component to 3.3/3.5 with peer supports?	Kate Neuhausen	This is similar to crisis stabilization without the detox unit, which is a 15 day cycle; need to consider the pay rate, as they are compensated more than 3.3/3.5; the license is more comparable to 3.7... will review	TBD by next meeting
3/31/2016	Yes	Medically Monitored Inpatient Withdrawal Management (ASAM3.7-WM): This appears to be comparable to 3.7; the issue is the availability of physicians and nursing on site.	Kate Neuhausen/DHP	The allowance for LPNs to assist under the supervision of RNs makes this more helpful. Some psych units are not licensed by DBHDS to operate on 4.0 level because they don't have the medical component. Therefore, would fall under this level of care. Will follow up with DHP for clarification on LPN/RN role	TBD by next meeting
3/31/2016	Yes	Medically Managed IOP Withdrawal Management (ASAM4-WM): There is no mention that the physician would visit/physicially see the patient daily, seems out of clinical practice.	Kate Neuhausen/CMS	Will follow up on criteria	TBD by next meeting

3/31/2016	Yes	Medically Managed IOP Withdrawal Management (ASAM4-WM): Would this be a medical hospital with a unit? A stand alone like Poplar would not have all of the components. A lot of the medical hospitals generally don't often have addiction counselors in the acute setting. A lot of the smaller hospitals won't have psychologist/psychiatrists on staff. Would tele-medicine be an option? Even some of the larger hospitals don't have all treatment components.	Kate Neuhausen/Mee Lee	ASAM manual is pretty flexible with criteria. Will follow up with Dave Mee Lee on clinical staffing requirements	TBD by 7/12/2016 meeting
3/31/2016	No	MAT requirements- can amphetamines be added to the list of medications?	N/A	Dr. Melton- yes	N/A
3/31/2016	Yes	MAT requirements- there is a need for a prior auth for payers and need to come up with protocol in order to guide better facilitation of the program (i.e. to ensure the counseling component is happening), yet not to deter providers from wanting to provide services or having to increase out of pocket pay. Suggestion: Uniformity/consistent panel on what to look for with drug screening to ensure efficiency and decrease variability.	All Plans	Plans will come up with proposed plan	Will be developed during benefits management workgroup activity
3/31/2016	Yes	MAT requirements-What is the key lever to manage without intrusion and increase network?"Pill-mills" and providers not willing to taper the dose seems to be an issue. How do we combat this? Credentialing is critical. Need for concise program with uniformity; keeping the patient in mind to help them with getting better (thought process for "good providers" that are dedicated to the cause). Should 16 mg be the maximum dose?	All Plans	Plans are charged with creating possible solutions for data mining	Will be developed during benefits management workgroup activity and credentialing standards workgroup meetings

3/31/2016	No	MAT requirements- Should suboxone be bundled? Recommendation not to bundle to hold physicians accountable for the family counseling component; this helps with compliance and ensure service delivery. Other recommendation: H0020 with modifier should be added to this in order to incentivize providers to get waived so that they could get the staff needed to deliver the counseling component.	All Plans	There is opposition as to whether this code applies to both methadone and suboxone. Methone already has requirements so bundling makes sense for that as opposed to for suboxone where the providers may not be held accountable. We need to focus on creating linkages to have enough counselors to provide services. Therefore, suboxone should be more detailed in billing rather than bundling together-therapy and suboxone; this would essentially double the payment thus, incentivizing for providers. The next step would be to outline which providers would be able to utilize this. Encouraged to create a proposed plan	no bundling, refer to reimbursement structure for details on MAT billing
3/31/2016	No	MAT requirements- Methadone bundling?- The rate and take home meds are an issue; have the face-to-face requirements changed? Only allowed to bill for the day patients pick up the meds; very few providers will opt to provide services for this reason. Suggestion to incentivize daily visits instead	All Plans	Charged with proposing a plan	no bundling, refer to reimbursement structure for details on MAT billing
4/7/2016	No	H0006- How would you establish time that is not in the 15 min increments? Would you round up or down? Traditionally, physicans round up.	N/A		Will review for further discussion
4/7/2016	Yes	H0006- Will patients be allowed to have MH CM at the same time as targeted SA CM? When patients need both, how would you determine which one takes priority and who makes the decision? This also effects other levels of care.	DMAS/Magellan	One Case Manager should be working with the patient holistically therefore, they should not be receiving both simutaneously; targeted CM should trump MH CM. Perhaps the decision around the Methadone bundling will make the decision clearer.	Will work with Magellan for further discussion regarding benefit management
4/7/2016	No	IOP- Initial session allowance? Would like to see assessment before approving the group and would not require an auth (using E/M and CPT codes)			refer to reimbursement astructure document for authorization criteria, further details pending

4/7/2016	No	IOP- What would be the MAT? Would there be a uniform process for PA submission; what would be the core elements?	N/A	IOP should be a supported service to MAT for emergent cases. Providers need to be prompt in submission of prior auth for processing; PA will be retroactive and should be processed within 72 hrs. Discussion with CMS has resulted in the recommendation of uniformity across all plans for PA submission. There are still providers who have not embraced the electronic submissions, so it's suggested that there should be paper/fax options. There is concern about the development of "pill mills" based on the increased rate structure being higher than payments from commercial plans	Will table the issue of submission via paper/fax. Will make note of billing units: 1=3 for adults and 1=2 for adolescents and time for processing Prior Auths to be processed within 72 hours with consideration to retroactive auths for urgent approvals
4/7/2016	No	IOP- What are the license requirements? Can they be tightened to keep out the "bad" providers?			refer to DBHDS licensing standards, plans will also implement strict credentialing standards to enforce ASAM model.
4/7/2016	No	Partial Hospitalization- Does this deserve any different tx from IOP?	N/A	The consensus is that the requirements mentioned for IOP be applied to partial as they are similar services	Prior Auths to be processed within 72 hours with consideration to retroactive auths
4/7/2016	No	SUD Crisis Intervention- What are thoughts on taking this away as a segregated service; BH and SA crises should be handled the same therefore merged together.	N/A	How would this work if CSBs are the only entities that complete the screenings?	Consensus was to integrate MH and SA together in relation to crisis intervention services. Requires state plan amendment.
4/7/2016	No	H2034- Someone other than the provider would have to do the assessment as agreed on discussion with CMS: how would this happen?	Kate Neuhausen/ Karen Kimsey/CMS	Authorizations are required for this service-- It's similar to doing a prior auth however, this would be done by the care coordinator affiliated with 3rd party health plan- thoughts on how to operationalize this: interviewing the member would be a challenge (timewise). There will be a delay in time and care, blocking patients to getting the care they need. There appears to be a stricter rule for a lower intensity of care, should be the reverse. Plans have alternative independent review methods in place for non SA/MH cases; would it be possible to utilize these instead?	Can be done in house as plans' utilization management structure
4/7/2016	No	H0010- Licensing requirements are slightly different between 3.3 and 3.5	Brian Campbell		Resolved on 5/26- review by Cleo Booker
4/7/2016	No	H0010- is medication a part of the bundling rate? MAT is more intense in the induction period; on the commercial side, a separate induction fee is not usually paid, the doctor would bill after consultation	N/A		Yes; 393 rate should include all of the therapeutic components and the others would be billed separately (meds, physician, drug screening and labs, etc)
4/7/2016	No	H0011- Should there be a prior auth? And what would be the TAT?	N/A	N/A	Urgent telephonic approval, 1 calendar day if not able to get immediate response
4/7/2016		H0006- How would the claim be controlled?			

4/7/2016	No	H0020- Providers would be making more with the separate code billing; this would incentivize providers to be interested in joining the network to provide services		This is more stablized and creates more control for meds and counseling yet, may be challenging for existing providers	
4/7/2016	Yes	Value-based purchasing- could start with pay for reporting before getting to the concept of paying for performance. Feedback on how to implement this concept	All Plans	Survey sent to plans has about 4 items based on NQF factors related to reporting; payment should be used as leverage to get good reporting. Ways to evaluate successful delivery of care should be considered also. Plans are charged to finish the survey before next meeting and send other suggestions/recommendations as they apply	TBD at a later date
4/14/2016	No	PUMS- Are patients locked in to specific locations and for specific meds or all meds?	N/A	Patients can be locked-in in any way seen fit; the structure does allow for good tracking.	N/A
4/14/2016	Yes	Peer Services-Should we allow for a levels of care as recommended by DBHDS	Kate Neuhausen DBHDS, CMS and Team	There is a general concensus that all agree that peers should be present at 3.7 and below. there are concerns for 4.0: how many patients are actually lucid enough to benefit from services, staff may not use peers as intended ("as sitters") and the payment structure. The GA rule on background checks on those who have committed barrier crimes (years/decades ago); if there is evidence of good record and time of sobriety following, can they be considered eligible to apply as a peer? This inhibits good people from being able to serve.	Tabled for later discussion on future workgroup meetings (6/23).
4/14/2016	No	Peer Services- Are there others states with this model that could be viewed?	N/A	States like PA have long experience and a good model. Others are kind of sparce, creating a oppportunity for VA to implement some good options.	Virginia is continuing to research the Pa model and how it uses a peer support supervisor in conjunction woth the licensed supervisor of the agency within which the Peer service is allowed for reimbursement.
4/14/2016	Yes	Sample PA- the structure is fine, but this seems to be a high level document that doesn't have enough supporting information to make a determination.	Kate Neuhausen/CMS	Providers are on board with the idea of uniformity. Reviews will be done in 3 and 6 month increments. More fields can be added to submit clinical information to resolove the issue; to get a history of patient, would suggest adding a field that would allow for adding past levels of care and reasons for unsuccessful attempts. Recommended to add the list of health care plans to the PA in the event that it needs to be sent to another entity rather than filling out a completely new form.	Still in progress

4/14/2016	Yes	Buprenorphine PA- What are thoughts on proposed PA?	Kate Neuhausen	Does this apply to those on the 7 day inductions? Is it clear that males are not to receive this? Or will exceptions be allowed (ex, for those with allergies)? The concern is regarding providers "pill mills" who will abuse this for higher payment/street value. Urine drug screens should be done to insure that there's compliant and justify exception as needed. When request is denied, there will be appeals. There will be outliers with regard to dosage however, there is a consensus on the dose max stipulation as 16mg and up to 24mg with clinical justification on a case by case basis. Would like to trend to see how well this approach is working.	Will make adjustments to PA; Will specify that this applies to post 7 day induction supply (1 time without PA); for now, policy will stand with serving for pregnant women only. Those with allergies can appeal. Still need to address with credentialing and benefit management standards.
4/14/2016	Yes	Concurrent use: Should all Benzos be allowed?	Dr. Hughes Melton/Dr. McMasters	Stimulants seems to be more of an issue; there seems to be support of benzos on the list. There is a risk for over dose thus concern. Are we creating a barrier to tx for those who have been on benzos for years then turning to other opioids. This could be fine tuned; perhaps adding note that both should be prescribed by the same physician. Perhaps there should be a limit on benzos given.	Will make adjustments to document to include: Same provider should prescribe both; 3 months to taper off of benzos, all benzos will not be prescribed concurrently
4/14/2016	Yes	Buprenorphine Maintenance- Thoughts from plans?	Dr. Hughes Melton/Dr. McMasters	3rd and subsequent requests should have a 6 month time frame. There is a consensus on plan proposed. There should be uniformity with regard to the drug screening, monitoring and counseling components to operationalize the system; this will enhance the quality of providers and service delivery and weed out "pill mills". Duration- providers may interpret this to mean "up to 24 mg indefinitely without changes". Suggesting guideline for tapering. Should THC be added to the list of drugs to screen for?	Will make adjustments based on feedback; will not require another PA for dose adjustments; no evidence for suggesting tapering however will take this PA. VA Premier will send guidelines they use for drug screenings
4/14/2016	No	Lock in- block opioids and benzos	N/A	Block would take place after 3 month tapering allowance; using claims data to monitor counseling.	N/A

4/21/2016	No	Narcane spray without a PA- thoughts?	N/A	There are 2 intranasal versions; there is a missing link to getting the member to a provider; there in debate as to whether there should be quantity limits. It is recommended that there be 2 doses on hand per episode; no distinction on how many doses per month/year. Suggested that as the program develops the peer certification portion, perhaps the peer should be incorporated at this level. The med is very potent and has an uncomfortable effect on the member. There is concern over the safety and efficacy of the med; it was reported that the med is generally safe and does not pose harm to others unless they happen to have opioids in their possession. There is a huge difference in cost between the tx; it was suggested to rule out the syringe method of tx.	Going to table the discussion about the injectible version. Consensus from the group: There will not be a PA; Dr. Melton suggests not to impose a quantity limit and to review a year later.
4/21/2016	No	Vivitrol/Naltrexone-	N/A	Is the for prevention of opioid dependence or for treatment? The FDA has is it listed as a means for prevention of opioid dependence. Member has to to into detox before admistering, thus wording to support prevention.	N/A
4/21/2016	No	Vivitrol/Naltrexone- feedback concerning the uniformity of a PA	N/A	For alcohol- The injections seem to do well with those who can afford it as opposed to the oral; there is not as much compliance, which stimulates overdoses. Success with the oral method has been shown with patients who have support of family who demonstrates responsibility with taking as intended. It has been suggested that the oral has been very effective with tx for opioid. It is suggested to attempt oral prior to use of the injectible tx; there are mixed reviewed on this comment. Prior auth is usually after the drug has been administered; is the patient doesn't meet criteria, then the insurance plan would be responsible for the cost. Suggested that the plans should be able to decide how providers will access the meds	Consensus was reached for PA not to be required for alcohol or opioid
4/21/2016	No	MAT meds- Are there other meds that should be considered other than the ones mentioned?	N/A	Perhaps clonidine; no other comments added	N/A

4/21/2016		Prescription Opioid Abuse- Thoughts on PA		<p>There's inconsistencies on the calculator for morphine equivalent conversion provided by D.C.</p> <p>There has been issues with the drug screenings; specificity should be added to the list of drugs being tested for (currently there is a list of 10). Is quantification (how much is in the urine) a factor once determining that there are traces in urine? Recommending that urine testing be standardized but further study with regard to quantification should be limited and preauthorized; also suggesting the removal of THC and metabolites from the list.</p> <p>Discussion with the group resulted in agreement of keeping THC, as there was not enough rationale to support the removal. There should be consistency across the board with the PAs. Some providers give members short-acting version as prior to the long-acting in order to facilitate a breakthrough-- should there be a PA for the long-acting?</p>	
5/19/2016	No	SUD Reimbursement Structure- 99408/99409 (outpatient); should differentiate between assessment and screening, as they mean different things	N/A	N/A	Will be tabled; to review when discussing structure of programs.
5/19/2016	No	SUD Reimbursement Structure- 99408/99409 (outpatient)There is concern about whether these codes will increase submitted claims for screenings on those who wouldn't necessary meet criteria	N/A	This is an under-utilized code, increase may come with promotion.	This will be tracked and will make light of the situation as the need arises
5/19/2016		MAT Reimbursement Structure- Concerns with not bundling Methadone		<p>May be a deturrent with providers participation as they are used to the current method of reimbursement. However, failing to bundle will decrease the opportunity to track the utilization of service delivery (reporting). Suggestion- "meet providers where they are" and make adjustments where needed to provide a "happy medium". This will be a heavily reported program; as long as there is a way to compromise that will not adversely effect the reporting aspect then it will be possible to consider.</p> <p>MCOs are facing barriers with regard to accessing information in BH (after numerous attempts) so the same barrier may be faced with regard to SUD</p>	
5/19/2016	No	MAT Reimbursement Structure- What category would private providers who are not physicians fit?	N/A	They would be licensed under DBHDS regs as an OTP provider, using the DEX number of overseeing physician.	Will table and review at a later date.

5/19/2016	Yes	PA Requests- Maintenance criteria: mandating the counseling component with suboxone seems problematic.	Brian and team	Providers should be given the option to make the decision, as this could present as detrimental to individuals' health, triggering relapse. There is a wide variety of functioning levels, where different approaches/treatment have yielded various results. It is understood that there is a need for uniformity as it pertains to the delivery of service, plans should be able to use discretion and make exceptions as needed. The physician treating the member should be the one to make the decision, as they are the one who is has done the assessment; their attestation should suffice. Suggestion- perhaps lengthing the timeframe from one month to 3...It appears that the requirements have become too strict as a result of trying to reduce the influx of "pill mills"	Good points however needs more thought- will consult with Dr. Mee-Lee for guidance.
5/19/2016	No	Request for Definitive Drug Testing- This is a way for physicians to increase income. Therefore, maintaining control of testing (confirmatory testing) would reduce "pill mills" Recommend that tests be sent to national labs for analysis rather than in doctors' offices or labs.	N/A	N/A	Medicaid doesn't have the ability to limit as MCOs do; will look into this further for later discussion
5/19/2016	Yes	Should match network list to addresses on file as licensed providers with DBHDS	Brian	N/A	Will consider- list was sent after 5/26 meeting. Will reassess
5/26/2016	Yes	Licensing: would there be an opportunity to reimburse 3.7 with rates regardless of whether or not they are residential or psych hospitals?-- there is concern that they will not be willing to provide services with the rates proposed by DMAS	Brian and team		Will table and discuss with team to identify resolve