



COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Benefits Collaborative Public Meeting: Substance Use Disorder

Friday, November 15th, 2013

1:00 p.m. – 4:00 p.m.

225 E 16th Ave., Denver CO 80203

1st Floor Conference Room

Notes

Time	Topic/Agenda Item	Responsible
1:00 – 1:10 p.m.	Welcome and Introductions <ul style="list-style-type: none">• Ground Rules & Phone Etiquette• Staff Contact Info	Kimberley Smith
1:10 – 1:20 p.m.	Benefits Collaborative Overview <ul style="list-style-type: none">• Purpose of the Benefits Collaborative• Review the role of participants and the Department• Parking Lot List	Kimberley Smith
1:20 – 3:40 p.m.	Review and Discuss Draft Coverage Standard	Alex Stephens
3:50 – 3:55 p.m.	Roadmap Moving Forward	Kimberley Smith

Facilitators:

- Kimberley Smith, Benefits Collaborative Manager, Department of Health Care Policy & Financing (HCPF)
- Alex Stephens, Substance Use Disorder Policy Specialist, HCPF

Welcome

Kimberley Smith introduced herself as the Benefits Collaborative Coordinator and provided her contact information (Kimberley.Smith@state.co.us 303-866-3977), to which participants can address their future questions and suggestions.

She then asked participants to introduce themselves. The Department was represented by Kimberley, Alex Stephens, Substance Use Disorder Policy Specialist and Laurel Karabatsos, Deputy Medicaid Director.

Benefits Collaborative Overview

Kimberley then briefly reviewed the concept of a Benefits Collaborative. She explained that the purpose of the Benefits Collaborative is to create a benefit coverage standard, which is the term the Department uses to refer to a benefit policy. It is a process that culminates when the standard is brought before the Medical Services Board for incorporation by reference into Colorado Medicaid Volume 8 Rule.

Kimberley explained that all benefit coverage standards must:

- Be guided by recent clinical research and evidence based best practices
- Be cost effective and establish reasonable limits upon services
- Promote the health and functioning of Medicaid clients

Kimberley then reviewed the role of participants and the role of the Department within (and between) Dental Benefits Collaborative meetings. The collaborative exists to assist the Department in making informed decisions by contributing in the following ways:

- Share diverse perspectives to expand understanding ahead of decision making
- Share new information/research
- Ask questions and provide informed insight in response to analysis offered and suggestions made

In turn, The Department will:

- Work with participants to ensure that concerns are consistently understood and considered
- Wherever possible, work to ensure concerns are reflected in alternatives developed; and
- Provide feedback on how public input influenced decisions made and explanation when input cannot be incorporated/adopted

Kimberley informed participants that any unanswered questions and all suggestions made will be tracked in a Listening Log, posted online, and that each question/suggestion will receive a response from the Department. She encouraged participants to also check the log if they desire to see the kinds of comments the Department receives outside of the Benefits Collaborative meetings.

She then established some ground rules for this and any future Dental Benefits Collaborative meetings, they include:

- Tough on issues, not people
- One person speaking at a time
- Be concise/ share the air
- Listen for understanding, not disagreement
- Speak up here, not outside
- In the room: Phones on silent/vibrate
- On the phone: Please mute your line
- Please introduce yourself when asking a question or making a comment

Discussion of Draft Coverage Standard

Kimberley referred participants to the draft standard in front of them. She began by explaining what is meant by “Substance Use Disorder Fee for Service”. She explained that most Medicaid clients are enrolled in a Behavioral Health Organization (BHO) and receive Substance Use Disorder (SUD) services, when needed, through the BHO. The standard here discussed applies

to the few individuals who have opted not to receive services through the BHO and would therefore access SUD services through the state plan, fee for service (FFS). Laurel Karabatsos, Deputy Medicaid Director, corrected Kimberley. SUD services *will be* provided to the majority of Medicaid clients through the BHOs as of January 1, 2014. At that time, there will be a small minority of individuals who have opted not to receive services through a BHO that will access SUD through the state plan, FFS. This standard specifically addresses those SUD services offered through the state plan.

Laurel provided the following background: In 2006 the Department brought up its limited SUD benefit, provided on a FFS basis. This last year we requested of the legislature the authority to expand the limits on those services and to integrate them with our BHO program, with our mental health services.

All Medicaid clients are automatically enrolled in a BHO when they become Medicaid eligible but there are some clients who are exempted from a BHO and it is still important to us as a Department to define our Medicaid benefits in FFS. BHOs, by nature of being a managed care organization, will have greater flexibility to manage and pay for services that they deem cost effective. The Department is defining the benefit as it would look in FFS, so that Medicaid defines it, and that will be sort of a base level for the BHOs – and they will be able to manage it individually to each client’s needs with a little bit greater flexibility.

QUESTION – (unattributed commenter) pointed to Laurel’s comment that FFS is a “base level” and asked if that means the FFS benefit coverage standard will influence the BHO benefit?

RESPONSE – Laurel replied that, certainly, with any services we provide in a managed care setting, The Department takes what we cover in FFS as the basis for BHO rates. When our Budget Division looked at what to put into the BHO rate, they looked at the cost of an average course of treatment in FFS to set the rate. That said, a BHO gets a pot of money and can manage to their clients’ needs. So, for example, a BHO can determine that providing a tenth service to a client would prevent that client’s condition from deteriorating and incurring further cost to the BHO, they can provide that service, whereas, in FFS, a particular service might be capped in our Medicaid Management Information System that does not go past nine (Laurel was not speaking of any particular service and only used these numbers for the purpose of illustration).

QUESTION – (unattributed commenter) asked if BHOs would have to provide a minimum of care.

RESPONSE – Laurel replied that they will have flexibility and will be incentivized to address what the client needs.

QUESTION – (unattributed commentator) asked for an example of a client who would not be eligible for a BHO and would require SUD services through the state plan.

RESPONSE – Laurel noted that there are individuals who are partially enrolled in Medicaid for whom we pay Medicare premiums but do not provider services, she then pointed out that certain institutionalized individuals may not be enrolled in a BHO.

QUESTION – Rich Gebhardt with Signal Behavioral Health Network (Signal), asked if, when the Department figured out the amount they could allocate for FFS, it took into account that someone may be receiving substance use treatment under managed care but is transitioning to FFS and could expand to the level of very intensive residential care.

RESPONSE – Laurel replied yes and no. The services the legislature authorized did not include residential. They are just outpatient services. The BHO rates are based on outpatient services. We did anticipate greater access now that SUD is added and we did add to the FFS base rate.

QUESTION – Rich Gebhardt clarified his question by asking if the Department accounted for somebody who needs to be in a facility receiving intensive care because the nature of where they ended up on the substance use spectrum requires that kind of care.

RESPONSE – Laurel noted that one of the challenges the Department faced when establishing a rate for the BHOs is that Medicaid already pays for some inpatient detoxification for clients that have a primary substance use disorder diagnosis. If someone is, for example, a severe diabetic or has a diagnosis of liver damage, we may pay for inpatient detox under medical. So, there are claims that are paid FFS for primary diagnoses like this in the inpatient setting.

The Department looked at all of those dollars and transferring it over to a BHO rate and found that our actuaries believed that there would be such increased utilization that we did not have the funding to move responsibility for inpatient SUD treatment into the BHO contract. January 1st, the Department will be moving outpatient SUD services into the BHOs contract. We hope, over time, to collect utilization data and have the funding to move inpatient SUD over to the BHOs.

Laurel also asked that, in the interests of time, the group turn its attention back to a discussion of the draft standard at hand, which only refers to SUD FFS for those not enrolled in a BHO.

QUESTION – Rich Gebhardt, with Signal, asked one extra question with regard to the above – would including inpatient SUD in the BHO contract require legislation?

RESPONSE – Laurel answered no.

Kimberley then began to walk the group through the draft coverage standard provided, beginning with the Brief Coverage Statement. Kimberley read this section out loud, as it encapsulates all the content that follows within the standard. The Brief Coverage Statement reads as follows:

Outpatient Substance Use Disorder (SUD) Fee-For-Service (FFS) Treatment Services are available for the treatment of substance use disorders for clients who are not enrolled with a Behavioral Health Organization (BHO).

Medicaid provides outpatient SUD services administered and managed through BHOs. Most clients receive outpatient SUD services through the BHO. This benefit is available to the small percentage of clients not enrolled in a BHO, who need to access their services in “regular” or FFS Medicaid.

This standard outlines the services available on a FFS basis.

Kimberley then invited comment on this section.

QUESTION – Lin Wilder from the Health District of Northern Larimer County, Ft. Collins, also representing the Mental Health and Substance Abuse Partnership, asked for further examples of who would be receiving the services defined in this standard. She asked if they are not eligible for a BHO or that they are not enrolled.

RESPONSE – Kimberley explained that that individuals receiving these services are those not enrolled in a BHO, which could be for several reasons. She invited Laurel to provide further examples.

Laurel explained that, in Colorado, we have a Behavioral Health program that we operate under a waiver, so all Medicaid eligible individuals are automatically enrolled into a BHO *with the exception* of very few categories of individuals, such as someone who is institutionalized or someone who has requested an exemption from the BHO (which is allowed in statute), perhaps because they have a relationship with some other provider who is not part of the BHO system – this may apply to as few as twenty individuals. These are individuals who can access SUD FFS through regular state plan Medicaid.

QUESTION – Lisa Gawenus with Denver Health asked if, as of January 1st, Medicaid will pay SUD FFS for QIMBI individuals (for whom Medicaid pays their Medicare premiums).

RESPONSE – Laurel replied no. Earlier, in mentioning this population, she was simply listing the types of individuals who may not be enrolled in a BHO.

Kimberley then moved on to the Services Addressed in Other Policies section. This section points the reader to other related standards. In this case, the Mental Health FFS standard is listed. Kimberley pointed out that this standard does not presently exist; it is in a drafting phase.

The group then discussed the Eligible Providers section, which contains the table below.

Kimberley explained that the table is a visual representation of who is eligible to provide the services outlined later in the standard. The far right column indicates that any facility licensed through OBH to provide SUD treatment is an eligible provider. In addition, anyone outside of those facilities who has the credentials listed in the middle and left column may also provide services.

Licensed physicians who are also:	Licensed non-physicians who are also:	Facilities
Certified in addiction medicine by the American Society of Addiction Medicine (ASAM), Or Certified Addiction Counselors (CAC II or CAC III) or Licensed Addiction Counselors (LAC) by Department of Regulatory Affairs (DORA), Or Certified by the National Association of Alcohol and Drug Abuse Counselors (NAADAC) as an NCAC II or MAC, Or Certified in addiction psychiatry by the American Board of Psychiatry and Neurology certified in Addiction Psychiatry (ABPN) Or, MD and CAC II, CAC III, NCAC II, or MAC.	Psychologist, PhD, Nurse Practitioner, LCSW, LPC, or LAC And one or both of the following: Certified by DORA as a CAC II or CAC III, Or Certified by NAADAC as an NCAC II or MAC.	Licensed to provide substance use disorder treatment services by the Office of Behavioral Health (OBH).

QUESTION – (unattributed commentator) asked if the eligible provider types listed are the same as those that appear in the SUD Manual.

RESPONSE – Alex Stephens, SUD Policy Specialist, answered yes – it is the same as in the manual and as currently appears in Medicaid rule.

The commentator then noted one discrepancy; in the SUD Manual, CAC I and CAC II can jointly provide individual and group therapy but CAC I’s are not identified in the table above.

Alex thanked the commentator for bringing this to the Department’s attention. The Department will look into this further.

Jim Rowan with the Office of Behavioral Health (OBH) stated that CAC I's are not authorized to provide therapy at this point in time; they may co-facilitate therapy.

Laurel recalled that CAC I's cannot be reimbursed by Medicaid per Federal regulation.

Kimberley then invited the group to review the Eligible Clients section of the draft standard.

QUESTION – (unattributed) When will all of the clients be captured by the regional care collaborative organization (RCCO) system? She clarified that she understands people will be assigned to BHOs, with few exceptions, but she has seen sporadic assignment to the RCCOs and wonders when all Medicaid clients will be automatically assigned to RCCOs.

RESPONSE – Laurel explained that all individuals, including those currently enrolled in the Accountable Care Collaborative (ACC) program with their respective RCCO will be enrolled in a BHO as of January 1st, except for the select individuals under discussion.

Currently, roughly 400,000 Medicaid clients are enrolled in the ACC (i.e. also have a medical home; not just a mental health/SUD home). There is not a set date when all clients will be enrolled in the ACC and some clients may not be enrolled in the ACC. One group of individuals that the Department has not thus far enrolled in the ACC are those that are dually eligible for Medicare and Medicaid. The Department is working on a demonstration project with the Centers for Medicare and Medicaid Services regarding this group of individuals. The Department is hopeful to have that program up and running in the spring, after which time it would begin to enroll dually eligible clients in the ACC.

Unlike the BHO program, the ACC is voluntary at this point. Clients can opt out of the ACC, especially if they are in Denver Health's area and part of Denver Health's managed care plan.

We continue to enroll clients in the ACC.

Kimberley then invited discussion of the Covered Services section, in order, beginning with the subpart outlining SUD Assessment.

QUESTION – Rich Gebhardt noted that, at Signal, there is evidence of a big increase in addiction coming from people who have gone too far down the prescription drug road. He asked if this would be covered.

RESPONSE – Discussion among participants followed. One noted that opioid dependence is covered. Another noted that the code used to treat this example

is H0020 and that will be covered as of January 2014, however, methodone, the medication, is not covered.

Kimberley noted that the plan is to speak to this issue when the group works through page three of the standard and, specifically, the subpart on Medication Assisted Treatment.

Kristen Dixon with Addiction Research and Treatment Services (ARTS) asked if there would be any coverage for synthetic cannabinoids (Spice/Synthetic marijuana) or any other synthetic drugs. She stated the huge surge of this and that early warning networks are recognizing this an emerging concern. Another participant, Susan Krill-Smith, Director of Synergy Outpatient (adolescent SUD treatment programs) stated that this a huge concern “especially with adolescents”.

Alex and Kimberley tabled this discussion for later in the meeting, during review of the Medication Assisted Treatment section, where it can enjoy more robust discussion.

Kimberley invited feedback on the Individual and Family Therapy subpart of the Covered Services section.

QUESTION – Lisa Gawenus with Denver Health pointed to language that reads, “individual/family therapy is limited to 35 sessions per State fiscal year, and billed at 15 minutes per unit, with up to four units (one hour) per session.” She asked if billing two 15 minute units would increase the sessions to 70. By cutting the session time in half, can providers increase the number of billable sessions?

RESPONSE – Alex clarified that the policy is up to 35 sessions per fiscal year. A session can be up to four units in length, so, one hour.

QUESTION – Lisa asked if the number of sessions can be negotiated. Thirty-five sessions is somewhat minimal for treatment of a chronic life-long problem.

RESPONSE – Alex noted existing budget constraints that limit the number of sessions.

Laurel also noted that, when the Department developed the budget request for this benefit we worked with OBH on what should be the standard treatment that is going to cover the vast majority of clients. The limits on sessions weren’t mandated by budget per se but we worked with other state agencies to identify reasonable limits and to curb overuse that can occur in a non-managed system.

QUESTION - Angela Bonaguidi, with ARTS, asked if there is an individual who would benefit from individual and family counseling would this benefit allow two services to occur on the same day. Another commentator added “especially for adolescents” and noted that this feedback was given in a previous Benefits Collaborative.

RESPONSE – Laurel replied that she is not aware of anything in our system that would limit more than one service being billed in a day. She believes an individual and family session may be billed on the same day, however, if two individual sessions were billed on the same day, the Department’s fraud contractors might pick that up because that can be a way for individuals to game the system.

Alex added a distinction between group therapy and individual and family therapy. Because they are coded in the same way, an individual could have an hour long individual session followed by a family session. That is separate and distinct from group therapy because the only patient involved is the individual, regardless of whether their family is present. We can verify this but we understand this is the way it works.

Several individuals noted that, in the past, individual and family therapy could not be billed on the same day because they were coded the same way.

Laurel and Alex noted that there may be system challenges that the Department needs to look into.

Laurel did note that many of these challenges will disappear once BHOs are managing SUD treatment for most Medicaid clients, because providers will not be submitting claims into the MMIS.

Tina McCauley (on the phone) also added that it is her understanding that BHOs will evaluate for medical necessity. Laurel agreed.

The group then moved on to a discussion of the Group Therapy subpart of the Covered Services section.

QUESTION – Rich Gebhardt, with Signal, asked if the 36 limit is a typo (should it be 35, like individual therapy)?

RESPONSE – Alex noted that this is not a typo, it is 35 for individual, 36 for groups.

Discussion then tuned to Alcohol and Drug Screening.

QUESTION – Jacquelyn Cully, with ARTS, asked about other necessary lab work. Will other types of screening tests necessary to cover methodone or suboxone be covered?

RESPONSE – Alex is not aware of any other screening types being covered that are not mentioned within this standard.

Jim Rowan with OBH noted that he sees this whole issue of drug screening and analysis in two separate stages. One is that the agency gets paid for the collection of the specimen and then the lab gets paid by Medicaid for the analysis of that specimen. So, this only addresses the collection piece and not the lab piece. Is that correct?

Laurel and Alex agreed. When we look back at the services that are billed by the provider under this benefit they are just those services billed by the providers on the front sheet that are allowed when Alex does his quarterly review. They are codes that are used by the facility or provider to collect the sample.

Laurel is not well versed on Methodone and what the Department does and does not pay for. There are other types of lab work that are covered under physical health care. To the extent that reference is made to lab services already covered on the physical health side, which will remain the case. If something is not currently covered, that may be something the Department needs to look into further.

Kimberley invited Jaqueline to email her with specific screenings she is interested in and the Department can look into whether they are covered.

Laurel asked if Jaqueline knows if some of the screenings she is referring to are currently covered.

Jacquelyn replied that they are not. They are covered if there is a medical diagnosis provided that would warrant that type of screening.

Laurel noted that, in that case, it would continue to be our policy, as this is a limited benefit but invited Jaqueline to send the information on.

Jacquelyn noted that labs can bill lab codes and be reimbursed but SUD treatment providers still have to collect those in order to send to the lab.

QUESTION – Angela Bonaguidi, with ARTS, asked about the coverage of pregnancy tests, Breathalyzer and ETGs.

RESPONSE – Alex replied that these three services would not be addressed within this benefit. He postulated that they might be a Special Connections

Benefit. Kimberley noted that there is a Maternity Benefit Coverage Standard and a Women's Health Benefit Coverage Standard; the services may be located in one of these. Kimberley offered to look and provide that reference.

COMMENT – Jim Rowan, with the Office of Behavioral Health, noted that, while he thinks this Medicaid benefit is a wonderful thing the group should not lose sight of the fact that there are block grant dollars to pay for some of these things, especially around special women's services, for clients who might not be signed up for Medicaid or eligible for certain types of insurances. Special Connections is a carve-out of Medicaid. His recollection is that, part of the discussion OBH had when giving input into the Medicaid benefit, that those dollars that are handled through managed services organizations, like Signal, would not be supplanted, replaced or supplemented by this benefit.

QUESTION – Susan Turowski-reher, with ARTS, asked about breathelizers and also the ATGs, that allow providers to detect alcohol used more recently.

RESPONSE – Alex noted that these services certainly sound like services that would be available through the BHOs but, currently, those are not services that are included in this benefit.

QUESTION – BJ Dean, with Arapahoe House, noted that, when talking about the ETG, that is a urinalysis that is a little more expensive than the regular one because it also screens for alcohol. She noted that fees aren't discussed in the benefit. She asked if the Department is saying that they would not pay the additional expense.

RESPONSE – Laurel noted that this is just defining those services that are paid for under the SUD benefit. Other services may be covered in other benefit standards. To the extent that labs currently have the code available to them and the Department reimburses for that service, which would not change. Laurel offered to check which specific codes are open if BJ were to provide specific codes for us to research.

BJ noted that would be helpful.

QUESTION – (unattributed commentator) asked if Laurel could clarify her statement. Did she just express that the provider can review the urinalysis with the client and bill in that capacity and then the lab can also bill on the physical Medicaid side for the processing?

RESPONSE – Lab work is not a SUD service and Laurel was not clear on whether a SUD diagnosis can be put on lab work and get it to bill. The Department will have to check on that.

Jim Rowan, with OBH, stated that, in his experience, if the provider give the lab the Medicaid number, generally, the lab will bill Medicaid directly and it is separate from anything having to do with this benefit.

The group turned to discussion of the Targeted Case Management subpart of the Covered Services section.

QUESTION – BJ Dean with Arapahoe House explained that, in the past, she and colleagues were told that targeted case management under SUD was provided only when the client is present but, in the standard, it states that “provided with or on behalf of the client”. Is the definition being expanded or were we miss informed?

RESPONSE – Alex offered to look into this. In the case of a few of the covered services within this standard, the definitions and limits were expanded upon. He will check.

BJ thanked Alex and noted that care coordination could occur outside of the presence of the individual.

COMMENT – Jim Rowan, with OBH, noted that he is glad to see the extra language in there because, before, case management was looked at from a public safety standpoint and now it includes all of those things that he thinks have always been inherent in SUD and mental health case management – that is the advocacy piece. If that is not true, he would be disappointed.

RESPONSE – Laurel expressed her concern that our federal partners at CMS have a pretty specific definition of case management vs. targeted case management and, while she could not summon the specific at that moment, she had a feeling that there might be some clarification we will be coming back with.

QUESTION – BJ Dean, with Arapahoe House, also asked a question about the 52 contact limit. There is no time involved. One contact a day would be one, regardless of length of time?

RESPONSE – Alex agreed, they are encounter rates. One encounter may be billed per day.

QUESTION – Rich Gebhardt, with Signal, asked for a distinction between case management and targeted case management.

RESPONSE – Kimberley noted, given Laurel’s comment above, that all might be better served by the Department pulling up the exact definition and providing it after the meeting.

QUESTION – (unattributed commentator) asked if the BHOs be able to limit this benefit (less than 52 encounters).

RESPONSE – Alex noted that, while we are talking specifically about the FFS SUD benefit and he is not familiar with the BHO contract, the BHOs are managed care organizations and should be providing whatever care is necessary to treat a particular client.

Laurel added that, while a BHO is not subject to the same limit restrictions, it is written into their contract that they have a responsibility to the Department not to provide excessive services and to combat fraud, so they certainly will manage service amounts. Again, they are incentivized financially to provide the care that will achieve better health outcomes.

The group then began to discuss the Social and Ambulatory Detoxification subpart of the Covered Services section.

QUESTION – BJ Dean, with Arapahoe House, noted that, it looks like we are proposing to do what was done in the past. She also asked if providers have another funding source for room and board can they fund it.

RESPONSE – Laurel replied yes, Medicaid cannot pay for room and board with few exceptions.

QUESTION – (unattributed commentator) sought clarity: clients can come into a social detox five separate times and each time the provider can be paid up to three days of the client's stay?

RESPONSE – Alex replied yes.

Brenda from Northeast (on the phone) asked if the client can be billed for the subsequent days if no other funding is available.

Laurel believed yes, because it is not a Medicaid covered service.

The group then began discussion of Medication-Assisted Treatment (MAT)

MAT consists of administration, management, and oversight of methodone or another approved controlled substance to an opiate dependent person for the purpose of decreasing or eliminating dependence on opiate substances.

QUESTION – Lisa Gawenus with Denver Health noted that it is really nice to see the Methodone and medication assisted therapies are part of the benefit. She noted that it

fulfills all three purposes of the Benefits Collaborative (cost effective, evidence guided and promotes client health). She congratulated the Department on their inclusion.

She then pointed to the apteryx below that states (in bold),

**Note: the drugs themselves are billed fee-for-service pharmacy and are not included in the MAT benefit.*

She asked if Kimberley, Alex and Laurel recognize that OTPs are not pharmacies (and therefore cannot bill a pharmacy benefit).

RESPONSE – Laurel explained that, just because a service does not appear in this benefit, it does not mean that Medicaid does not cover it. She is not the authority on what the Pharmacy unit of the Department does and does not cover. Whatever the current policy is would still apply.

Lisa then asked if this is negotiable.

Laurel explained that the Department does would need a budget action if it does not currently cover methodone as a pharmacy benefit.

Lisa explained that, presently, Medicaid does not cover the dispensing of the Methodone or the medication.

Lisa and others asked how one would go about making a budget request to the legislature and if a change to the state plan would then allow dispensing to be covered.

Unattributed commentator explained that, in Colorado, Methodone has never been dispensed at a pharmacy, it has always been dispensed at a clinic.

Laurel noted that she is not the subject matter expert but, if we don't cover it, we would need authority to cover it.

Lisa again asked how to go about creating a budget action request and also asked, if Laurel is not the subject matter expert, who then at the Department is?

Laurel explained that, because it is not a covered benefit, there is no staff resource allotted to it. Right now the Department would work with partners at OBH or other providers that are more familiar. If we don't cover a certain benefit we are not allocated resources to hire and train staff. Some in the Department's pharmacy staff, under Dr. Judy Zerzan, might be more familiar with what is and is not covered.

In terms of a budget action, Laurel encouraged the participants to work with each other. She stated that people can approach their legislature associations and lobbies and bring this to the Department. It just hasn't been brought to us yet and also, in the Department's discussions with OBH on what was important to get covered right away, it was not at the top of the list.

Unattributed commentator noted that it seems the Department covers medication administration but not the medication itself, which seems odd.

Another unattributed commentator addressed participant Jim with OBH. She stated that, instead of advocating through several state agencies, OBH could change licensing requirements to allow GPs (sp?) to bill for this service without being required to be a pharmacy.

Laurel offered that it may be outside of OBH; it may also be a DORA issue.

Jim Rowan with OBH was not involved in all of the discussions around this particular benefit in his office, he did offer that Methodone is very cheap. There are other drugs out there that OBH did not feel it should say "yes" to one and "no" to others that are far more expensive but may be a better choice at some point in time.

Angela Bonaguidi, with ARTS, noted that Methodone is currently the gold standard for treatment of individuals with opioid dependence. So it does make sense, if not now than in the future, to reconsider that whereas, other states, especially on the east coast, have introduced Methodone into this benefit.

QUESTION – Angela asked for a definition of "administration" and "management" of MAT.

COMMENT – Tina McCauley (on the phone) offered her understanding that there are a couple of actual procedure codes associated with the administration of MAT that are allowed and that her understanding is that the injections themselves remain under pharmacy FFS.

COMMENT – (unattributed commentator) offered, as a point of clarification, that this medication is usually provided orally. Vivitrol is the medication that might be injected.

COMMENT – Kristen Dixon, with ARTS, offered that "opiate" should be changed to "opioid", which includes semi-synthetic, synthetic and naturally occurring opioids. This was seconded.

Kimberley asked the group, if the medication is not covered, how and if the language in this section should be changed to make that clear.

COMMENT – Angela Bonaguidi, with ARTS, repeated that a definition of “administration” and “management” of MAT is needed because, it is clear that it is not covered but does “administration” mean dosing? Does it mean a session with an individual providing some assistance around dosing, perhaps a nurse?

RESPONSE – Laurel offered to look up those codes and provide some clarification. She cautioned that the Department can’t advise providers on how to bill, so it will still be up to providers to research those codes and decide what to bill. The Department can also visit with some of the individuals who were involved in working on this budget action and see what other history and discussion we can bring back to you.

Jim Rowan with OBH also noted that the State does not typically tell providers how to bill or run their agencies but that, one of the things that we typically lose sight of in many of the medical clinics in the state is that it is an outpatient service – so you certainly can bill for those services under an individual outpatient benefit. Jim did not think dosing was administration.

QUESTION – Susan Turowski-reher, with ARTS, noted that there could be other associated costs. For example, if a person is in a hospital and the provider has to take the dose to them, is that covered?

RESPONSE – Laurel stated that this benefit only pertains to the outpatient setting.

Susan clarified that the client is an outpatient to her organization. The client has a medical condition that does not allow them to come to her organization while they are in the hospital, so someone has to transport that methodone to them.

Several people responded that there is a system in place specifically for instances such as this and one person at OBH named Denise takes care of it.

Lisa Guwenas noted that Denise is responsible for oversight but does not have funding for transportation of Methodone.

COMMENT – BJ Dean, with Arapahoe House, noted that outside agencies do visit to provide doses to clients, while there. Sometimes they bring one dose, sometimes three at a time. She would think that would pay as one unit for the date of the visit. Someone else seconded that this would be excellent.

RESPONSE – the Department will look into this.

QUESTION – (unattributed commentator) asked, in the event that the Department does not have much ability to adjust anything, would you be able to add things like what is limiting to each benefit.

RESPONSE – Kimberley noted that the Department can add additional clarifying language and definitely invites suggestions.

Laurel noted that suggestions would be helpful. When the Department comes back with some of these answers perhaps the group can provide guidance on where and how to be more explicit.

Kimberley then invited the group to review the Procedure Coding section. She noted that the first bullet reads “please refer to the Outpatient Substance Abuse Billing Manual” but that this manual has recently been retitled “Substance Use Disorder Treatment Billing Manual” and this language will be changes to reflect that.

COMMENT – (unattributed commentator) stated it is called the “Coding Manual”.

RESPONSE – Alex explained that there are two manuals. The Coding Manual is quite large and the Treatment Billing Manual, which is on the Department’s website, is only about 30 or 40 pages long. The Coding Manual contains many codes that are not found in this FFS benefit.

Kimberley then moved on to the Prior Authorization Requirements section and noted that there are none for outpatient SUD and dependency treatment services.

The group then moved to the Non-Covered services. Kimberley explained that, if a service is not mentioned in the Covered Services section it is not covered. However, the Department uses the Non-Covered Services section to highlight specific services that people may think are perhaps covered, if the Department were not to point them out. Therefore, non-covered services include, but are not limited to, the services listed under the Non-Covered services section.

COMMENT – Susan Turowski-reher, with ARTS, asked if the second to last bullet under Non-Covered Services is meant to say “psychiatric residential treatment facilities” instead of “pediatric”.

RESPONSE – Laurel noted that the language probably needs to be changed here. Child welfare often places children in RCCFs as well as PRTFs.

Susan agreed but noted that RCCFs do not pay for SUD, they only pay for the mental health diagnosis.

Laurel believes that, in rule, there is some language around SUD for both.

Susan stated that providers cannot bill for SUD.

Laurel offered to pull up the rule and check.

Susan noted that SUD is specifically excluded, although it would be nice for it to be covered.

Jim Rowan, with OBH, said that this was a topic (co-occurring disorders) missed when they were trying to put all of this together and how to pay for clients with both. This would be good for future conversation. He acknowledged that this is “a huge deal” and OBH has to think about the next step in addressing co-occurring disorders.

COMMENT – BJ Dean, with Arapahoe House, asked a clarifying question with respect to peer advocate services – BHOs will be able to provide this service (for parity with Medicaid mental health services), correct?

RESPONSE – Laurel replied that is correct. She explained that peer advocate services are not covered in the Medicaid state plan with CMS. What can be covered under the state plan must be more traditional medical services. The only way the Department offers things like peer advocate services, drop-in centers and vocational rehabilitation is through the authority in the Behavioral Health Waiver to provide alternative “B3” services. The Department does have authority to provide these services under the BHO waiver.

To be clear, when the Department talks about FFS, it is talking about state plan (also known as “regular”) Medicaid services.

Laurel took this opportunity to express the following. This is an important step for the Department. Laurel understands that some of the answers to questions asked today are probably a little frustrating given that we still exist in a somewhat siloed world in terms of how services are paid for. It is the goal of the Department to move to more integrated services – that is part of why we are moving these in with the mental health services, so we don’t have to keep distinguishing primary diagnosis and you can treat the whole person. We understand that there is still a way to go and are doing a lot through our Accountable Care Collaborative program to look at further payment reforms, where everything isn’t paid on an FFS basis and where we can make arrangements with the Federal government that allow for greater flexibility, such as the ability to pay for whole episodes of care through bundled payments. So, there is more on the horizon to where we can truly treat the whole person, including more social services like case management and care coordination. So, that is the goal. Unfortunately, there are steps to go through and we are not all the way there yet. We want to keep working with you on that.

QUESTION – (unattributed commentator) stated that her organization has been contacted a lot lately by SUD providers, mostly in an integrated model, that are trying to provide and bill for screen and brief intervention services and are currently not able to do that in FFS or in the BHO contracts. This is a challenge. Is this something in the plan for payment reform?

RESPONSE – Laurel explained that this benefit is limited. The Department does cover SBIRT in Medicaid under the medical side of things (where we get funding and authority). Right now there is no action to move SBIRT under the BHOs, although the BHOs have asked about the program and how to manage it. It would require a budget action and the Department has not taken this on yet.

The Department is trying to move away from opening up “more and more codes to more and more providers in more and more settings that are paid on an FFS basis that awards volume not health outcomes and value.” It is tricky when a provider says “we want to bill for SBIRT” in a non-managed environment the Department is not really sure if that will provide value. Instead of just opening billable codes, the Department is trying how to incentivize outcomes and then give providers flexibility – in some sort of bundled or global payment – to use any of the services that help you get to that desired outcome.

Kimberley invited comment on the Definitions section.

COMMENT – BJ Dean, with Arapahoe House, pointed to the definition of “Masters level clinician” and noted that it does not say “licensed” there – but does elsewhere. Why is licensed not included?

BJ also pointed out that the “Targeted case management” definition is the same as it is in the body of the standard and if, after the Department checks, it is changed in the body of the standard it should also be changed here.

Lastly, “Peer advocate services” says “receiving behavioral health services”. Does this mean clients still have to be in treatment under this benefit?

RESPONSE – Alex explained again that peer advocate services are not included in the benefit. The definition appears in this section to explain what was meant when said services were referred to in the Non-Covered Section.

Kimberley offered that, perhaps, the Department can add a sentence at the beginning of the Definitions section that explains “all the terms herein are not necessarily part of the benefit but are mentioned within the benefit and deserve definition”.

BJ pointed out that, regardless, “receiving behavioral health services” and “scheduled therapeutic activity” could imply that the Department would pay for services for people who are in recovery if they are currently a client. So, perhaps the peer advocate definition needs to change, regardless.

Roadmap Moving Forward

Kimberley provided the group with a roadmap for the process moving forward.

As a result of today’s discussion the Department will likely do additional research and may make changes to the draft standard before it moves on to the Medical Advisory Council. Depending on the nature and quantity of revision the Department may convene another stakeholder meeting or may email the standard to the group for further comment. Throughout the Benefits Collaborative Process the Department may make further revisions and stakeholders will have further opportunity to comment on the draft standard during the 45 day public notice period.

The Listening Log is how the Department makes the group aware of how their input is being used and how the Department communicates with stakeholders outside of this meeting. Kimberley encouraged the group to visit the Benefits Collaborative website, read through the Listening Log, send Kimberley additional feedback and questions and the Department will continue to post responses to the log, as they become available.

Kimberley will send participants an email when today’s meeting minutes are posted, when the Listening Log is posted and what the Department plans to do as a next step.

QUESTION – (unattributed commentator) asked when can we expect the new SUD FFS policy to take effect?

RESPONSE – Kimberley explained this is hard to say. The Benefits Collaborative process can take anywhere from 3 to 6 months and, until it is signed by the Medicaid Director, the “old” policy is in place.

Laurel added that, ideally, the Department would role this out with the new BHO contract in January, but the Department is so busy with many important initiatives that the timeline is just not ideal.

QUESTION – (unattributed commentator) asked how will providers know if a client is FFS or in a BHO when they come for services (given that the services they are eligible for are different)?

RESPONSE – It will say on the eligibility report.