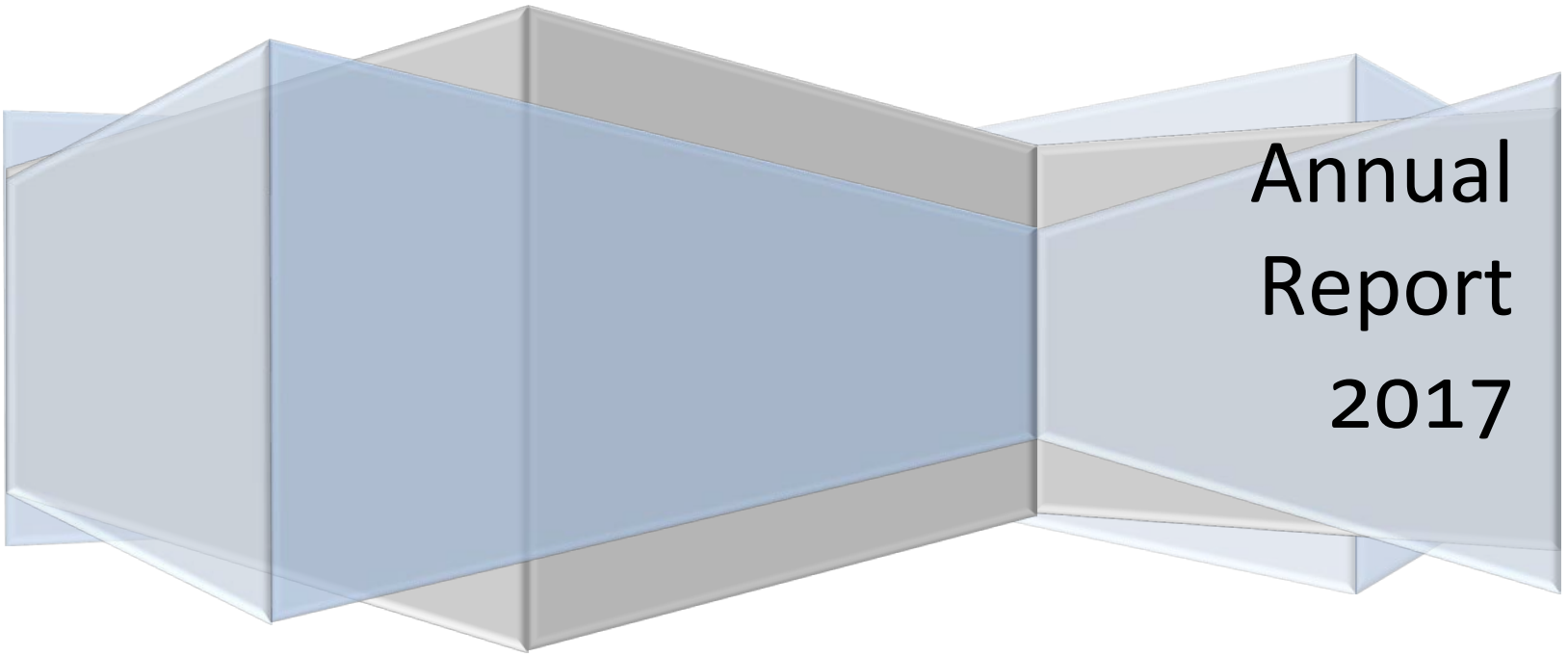
Virginia Department of Medical Assistance Services

The Virginia Governor's Access Plan (GAP), Addiction, and Recovery Treatment Services (ARTS) and Former Foster Care Youth (FFCY) Delivery System Transformation

Section 1115 Annual Report

Demonstration Waiver 1115
Project 11 – W-00297/3

Demonstration Year 3 - 2017



FFCY
Former Foster Care Youth

INTRODUCTION

In September 2014, Governor McAuliffe announced a significant step toward providing health insurance to uninsured Virginians when he rolled out his plan, *A Healthy Virginia*. *A Healthy Virginia* was a ten-step plan that expanded access to care, improved care for veterans and for individuals with serious mental illnesses (SMI), and enhanced value and innovation across our health system. The first step in the plan was the establishment of the **Governor's Access Plan (GAP)** for the Seriously Mentally Ill. The GAP launched in 2015 to expand healthcare services in Virginia. GAP is a Medicaid plan that provides limited medical and behavioral health care coverage for low-income individuals with Serious Mental Illness (SMI). The initial GAP Demonstration included mental health and substance use treatment services, medical doctor visits, medications, access to a 24-hour crisis line, recovery navigation (peer support) services, and care coordination.

In September 2014, addressing the prescription drug and heroin overdoses taking the lives of thousands of Virginians, Governor McAuliffe signed Executive Order 29 creating the Governor's Task Force on Prescription Drug and Heroin Abuse. Dovetailing with Virginia's concern, in July 2015, the Centers for Medicare and Medicaid Services (CMS) issued CMS State Medicaid Director letter, #15-003[1] to Medicaid Directors that highlighted new service delivery and funding opportunities for Medicaid members experiencing a SUD. The CMS opportunities significantly aligned with the Governor's Task Force conclusions. In 2016, the Virginia General Assembly and Governor McAuliffe authorized the Department of Medical Assistance Services (DMAS) to make changes to its existing substance use disorder treatment services, **Addiction and Recovery Treatment Services (ARTS)**. Under this authority, DMAS has developed, in collaboration with the Department of Behavioral Health and Developmental Services (DBHDS), Virginia Department of Health (VDH), Department of Health Professions (DHP) and other stakeholders, an enhanced and comprehensive benefit package to cover addiction and recovery treatment services and also received CMS 1115 Demonstration waiver authority to waive the limits for using Medicaid federal dollars to fund individuals seeking treatment in Institution for Mental Diseases (IMDs) and amend the GAP waiver.

In May 2018, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to **former foster care youth (FFCY)** who were

[1] CMS State Medicaid Director letter, #15-003: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

enrolled in Medicaid and foster care in another state and who are now living in Virginia and are applying for Virginia Medicaid. Approval of the waiver amendment was received on September 22, 2017. Virginia's overall goal for the FFCY benefit is to serve foster care youth with the access to health services they need, with full Medicaid coverage.

This report highlights progress made during Quarters one through four of the third year of the GAP Demonstration. This report is organized to reflect the GAP, ARTS, and FFCY components of the waiver.

GAP

BACKGROUND

Without access to treatment and other supports such as healthcare, care coordination, and Recovery Navigation, individuals with SMI are often unnecessarily hospitalized, may be unable to find and sustain employment, struggle with finding affordable and available housing, become involved with the criminal justice system, and suffer with social and interpersonal isolation. The opportunities provided through the GAP Demonstration are enabling persons with SMI to access both behavioral health and primary health services, enhancing the treatment they can receive, allowing their care to be coordinated among providers, and therefore addressing the severity of their condition. With treatment and support, individuals with SMI and co-occurring or co-morbid conditions are beginning to recover and live, work, parent, learn and participate fully in their community.

The implementation of the GAP Demonstration required the Department of Medical Assistance Services (DMAS) to work with stakeholders and community mental health and healthcare providers, primary health care providers, Magellan of Virginia, the Behavioral Health Services Administrator (BHSA), and the Virginia Department of Behavioral Health and Developmental Services (DBHDS). To date, these partners continue to work together to ensure a successful implementation of the program. Outreach and training efforts ensure that individuals know the program exists and that providers are aware of and able to offer the care GAP members' need.

Magellan administers all behavioral health services for members enrolled in Virginia's Medicaid and FAMIS fee-for-service programs. Specific to the GAP benefit plan, Magellan also offers care coordination, a crisis line, and Recovery Navigator services to assist members with managing their behavioral health and primary healthcare needs.

For primary healthcare needs, DMAS relies on fee-for-service health care providers to serve members. These are primary care physicians, specialists and federally qualified health clinics (FQHCs) already enrolled as Medicaid providers. For services not covered by the GAP benefit plan, members rely on the indigent care providers in the local communities known as our "preferred pathways" providers as we prefer they access these providers in lieu of the emergency rooms of hospitals. We continue to identify and collaborate with these providers.

GOALS

The three key goals of the GAP Demonstration are to:

1. To improve access to health care for a segment of the uninsured population in Virginia who have significant behavioral and medical needs;
2. To improve health and behavioral health outcomes of Demonstration participants; and,
3. To serve as a bridge to closing the insurance coverage gap for uninsured Virginians.

ELIGIBILITY AND BENEFIT INFORMATION

The Virginia GAP Demonstration Waiver current eligibility guidelines are as follows:

Figure 1, GAP Eligibility Requirements

GAP Eligibility Requirements
Ages 21 through 64
U.S. Citizen or lawfully residing immigrant
Not eligible for any existing entitlement program
Resident of VA
Income below 100% of Federal Poverty Level (FPL) as of 10/1/17
Uninsured
Does not reside in long-term care facility, mental health facility or penal institution
Screened and meet GAP Serious Mental Illness (SMI) criteria

DMAS has continued to see increased enrollment with the Demonstration. Individuals are receiving information about the program and applying through their relationships with local entities. The partnerships DMAS has with the local Community Services Boards (CSBs) and Magellan of Virginia, in addition to a growing relationship with the Federally Qualified Health Centers (FQHCs), are attributable to the continued success.

During Virginia's 2017 legislative session, members of the House and Senate came together during the budget conference process and agreed upon a proposal to increase the income eligibility limits for GAP from 80% to 100% FPL, effective October 1, 2017. This change was

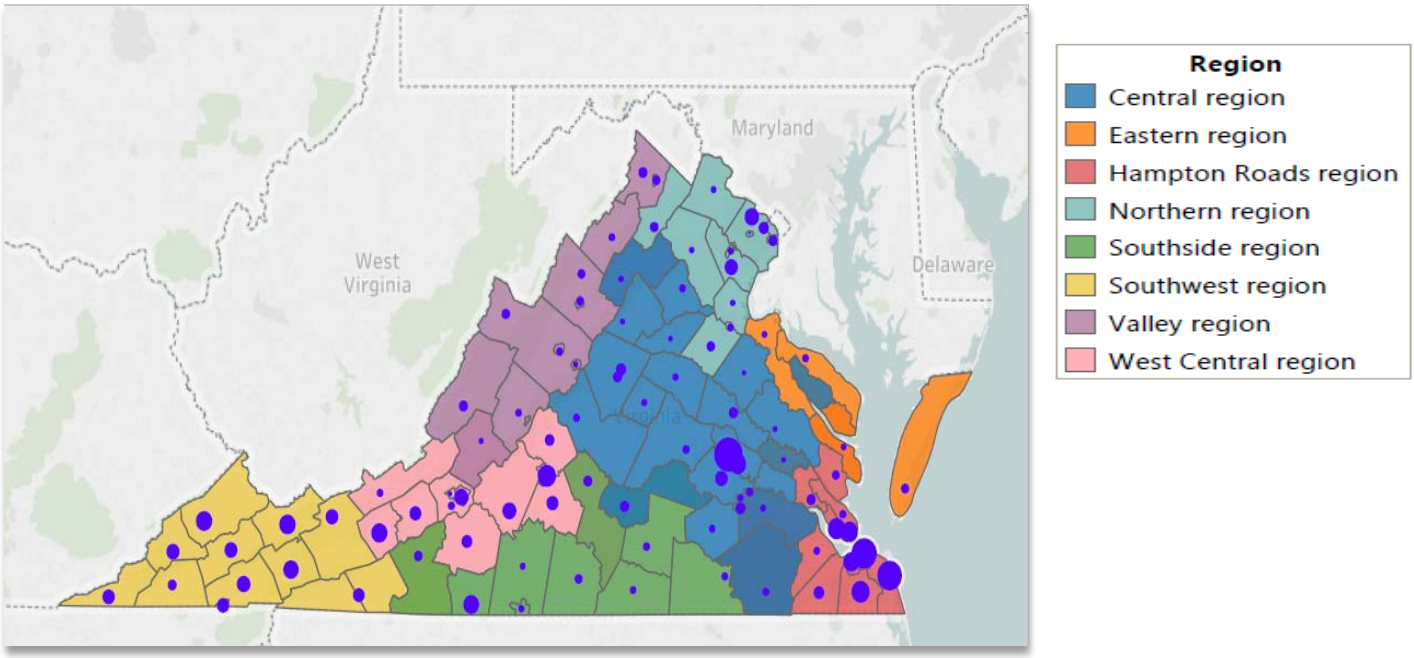
ultimately approved by both chambers of the legislature and the Governor. As an action of the Virginia legislature, this process was public and received both formal and informal participation and monitoring by advocates, stakeholders, and state staff. Many advocates in Virginia voiced their approval of the decision to expand program eligibility requirements. In response to the change in eligibility, DMAS updated documents and informational fliers that highlighted the revised eligibility criteria as well as the benefits included in the GAP demonstration. These documents are used across Virginia by CSBs and other local partners to ensure individuals are hearing about the program and are being supported in their application process.

ENROLLMENT COUNTS FOR YEAR TO DATE

Active GAP Member Population

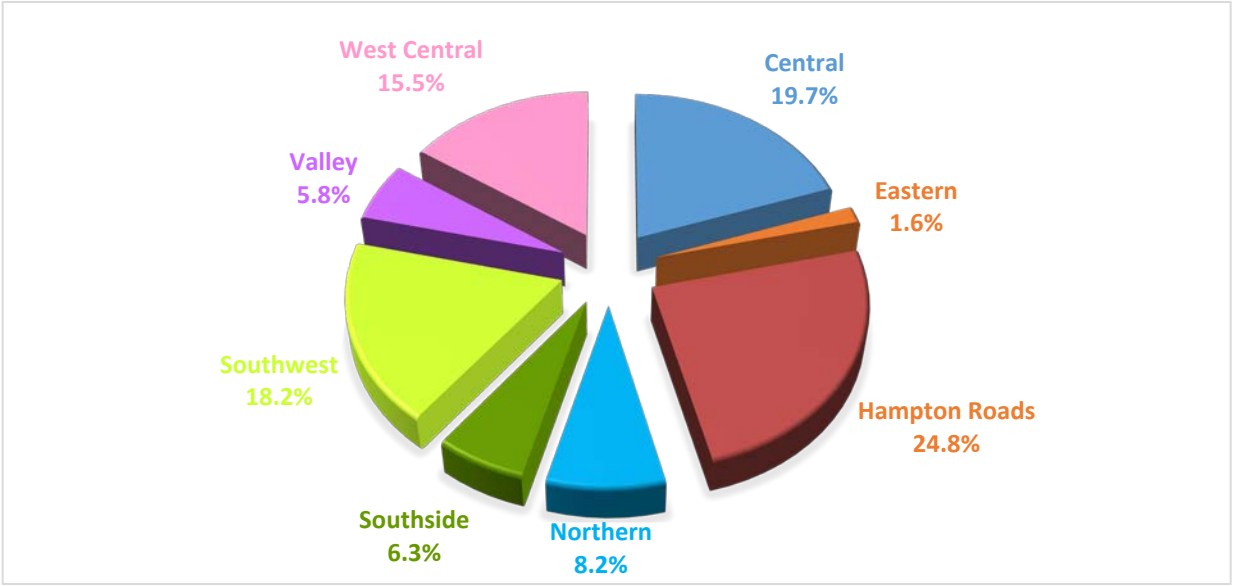
Department of Medical Assistance Services currently provides coverage to approximately 1,236,518 enrolled in Medicaid. Approximately 1.12% of these beneficiaries are enrolled in GAP. In the following Figures and Tables, the population displayed includes GAP members categorized by location, race/ethnicity, gender, age group and primary diagnosis.

Figure 2: GAP Enrollment, 2017



The GAP Demonstration continues to grow in membership. For the quarter ending on December 31, 2017 there were 13,857 individuals enrolled from 266 unique localities across the Commonwealth. The map shown in Figure 2 shows the location of members enrolled across the state of Virginia.

Figure 3: GAP Members of the Commonwealth by Regions, 2017



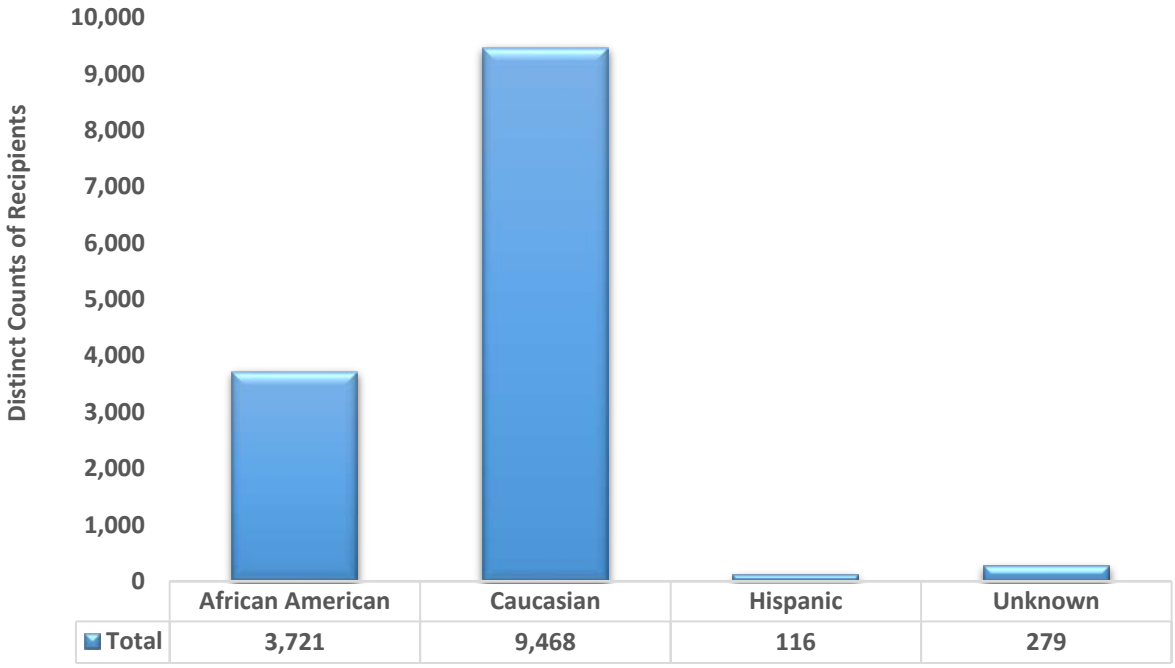
The figure above displays the geographic distribution of the active GAP population by regions. As measured in throughout the year, the Hampton Roads region continues to house the largest population of GAP members at 3,431, followed by the Central and Southwest regions totaling 37.88%.

Figure 4: GAP Enrollment, 2017

Demonstration Population	Number of Members 2015	Number of Members 2016	Number of Members 2017	TOTAL Members Enrolled 2015-2017
GAP Members Enrolled	7,999	9,947	13,857	19,259

As shown in Figure 4, there have been 19,259 unique members enrolled since the implementation of the Demonstration. The difference between the TOTAL members' number and the 2017 number is due to individuals dis-enrolling from GAP for any number of reasons (gaining employment, enrolling in full Medicaid, incomplete re-enrollment, etc.).

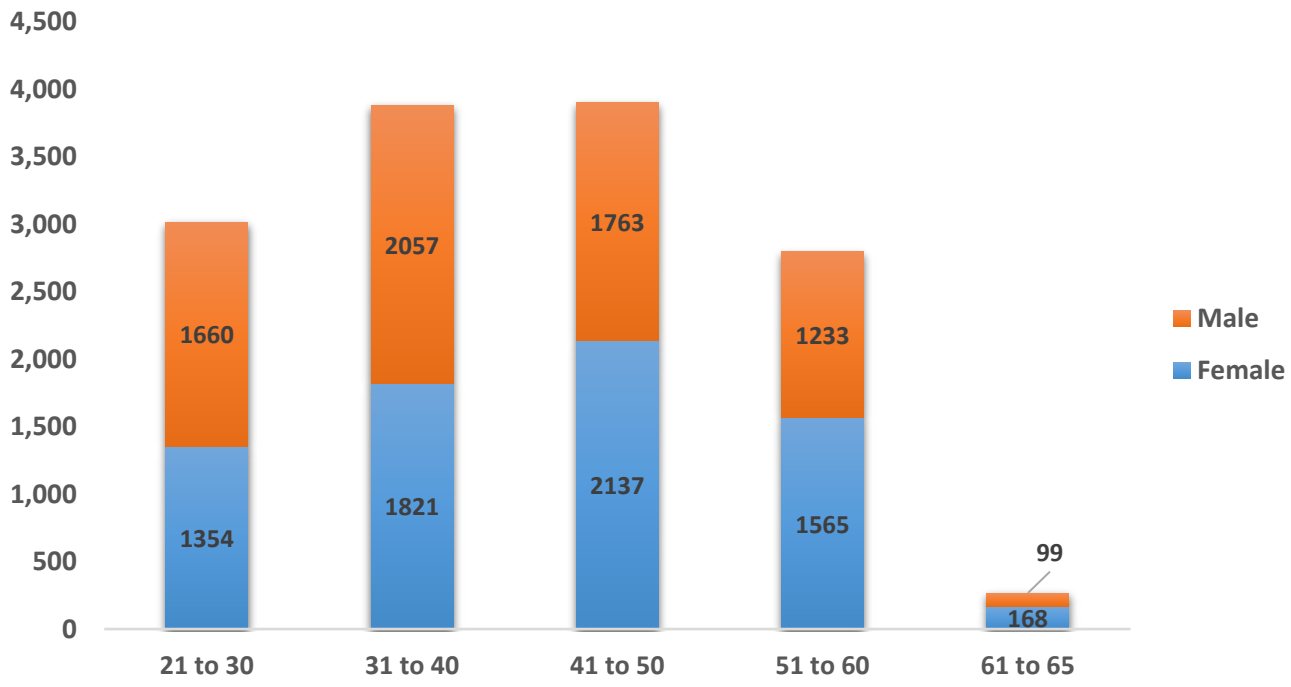
Figure 5: GAP Members by Race and Ethnicity, 2017



The figure above displays the frequency of the primary four ethnicity groups of the GAP population. The four primary ethnic groups represent 98.0% of the population. Approximately 68.3% of enrollees are Caucasian, 26.8% are African American, 2.0% did not choose to elect an ethnicity and roughly, 1.0% of enrollees are Hispanic. In accordance with the Substance Abuse and Mental Health Services Administration, African Americans and Hispanic Americans each use mental health services at about one-half the rate of Caucasian Americans[2]. Our member breakdown appears in line with this finding.

[2] Substance Abuse and Mental Health Services Administration, *Racial/Ethnic Differences in Mental Health Service Use among Adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Retrieved January 17, 2018, from https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults

Figure 6: Male and Female GAP Members by Age Group, 2017



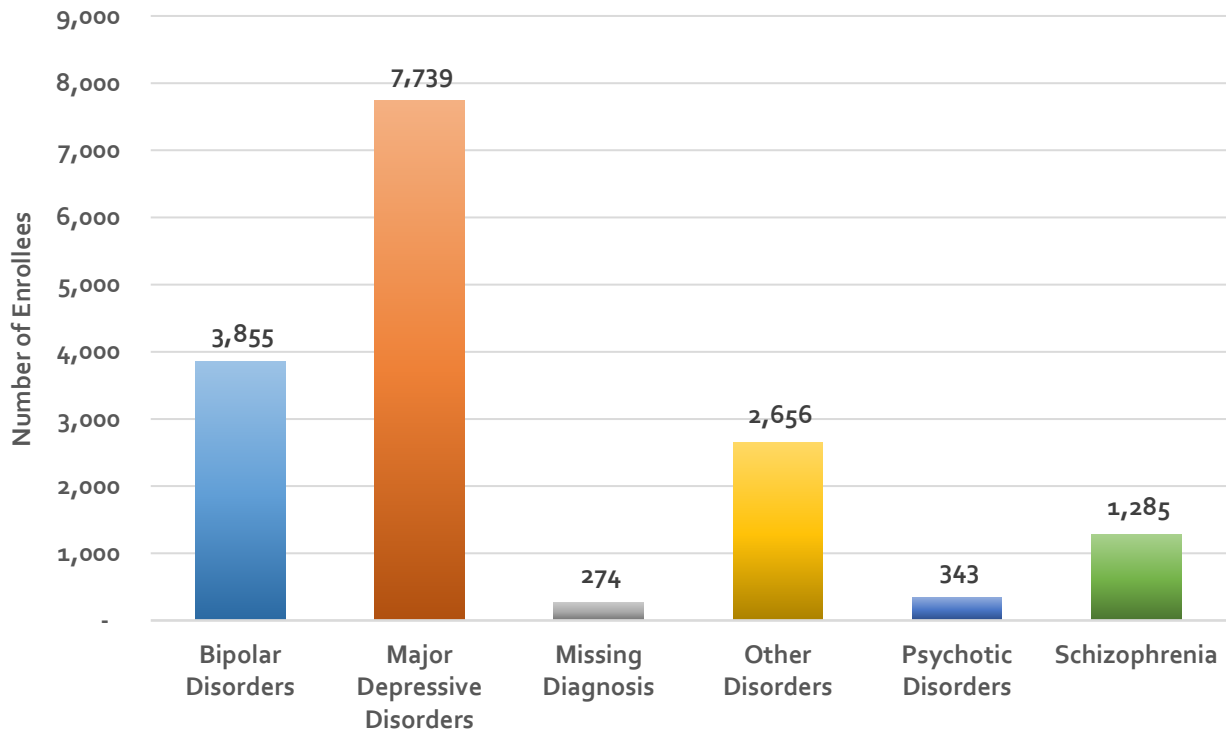
According to the National Institute of Health, more women with SMI (68.8%) received mental health treatment than men with any mental illness (57.4%).[3] Figure 6 presents data within the past year by GAP adults 21 or older with serious mental illness (SMI). The prevalence of SMI was higher among women (50.84%) than men (49.16%). Adults aged 31 to 50 years had the highest prevalence of SMI (56.13%) compared to adults aged 21 to 30 years (21.75%), aged 51 and older (22.12%). Our GAP members' gender breakdown appears in line with the National Institute of Health's findings.

GAP Annual Population

During 2017, the population consisted of anyone that was eligible in the GAP program during the period of January 1, 2017 to December 31, 2017. This includes individuals that were enrolled prior to January 2017 but continued enrollment after January 1, 2017. There were 16,152 that became eligible based on diagnosis, claims data and service authorizations during the analysis period. This section displays the GAP population and the utilization of behavioral health services based on GAP eligibility diagnosis.

[3] Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry.* 2010 Oct;49(10):980-9. PMID: 20855043. Retrieved January 17, 2018, from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154790

Figure 7: Eligible GAP Population by Diagnosis Category, 2017



Major depressive disorder is the leading cause of disability in the U.S. for ages 15-44.[3] During the evaluation period of 2017, Major Depression disorder continues to be the largest diagnosis population in the GAP program at 47.9%, followed by 23.86% of members diagnosed with Bipolar Disorders. The GAP team Analyst is further exploring the missing diagnosis category. This breakdown of GAP members by diagnoses also reflects Virginia Medicaid's fee for service behavioral health population as having depressive disorders as the most prevalent condition.

Figure 8: GAP Eligibility Primary Diagnosis Category by Service Authorization Category, 2017

Primary Diagnosis Category by Service Authorization Category	Distinct Count of GAP Recipients
Bipolar Disorders	**1,513**
ASAM 1 Outpatient Services	199
Clinically Managed Low Intensity Residential Services ASAM Level 3.1	2
Crisis Intervention	425
Crisis Stabilization	62
GAP Case Management	786
High Intensity Residential Service Adult ASAM Level 3.5	6
Intensive Inpatient Services Adult ASAM Level 3.7	4
Partial Hospitalization ASAM Level 2.5	1
Psychosocial Rehab	8
SUDs Intensive Outpatient	20
Major Depressive Disorders	**2,553**
ASAM 1 Outpatient Services	358
Clinically Managed Low Intensity Residential Services ASAM Level 3.1	5
Crisis Intervention	653
Crisis Stabilization	162
GAP Case Management	1,274
High Intensity Residential Service Adult ASAM Level 3.5	10
Intensive Inpatient Services Adult ASAM Level 3.7	10
Partial Hospitalization ASAM Level 2.5	8
Psychosocial Rehab	21
SUDs Intensive Outpatient	52
Missing Diagnosis	**15**
Clinically Managed Low Intensity Residential Services ASAM Level 3.1	1
Crisis Intervention	5
GAP Case Management	7
Partial Hospitalization ASAM Level 2.5	1
SUDs Intensive Outpatient	1
Other Disorders	**778**
ASAM 1 Outpatient Services	119
Clinically Managed Low Intensity Residential Services ASAM Level 3.1	3
Crisis Intervention	203
Crisis Stabilization	42
GAP Case Management	369
High Intensity Residential Service Adult ASAM Level 3.5	1
Intensive Inpatient Services Adult ASAM Level 3.7	2
Partial Hospitalization ASAM Level 2.5	1
Psychosocial Rehab	6
SUDs Intensive Outpatient	32
Psychotic Disorders	**161**
ASAM 1 Outpatient Services	9
Crisis Intervention	40

Crisis Stabilization	10
GAP Case Management	99
Psychosocial Rehab	1
SUDs Intensive Outpatient	2
Schizophrenia	**640**
ASAM 1 Outpatient Services	24
Clinically Managed Low Intensity Residential Services ASAM Level 3.1	1
Crisis Intervention	155
Crisis Stabilization	12
GAP Case Management	431
High Intensity Residential Service Adult ASAM Level 3.5	2
Psychosocial Rehab	12
SUDs Intensive Outpatient	3
Grand Total	**5,660**

Figure 8 presents data on behavioral health treatment received within the past year by the GAP population with serious mental illness (SMI). Between January 2017 to December 2017, a total of 5,660 (5,660 of the 16,152 in Figure 4) GAP enrollees requested BHSA services. However, pharmacy data reflects that GAP members are also receiving medications typically prescribed for behavioral health conditions are being prescribed by medical care providers. DMAS will explore the medical care data further in the next Demonstration Year. (GAP members identified in the Other Disorders category includes Posttraumatic Stress Disorder, Agoraphobia without history of panic disorder, Obsessive Compulsive Disorder, Panic Disorder with Agoraphobia, and Panic Disorder without Agoraphobia. Please note that there is no longer a service registration or authorization requirement for Psychotherapy after 10/26/2017.)

Effective October 1, 2017, GAP members also have access to additional substance use services per the Addiction and Recovery Treatment Services (ARTS) who have a substance use diagnosis. Governor's Access Plan (GAP) benefit now includes expanded community-based addiction and recovery treatment services including coverage of partial hospitalization and residential substance use disorder treatment.

GAP Annual Population with Temporary Detention Orders

Temporary Detention Orders (TDOs) are issued by a magistrate, only after an in-person evaluation by the local community services board or their designee if it appears from all evidence readily available that a person is:

a) mentally ill and in need of hospitalization,
b) the person presents imminent danger to self or others as a result of mental illness, or
c) is so seriously mentally ill as to be substantially unable to care for self, and
d) is incapable of volunteering or unwilling to volunteer for treatment.

By evaluating claims data, the frequency of Temporary Detention Orders in the GAP population serves as one way to track and monitor the effectiveness of the GAP waiver. If TDOs decrease subsequent to a member's enrollment, this shows that GAP members have access to the behavioral health, substance abuse, and medical care that they need. TDOs may occur during

GAP enrollment as a sign that the member requires more attention to their behavioral health needs, and therefore, care coordinators and recovery navigators from the Behavioral Health Administrator (BHSA) serve to track and meet those needs throughout the member's enrollment in GAP.

Figure 9: Demographic Characteristics by Gender, 2013-2017

Demographic Characteristics by Gender			
	Female (N=549)	**Male (N=874)**	**All GAP Recipients (N=1423)**
Race/Ethnicity Category (%)			
Caucasian	27.27	38.09	65.35
African American	8.85	18.9	27.76
American Indian/Alaskan Native	0.28	0.28	0.56
Asian	0.42	0.49	0.91
Hispanic	0.14	0.7	0.84
Native Hawaiian or other Pacific Islander	0.14	0.7	0.84
Asian and White	0	0.07	0.07
African American and Caucasian	0.42	0.49	0.91
Unknown	0.98	2.11	3.09
Asian and African American	0	0.07	0.07
Other	0	0.07	0.07
Asian Indian	0	0.07	0.07
Filipino	0	0.07	0.07
Other Asian	0	0.07	0.07
Primary Diagnosis Category (%)			
Bipolar Disorders	11.74	16.16	27.9
Major Depressive Disorders	16.16	21.93	38.09
Missing Diagnosis	0.42	0.63	1.05
Other Disorders	3.87	4.85	8.71
Psychotic Disorders	1.62	4.15	5.76
Schizophrenia	4.78	13.7	18.48
Age Group (%)			
21 to 30	9.42	22.49	31.9
31 to 40	11.88	18.55	30.43
41 to 50	10.19	13.56	23.75
51 to 60	6.18	6.11	12.3
61 to 65	0.91	0.7	1.62
Marital Status (%)			
Divorced	2.67	1.69	4.36
Single	15.6	25.09	40.69
Married	2.32	3.3	5.62
Separated	2.88	2.32	5.2
Unreported	14.27	28.81	43.08

Widow/Widower	0.84	0.21	1.05
Temporary Detaining Orders (%)			
Before Enrollment	19.4	28.11	47.51
During Enrollment	18.62	32.54	51.16
After Enrollment	0.56	0.77	1.34

Figure 9 provides descriptive demographic statistics for our GAP Recipients with Temporary Detention Orders before, during and after GAP enrollment.

Our analysis sample of 8.81% (1,423 of 16,152) generated a total of 8,219 TDO claims dating back to 2013. When comparing occurrence of TDOs before and during enrollment, a decrease of 10.0% in TDO frequency after transitioning into the GAP Program was noted.

GAP Team Analyst examined whether the mean frequency of TDO encounters decreased because of GAP enrollment. Based on our analysis, there is enough statistical evidence to conclude that the mean in TDO encounter scores significantly improves for the group with TDO claims generated during enrollment period ($p < 0.05$, $t = 30.47$, $df = 668$). Because of enrollment, TDO claims amounts decreased for the recipients that had TDOs during their enrollment period. When examining the change in the average of TDO encounters after GAP disenrollment, we concluded that the mean in TDO encounter scores significantly increase after GAP eligibility has ended ($p < 0.05$ $t = 85.5$). With respect to inpatient hospitalization, we found that GAP individuals who have transitioned into Medicaid are more likely to be hospitalized; DMAS is reviewing this finding. Overall, enrollment into the GAP program has the potential to improve the health for individuals with SMIs. Further analysis of Medicaid claims data concluded that 13.75% of the variation among GAP recipients with decreased TDO frequencies after enrollment can be explained by the recipient's amount of eligibility days, followed by the total number of behavioral health services (Crisis Intervention, Crisis Stabilization and GAP Case management) acquired during enrollment ($F = 79.56$, $df = 2$, $p < .001$). From this analysis, DMAS concludes that enrollment in the GAP waiver has helped members to decrease their TDO encounters compared to their TDO encounters prior to enrollment.

Figure 10: Cover Virginia Renewals in 2017

Of the **10,364** GAP renewals due to Cover Virginia in 2017:	**9,233** were approved
	1,123 were cancelled
	89.7% were approved

In November 2015, Cover Virginia began the exparte renewal process, which allowed for electronic systematic verification of information (such as income) to determine eligibility for members approaching their renewal. Figure 9 highlights the number of renewal approvals and cancellations completed in 2017.

The target population seems to be a transient community; therefore, many do not maintain a steady address or phone number. Cover Virginia's training for their Customer Service Representatives includes heavy emphasis on how to work with this vulnerable population. DMAS receives a monthly report from Cover Virginia of GAP members who need to submit additional information in order to complete their re-enrollment. Magellan has partnered with DMAS, and makes three attempts to call those members to encourage completion of the paper application/submit verification documentation in order to continue receiving GAP benefits. In 2017, Magellan attempted to contact 715 members who were facing cancellation to ensure they were aware they needed to complete financial renewal paperwork. Cover Virginia reports that these outreach attempts are very helpful in increasing renewal completion.

OPERATIONAL UPDATES

In Demonstration year 3, DMAS was heavily involved in the Commonwealth Coordinated Care Plus (CCC Plus) implementation, a new statewide Medicaid managed long term services and supports program. Implementation of the program was time-intensive and involved the assistance of multiple DMAS Departments. Administratively, DMAS was met with challenges in managing CCC Plus Implementation, and responding to internal (DMAS) and external (BHSA) leadership changes in the midst of operating the demonstration.

DMAS was also met with challenges in limited staffing for the delivery of GAP Care Coordination at the BHSA and turnover in clinical leadership related to GAP; Year 4 of the Demonstration will start off with a "waiver re-set" to re-orient the BHSA staff to the waiver demonstration. DMAS continues to monitor Recovery Navigation triggers for referral and processes for outreach to current members and potential members. DMAS continues to discuss areas of improvement and provide feedback on current processes so that Care Coordination for GAP members is rendered efficiently.

As discussed in the section entitled "*GAP Outreach / Innovation Activities to Assure Access,*" in an effort to increase GAP members' renewal application completion process and care coordination with such a transient population, DMAS and Magellan have been working towards ensuring that GAP members have access to receive free cell phone service through the SafeLink program (VA TracFones). Through Magellan of Virginia, GAP members receive

a free mobile phone, cellular minutes, and messaging services. Efforts to communicate with the transient GAP population regarding the Safelink registration and program benefit for eligible GAP members proves to be challenging. DMAS staff are working on ways to increase enrollment with Safelink by re-examining, with Magellan of Virginia, communication and marketing techniques that may assist with an increase in enrollment.

The 2017 General Assembly passed significant funding measures to strengthen the mental health care system including $2 million in new funding to expand the GAP household income allowance to 100% of the FPL and to include Addiction, Recovery and Treatment Services' residential and partial hospitalization services in the demonstration waiver. Both items were effective for GAP members beginning October 1, 2017. DMAS GAP staff have been working diligently to ensure that providers and members are aware of the increase in household income limits and updating outreach materials.

During the third quarter of 2017, DMAS staff revised the GAP Administrative Regulations to account for program changes mandated by the 2017 General Assembly. The changes are: increasing the eligibility from 80 – 100% of the Federal Poverty Level; adding partial hospitalization and residential treatment services for substance use disorder, and adding Peer Support Services provided by licensed providers.

In 2017, DMAS staff witnessed a substantial increase in the GAP enrollment population. Increased enrollment can be attributed to increased awareness of the GAP program as well as incentive to become a GAP member. Increased enrollment shows that GAP members have access to behavioral health, substance abuse, and medical care. TDO frequency after enrollment has decreased per evaluation of Medicaid claims data. For members that are no longer GAP eligible, their TDO frequency increased after GAP enrollment. The hope is that the recent eligibility requirement that GAP members' income level be below 100% of the federal poverty limit will help GAP members remain eligible for as long as they need access to GAP benefits.

Opportunities for public comments in Demonstration year 3 of the GAP demonstration were available when regulations were published for the ARTS implementation in April 2017, Peer supports in June 2017, and adding ARTS residential and partial hospitalization to the benefit plan in October 2017 . At the time of reporting, there are limited significant operational, systems, or fiscal developmental issues to disclose for 2017. There are no issues to report identified by beneficiaries; lawsuits or legal actions; or unusual or unanticipated trends. Since the launch of the Demonstration, DMAS continues to ensure that all systems are working together for the success of the Demonstration.

PERFORMANCE METRICS

The new reporting requirements, including documenting the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, as well as outcomes of care, quality and cost of care, and access to care, will be addressed in more detail in the next quarterly report.

OUTREACH/ INNOVATION ACTIVITIES TO ASSURE ACCESS

During 2017, DMAS continued to implement a multi-faceted approach to educate potential members, families, advocates, providers and other stakeholders about GAP. DMAS continued Phase II of the GAP outreach plan focusing on increasing awareness of the Demonstration.

DMAS continued to focus on collaborating with the state prisons as well as local and regional jails to promote the Demonstration and determine how they can be involved in assisting their clients in obtaining GAP eligibility as the inmate is nearing release. It is vital that inmates who are eligible become enrolled upon release to ensure quick access to health care once they return to the community. GAP staff continued to work with Virginia Department of Corrections (VADOC) to develop strategies that would allow VADOC staff to conduct SMI screenings and submit applications for "returning citizens" (VADOC's preferred term for inmates being released from their custody) prior to their release. DMAS collaborated with VADOC and the Department of Health Professions (DHP) regarding credentialing and training for GAP SMI screeners. Most VADOC mental health staff are non-licensed master's level employees but GAP regulations, reflecting guidance from DHP, require licensed mental health providers (LMHPs) to conduct the SMI screenings. DMAS staff identified an exception in the Board of Social Work regulations that allows non-licensed masters level social workers working for the Commonwealth to provide social work services. DHP confirmed that DOC and local/regional jails' masters-level clinicians, supervised by a licensed psychologist would meet the DHP regulation requirements that DMAS relies on for clinicians conducting the GAP SMI screenings. DHP also added that the supervision could also be done remotely via tele/video conferencing. This will allow the non-licensed masters level clinicians at VADOC and in the jails to conduct the SMI screenings. There were multiple conference calls with VADOC regarding how to coordinate screening during Quarter Two. Magellan posted training for DOC officials on their webpage with directions and clarification regarding how to complete and submit a SMI screening in April 2017. This process was postponed during Quarter 2 due to a state legislative House Bill 2183 workgroup that was formed.

DMAS has been involved with House Bill 2183 Workgroup to assist with Department of Corrections / local and regional jails and its efforts to decrease barriers to healthcare for incarcerated individuals at their time of release. The workgroup brainstormed ways to capture data at the time of admission to jail / correctional facility and potentially using Compensation Board as a centralized location for data to be submitted. The workgroup focused on how to coordinate application and potential benefit start date at time of release to decrease time with no access to behavioral health or medical services after release. The workgroup completed a recommendation summary to present to DMAS leadership and to the General Assembly for the funding that is needed to implement the recommendations.

In an effort to increase GAP members' renewal application completion process and care coordination with such a transient population, DMAS and Magellan have been working towards ensuring that GAP members have access to receive free cell phone service through the SafeLink program (VA TracFones). Through Magellan of Virginia, GAP members receive a free mobile phone, cellular minutes, and messaging services. Members also get additional

access to care and support as well as health and reminder tips. This special version of the program is specifically for members of Virginia's Medicaid behavioral health program. In 2017, there were 1,880 GAP members with access to VA TracFones. DMAS has partnered with Magellan to increase awareness of this program and to implement a Care Messaging platform with welcome messages, health reminders and health tips. This Care Messaging platform will be implemented in 2018.

Last year (2016), Virginia Commonwealth University (VCU) partnered with DMAS to conduct a quality improvement study. This quality improvement study assessed the reasons for lower than projected enrollment rates since the program's implementation in January 2015. To meet study objectives, VCU representatives engaged in data collection through interviews with SMI screeners and administrators from seven different sites who currently conduct SMI screenings for GAP. In Quarter One, VCU submitted the final deliverables for the study which includes a formal write-up of the study as well as a diagram. This study helped DMAS to confirm areas for improvement related to the eligibility and enrollment process. Some recommendations, which are detailed below, fall in line with current GAP outreach initiatives while others are not possible due to budget constraints.

DMAS continues to work on an outreach plan to target homeless shelters, soup kitchens, unemployment agencies, housing agencies, jails, and other mental health treatment facilities as part of the VCU recommendation.

VCU recommendations for improving GAP recruitment are as follows:

VCU Recommendations for GAP Recruitment

Preparation

In order to avoid confusion among the broader healthcare system we suggest conducting a targeted marketing campaign aimed at entities servicing populations that are potentially eligible for GAP enrollment. Some such entities include homeless shelters, soup kitchens, unemployment agencies, housing agencies, jails, and other mental health treatment facilities. By broadening the marketing scope to areas outside of the medical community, this would also increase awareness of the program and help reduce the "missed" individuals who are not caught for potential screening.

Identification and screening

Provide incentive for screening sites to conduct clinical screenings and provide financial application assistance during the same visit. This would take some of the responsibility off of the applicants and allow less time to lapse between clinical screening and financial application, causing fewer applicants to "fall by the wayside."

Expand clinical criteria to allow for any person receiving an SMI diagnosis in the last year to be eligible for GAP. This would cut down on the fluctuation of applicants in and out of eligibility. Also, expand clinical criteria to include diagnoses for SUDs, anxiety disorders, and personality disorders.

Coordination and follow-up

Allow universal access to application enrollment status. Many applicants visit a screening site solely for the clinical screening but because they aren't an established patient, there's no easy way to check whether a person has been enrolled or not without using a backdoor method. By creating an easier way for sites to

follow-up with a patient, this would allow recruiters to reduce the number of denied applications due to a simple typo or human error. Additionally, providing an easily recognizable reason for denial would allow sites to correct the error and potentially change an applicant's status from ineligible to eligible.

Since January 2015, DMAS and Magellan staff host weekly conference calls to answer questions from the provider network as well as provide GAP updates and announcements as needed. A low number of GAP issues continue to be identified on these weekly calls. GAP questions and responses are monitored weekly by DMAS staff to ensure accurate information is disseminated.

Another avenue for outreach has been the email address for the public to make inquiries about GAP[4]. This email inbox is monitored daily by DMAS GAP staff. Designed to address general information about the GAP plan and its policies, DMAS staff has been successful with supplying providers and members with electronic materials (such as the GAP supplemental manual and Medicaid memos) via email to increase awareness about the benefit plan. During 2017, the majority of the emails received came from providers; most inquires involved questions regarding covered services and procedure codes.

DMAS also maintains a GAP webpage on the DMAS website[5]. The webpage includes sections for individuals, providers and other stakeholders. The webpage has links to Cover Virginia and Magellan as well as other helpful information. During 2017, the GAP webpage was revamped to include a more user-friendly experience for individuals and families and providers.

The GAP webpage received 27,125 page views, of which 21,133 were unique page views between January 1, 2017 and December 31, 2017. DMAS staff receives weekly reports of GAP webpage views and the data from those reports shows that the GAP webpage is averaging approximately 520 views per week, of which 410 were unique page views. The only trend deduced from the GAP webpage statistics is that during the national holidays, such as July 4, 2017, Thanksgiving and Christmas GAP webpage views decreased significantly, which is to be expected. During 2017, DMAS staff updated educational flyers and outreach materials and worked on changing the format of the webpage to increase ease of finding information for members, families, and providers.

Cover Virginia's website[6] includes a webpage dedicated to GAP and outlines the financial eligibility criteria and application process. Visitors to the website can access a GAP Information Flyer in both English and Spanish, as well as review the GAP Handbook. The webpage also includes a picture of the GAP ID card.

[4] Email address for the public to make inquiries about GAP: BridgetheGAP@dmas.virginia.gov
[5] GAP webpage on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/gap.aspx
[6] Cover Virginia's website: http://www.coverva.org/gap.cfm

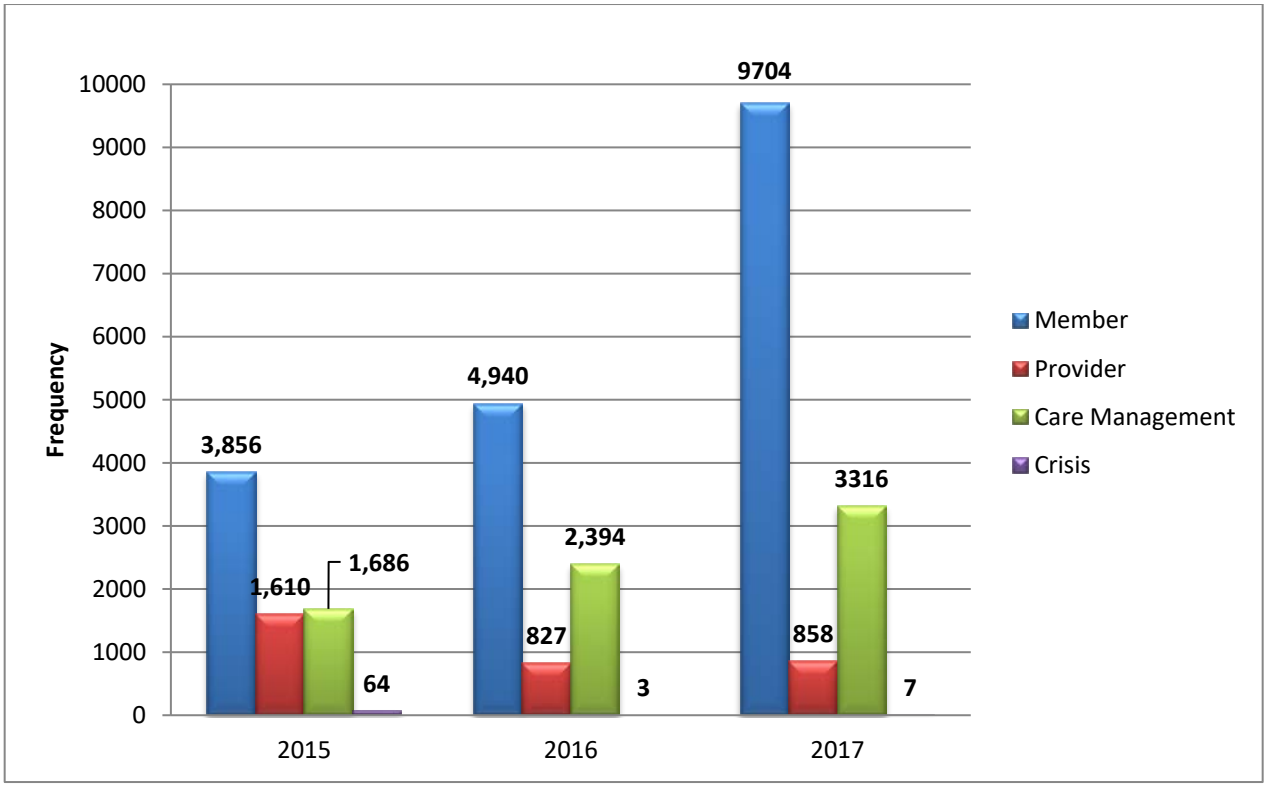
Magellan's website has a link for provider communication[7], where it has posted notices to providers about GAP. Magellan has a training page for providers[8], and developed a GAP specific webpage[9], for members, their family members and advocates.

COLLECTION AND VERIFICATION OF UTILIZATION AND ENROLLMENT DATA

DMAS collects and reviews data from contractors (Magellan and Cover Virginia) and uses data from its MMIS (Medicaid Management Information system). Weekly and monthly reports from the contractors are reviewed and analyzed and used for program monitoring, contract monitoring, training, outreach and DMAS reporting purposes.

The Magellan Call Center provides monthly data to DMAS about calls received related to GAP. Figure 17 below reflects the types of calls they receive:

Figure 11: Yearly BHSA Call Center Data, 2017



Each year, it is notable that there are significantly more contacts from GAP members than from providers. It does appear that members are becoming more engaged in their treatment and service planning by attempting to access and use their benefits. Members may contact Magellan for physical health care referrals and resources, as well as behavioral health care

[7] Magellan website link for provider communication: http://magellanofvirginia.com/for-providers-va/communications.aspx
[8] Magellan training page for providers: http://magellanofvirginia.com/for-providers-va/provider-training.aspx
[9] Magellan GAP specific webpage: http://www.magellanofvirginia.com/for-members/governor's-access-program-(gap).aspx

resources. This reflects the ongoing need for care coordination in order to access services and demonstrates that the integrated model appears to be successful.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix B of this Report, an updated budget neutrality workbook for the 2017 year that includes established baseline and member month's data that meets all the reporting requirements for monitoring budget neutrality.

CONSUMER ISSUES

DMAS is hearing anecdotally that members are experiencing wait times to access appointments for SMI screenings and barriers to scheduling appointments from providers who are unsure of what GAP coverage is. DMAS is collaborating with Magellan and following up with these allegations so DMAS can investigate this concern further. Magellan continues to assist members with accessing other screening entities to avoid delays in the eligibility application process.

DMAS is already seeing a growing usage of the ARTS residential treatment services benefit and no consumer issues have been reported at this time.

DMAS is aware that the majority of GAP members do not have adequate transportation. As with most individuals that have low social economic status, transportation is basic but a major barrier to health care access.[10] Transportation is an uncovered service for the GAP Program and DMAS has heard from various stakeholders, anecdotally, that this is a much-needed service.

CONTRACTOR REPORTING REQUIREMENTS

DMAS receives reporting from Magellan regarding care coordination, Peer Supports/Recovery Navigator Services, warm line and routine utilization. DMAS receives from Cover VA weekly reports to address the GAP eligibility applications being processed. In 2017, DMAS continued to receive all necessary reports from contractors using the data elements detailed above.

DMAS is exploring using predicative modeling tools to assist in identifying GAP members with the highest level of need. GAP staff were introduced to the Pharmacy Based Risk Adjustment Model Medicaid Rx risk model. The model can be used to capture high and low risk GAP Recipients from pharmacy data (medication management and adherence) based on cost of the medications. Pharmaceutical cost data offers a detailed, longitudinal record of utilization, diagnoses, procedures, and prescriptions across the full range of health care

[10] Syed, Samina T., Ben S. Gerber, and Lisa K. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." *Journal of community health* 38.5 (2013): 976–993. *PMC*. Web. 1 Feb. 2018

settings. Results of analyses could potentially give insight to and suggest higher levels of medical vulnerability and need for coordination of health and mental health services in the GAP population. DMAS continues to consider whether this model will relate appropriately to the goals of the waiver.

RECOVERY NAVIGATORS

The Recovery Navigators have continued efforts to deliver outstanding supports to our GAP members. Since inception, DMAS has only received positive feedback regarding their efforts. There are 5 Navigators positions located around the state: Northern Virginia/Central Virginia, Roanoke/Lynchburg, Far Southwest Virginia, and two in Tidewater.

The Recovery Navigators are continuing to provide in person outreach and education at crisis stabilization facilities operated by community services boards (CSBs). GAP members are being automatically referred for Recovery Navigation services at the time of crisis stabilization request. This increases the ability for the Recovery Navigator to initiate support while the member is still in the facility, to assist with the member's transition back into the community, and assist with putting supports in place to make the member's discharge successful.

In 2017, there were an average of 116 members enrolled in Recovery Navigation monthly. There is an average of 25 new enrollees per month to Recovery Navigation. The average number of days in Recovery Navigation is 138. There was an average of 29 calls to the Warmline each month, an evening and weekend support line each month, which is staffed by the Recovery Navigators. Of the supports delivered to GAP members by Recovery Navigation, emotional support, empathy, caring, concern, was primary delivery type followed by informational, providing knowledge and information about skills and training.

DMAS gathers success stories and experiences of these navigators; below is one account narrated by a Recovery Navigator:

A 32-year-old female GAP member presented with diagnosis of Bipolar Disorder and Posttraumatic Stress Disorder. She was experiencing symptoms of depression after the sudden loss of her husband. She was admitted to Crisis Stabilization 5 weeks after his death. She had to move in with her parents due to no financial support.
When the recovery navigator first met the GAP member she was tearful, depressed, unsure of herself and unable to make simple decisions. She was trying to cope with the recent loss and having to move back home.

She created a Wellness Recovery and Action Plan with Recovery Navigation and decided to go back to school. She continued to make improvements and expressed interest in becoming a Peer Recovery Specialist. She was accepted into the Peer Specialist Training program did exceptionally well, even sharing her own story with peers. She has graduated from the training and is looking forward to employment and helping others on their own path to recovery.

Figure 12, 8 Dimensions of Wellness

8 Dimensions of Wellness:	
	Emotional—Coping effectively with life and creating satisfying relationships
	Environmental—Good health by occupying pleasant, stimulating environments that support well-being
	Financial–Satisfaction with current and future financial situations
	Intellectual—Recognizing creative abilities and finding ways to expand knowledge and skills
	Occupational—Personal satisfaction and enrichment from one's work
	Physical—Recognizing the need for physical activity, healthy foods and sleep
	Social—Developing a sense of connection, belonging, and a well-developed support system
	Spiritual—Expanding our sense of purpose and meaning in life

Recovery Navigators offer support framed around the eight dimensions of wellness. Wellness means overall well-being. It includes the mental, emotional, physical, occupational, intellectual, and spiritual aspects of a person's life. The Eight Dimensions of Wellness, as defined by Substance Abuse, Mental Health Services Administration (SAMHSA) may also help people better manage their condition and experience recovery. Figure 14 describes each dimension.

A major focus of Recovery Navigation transformation efforts is the utilization of Temple University Collaborative Participation Survey results which assist in capturing the promotion of recovery and quality of life. Due to the increasing interest in enhancing community participation as a facilitator of recovery, the baseline and follow-up assessment will examine the community participation of GAP members and the relationship between various types of participation and recovery, quality of life and meaning of life activities. The Temple University Collaborative Participation Survey strives to: a) target obstacles that prevent people with serious mental illness from being full members of their communities; b) develop the supports GAP members need to enhance the prospects for community integration; and develop strategies to avoid future crisis. DMAS will pursue this with Magellan in order to access appropriate data and identify trends.

LESSONS LEARNED

DMAS continues to evaluate how processes and procedures can be refined and strengthened. At this stage of the Demonstration, DMAS believes that significant progress has been made to increase the awareness and outreach of the benefit plan since the implementation of the Demonstration. Working with all stakeholder groups has been critical

to the success of the program and DMAS believes the unified approach allowed for the program to have continued growth. Since implementation, DMAS has seen a low number of grievances or reconsiderations for the GAP Demonstration. Data from the Demonstration exhibits high utilization of non-mental health medications among members. This shows that members are continuing to access both medical and behavioral health services, which is one of the three GAP Demonstration goals.

In 2017 DMAS implemented the CCC Plus initiative, the ARTS initiative, Peer and Family Support Partner initiative and a large portion of the agency re-organized including the staff responsible for the GAP/ARTS demonstration. Some momentum for the GAP waiver was lost as a Full time position was shifted to another function but a part time data analyst was added to the team. The GAP manager assumed additional duties but with 2018 approaching, it is anticipated that more focus can return to GAP.

EVALUATION ACTIVITIES

DMAS was using an advisory expert panel to advise us about our evaluation and data resource/usages. Additional support was provided by DMAS' sister state agency, the Department of Behavioral Health and Developmental Services (DBHDS) with both data analysis and community mental health services. However, in the state budget reductions that position was eliminated and the employee was laid off.

DMAS has struggled with accessing and understanding how to use the data available for GAP reporting. Due to ongoing issues with data collection and analysis, the evaluation panel did not meet this year. The panel has been on hiatus while staff works on resolving the reporting issues. As a result, DMAS hired a part time analyst to be dedicated to GAP; this analyst has statistical/epidemiological background and is on the fast track to learn the MMIS system and the GAP waiver. A separate evaluation report will be submitted.

CONCLUSION

During 2017, DMAS made great progress with focusing on increasing access to healthcare for the criminal justice system's returning citizens with significant behavioral health and medical needs and is committed to recognizing how access to care impacts recidivism. DMAS has seen increased enrollment and growth in the GAP program, which allows more individuals gain access to health care in Virginia. DMAS is also committed to continued collaboration with its contractors and stakeholders to develop higher confidence in the data process as well as identifying additional opportunities to better serve our members throughout 2018.

ARTS

BACKGROUND

Virginia implemented the ARTS program in April 1, 2017 to increase access to treatment for Medicaid members with opioid or other substance use disorders. This section of the report highlights progress made during the first year of the ARTS Demonstration (quarters two through four of this demonstration year).

Virginia's 1.3 million members enrolled in Medicaid are disproportionately impacted by the substance use epidemic. In 2016, 1,428 Virginians died from opioid overdoses and by third quarter 2017, the number has the previous year's totals, at 1,515. The number of all fatal overdoses in 2016 compared to 2015 increased by 38.9%. Most alarmingly, the fatal fentanyl and/or heroin overdoses increased by 72.6% in 2016 when compared to 2015[11]. Nationally, Medicaid beneficiaries have higher rates for being prescribed opiates for pain relief that those with access to other insurances and higher rates of opioid use disorder[12]. The financial impact is nearly as great as the human cost. Virginia spent $44 million on Medicaid members with a primary or secondary diagnosis of SUD who were admitted to hospitals or Emergency Departments in 2014. The Governor's Task Force on Prescription Drug and Heroin Addiction, due to the overwhelming impact of substance use disorders for members enrolled in Medicaid, made a recommendation to increase access to treatment for opioid addiction for Virginia Medicaid members by increasing Medicaid reimbursement rates. Thus, DMAS developed a large stakeholder and provider workgroup to develop the comprehensive benefit for enhancing the Medicaid covered substance use disorder treatment services: **Addiction and Recovery Treatment Services (ARTS)**.

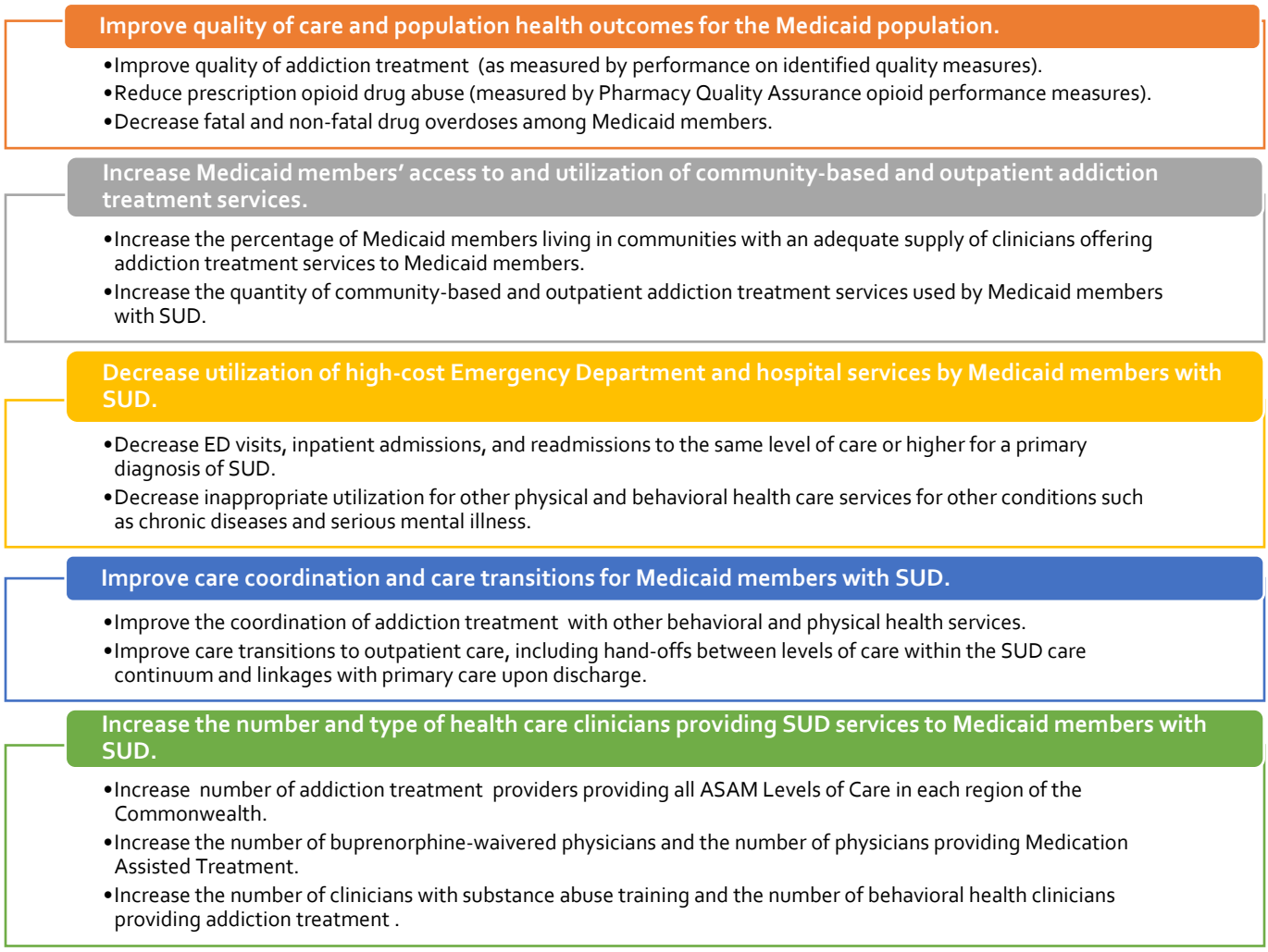
GOALS

Virginia's overall goal for the ARTS benefit is to achieve the Triple Aim of improved quality of care, improved population health, and decreased costs for the Medicaid population with SUD. DMAS' specific objectives for this benefit are outlined below:

[11] Data extracted from Kaiser Family Foundation Opioid Overdose Deaths, http://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity and the Virginia Department of Health's Office of the Chief Medical Examiner, http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology.

[12] MACPAC June 2017 Report to Congress on Medicaid and CHIP. https://www.macpac.gov/publication/medicaid-and-the-opioid-epidemic/

Figure 13: ARTS Benefit Objectives



ELIGIBILITY AND BENEFIT INFORMATION

The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and GAP (Note: FAMIS and FAMIS MOMS are programs covered by the Child Health Insurance Program (CHIP) benefit). The ARTS benefit is covered through the fee for service, Medallion 3.0 Managed Care, and Commonwealth Coordinated Care (CCC) Medicare/Medicaid Programs on April 1, 2017. Beginning in the 3rd Quarter of this demonstration year, DMAS implemented a regional roll out of the Commonwealth Coordinated Care Plus (CCC Plus) health plans. CCC Plus is a new statewide Medicaid managed long term services and supports program that will serve approximately 214,000 individuals with complex care needs, through an integrated delivery model, across the full continuum of care, including the full continuum of the ARTS benefit. The members covered by the CCC plans fully transitioned to the CCC Plus plans in December 2017. The following changes are required for SUD coverage in the DMAS contracted health plans as well as the Behavioral Health Services Administrator (BHSA):

Effective April 1, 2017

- Inpatient Detox
- Residential Treatment
- Partial Hospitalization
- Intensive Outpatient Programs
- Opioid Treatment Program
- Office-Based Opioid Treatment
- Case Management

Effective July 1, 2017

- Peer Recovery Supports

In October 2017, DMAS received an approval from CMS to amend the GAP benefit to expand substance use treatment services. This amendment approval added SUD partial hospitalization (ASAM Level 2.5), and SUD residential/inpatient psychiatric unit services (ASAM Level 3).

ENROLLMENT COUNTS FOR YEAR TO DATE

DMAS provides substance use disorder treatment services and co-occurring substance use and mental health disorder treatment services to over 1.3 million members enrolled in Medicaid, FAMIS, FAMIS MOMS and GAP.

The chart below shows the number of members who were identified with a substance use disorder and the percentage receiving treatment for April 1, 2017 to August 31, 2017.

About one-third of members with a diagnosis for substance use disorders received treatment during the first five months of ARTS, up from 22 percent in the prior year.

More than half (52 percent) of members with a diagnosis of opioid use disorder received treatment during the first five months of ARTS, up from 40 percent in the prior year.

Fewer people with an alcohol use disorder received treatment compared to those with an opioid use disorder, although treatment for alcohol use disorders increased substantially after ARTS implementation.

Figure 14: Total Members with a Substance Use Disorder Compared to Those Receiving Treatment

	Before ARTS April-August 2016	After ARTS April-August 2017	Percent Change
Total number of members with a substance use disorder (SUD)	**26,785**	**27,595**	**3%**
Member with SUD receiving any SUD treatment	5,815	9,460	63%
Percent receiving treatment	22%	34%	58%
Total number of members with an opioid use disorder (OUD)	**8,632**	**10,107**	**17%**
Members with OUD receiving any OUD treatment	3,439	5,207	51%
Percent receiving OUD treatment	40%	52%	29%
Total number of members with an alcohol use disorder (AUD)	**10,996**	**10,054**	**-9%**
Members with AUD receiving any AUD treatment	1,391	2,770	99%
Percent receiving AUD treatment	13%	28%	118%

Note: Services include those performed in an OBOT or Opioid Treatment Program setting, psychotherapy or counseling, physician evaluation or management, intensive outpatient, partial hospitalization, residential treatment, medically managed intensive inpatient services, and pharmacotherapy. Substance use disorder services and spending are counted using claims paid by plans to providers, (rather than the capitated rates that DMAS paid to health plans). Results are based on claims submitted between April and November, 2017 for services occurring between April 1 and August 31, 2017. As some claims may not have been submitted or paid at the time of analysis, actual utilization and spending may be higher than the estimates shown.

OPERATIONAL UPDATES

This annual report covers the first eight months of ARTS implementation. DMAS monitored activity with the managed care health plans and the BHSA to determine if there were any significant operational, policy, systems, or fiscal developmental issues. There were no issues identified by the health plans or Magellan of Virginia initially after implementation. Through the ARTS weekly technical assistance calls and the ARTS email box, providers indicated some issues with the service authorization process and claim denials for what they determined as covered services. DMAS worked very closely with the managed care health plans and the BHSA to share these concerns and monitored status to resolution. Many of the managed care health plans and the BHSA identified and corrected system issues related to the service authorizations and claim processing. DMAS encouraged the managed care health plans and the BHSA to provided technical assistance as needed to assist providers in correct claim practices. The BHSA developed a training webinar to address the top denial reasons for ARTS and tips on how providers could correct[13]. DMAS continues to

[13] http://www.magellanofvirginia.com/for-providers/arts-information/

promote the managed care health plans ARTS Care Coordinators, who are licensed practitioners, to help field clinical concerns and questions. DMAS holds monthly calls with the ARTS Care Coordinators to walk through issues identified and ways to assist providers and members. This included updating the ARTS Service Authorization with specific language from the American Society of Addiction Medicaid (ASAM) Multidimensional Assessment, specifically addressing the six dimensions to support that particular ASAM Level of Care.

DMAS worked with the ARTS Stakeholder Workgroup to create several clarification documents to assist providers. One of those documents notified providers of the required staff to perform the multidimensional assessment, development of the individual service plan and completion of the service authorization form. Another document notified providers of how the managed care health plans and the BHSA respond to service authorization notifications. These are posted online on the ARTS webpage[14].

DMAS also received feedback from providers and the health plans that there were discrepancies in consistently determining the ASAM Level of Care. This created frustration especially among residential treatment providers in working with the health plans. The main issue raised from providers was lengths of stay for pregnant women placed in residential treatment due to a court order. Prior to ARTS, Medicaid paid long-term treatment in residential settings for pregnant women. DMAS began working with the judicial system to help educate the judges on evidenced based treatment for pregnant women in the community setting, to lower the rate of court ordered residential treatment. DMAS also facilitated a workgroup with residential treatment providers and health plans ARTS Coordinators to discuss ASAM Criteria and how to best meet the needs of the pregnant members.

Another commonly reported provider concern was the lengths of stay approvals for intensive outpatient and partial hospitalization programs. Prior to ARTS, there were no service authorization requirements for intensive outpatient services. This was a significant change for current providers. DMAS worked with the managed care health plans and the BHSA to develop an average length of stay for initial requests. This is to help with consistency across plans for the initial approvals for these levels of care. DMAS notified providers that the State is required by CMS to have an independent third party review the medical necessity criteria to determine the best ASAM Level of Care and length of stay. This role is performed by the ARTS Care Coordinator who makes this clinical decision based on the information submitted on the provider request and the ASAM multidimensional assessment support that Level of Care.

[14] http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx

ARTS Provider Network

Residential Treatment

DMAS contracted with a vendor to perform site visits with the Residential Treatment providers to determine if the provider meets the requirements as defined by ASAM for the particular Level of Care they are attesting to meet.

DMAS contracted vendor performed 87 site visits to Residential Treatment providers to assess their capacity to provide services as defined in the ASAM Criteria during this reporting period. The chart below shows the outcome of the site visits. The contract ended June 30, 2017 and DMAS secured a contract with a new vendor in December 2017. The vendor for both contracts is Westat, Inc.

Figure 15: Residential Treatment Providers

ASAM Level 3 Category	Completed On-Site Surveys	Full Certifications All Criteria Sufficient	Full Certifications with Approved POC	Total Certifications based on Surveys
3.7	35	30	5	35
3.5	30	27	1	28
3.3	5	3	0	3
3.1	11	9	0	11
Totals: N =	81	59	6	77

Office Based Opioid Treatment

DMAS's physician review panel reviews the provider applications for the Preferred Office Based Opioid Treatment (OBOT) providers to ensure they meet the ASAM Criteria and specific requirements as set forth by DMAS. There were 49 OBOT providers approved during this demonstration year with a total of 162 individual buprenorphine waivered practitioners. DMAS notified the managed care health plans and the BHSA of the approved OBOT providers in order to finalize the credentialing process.

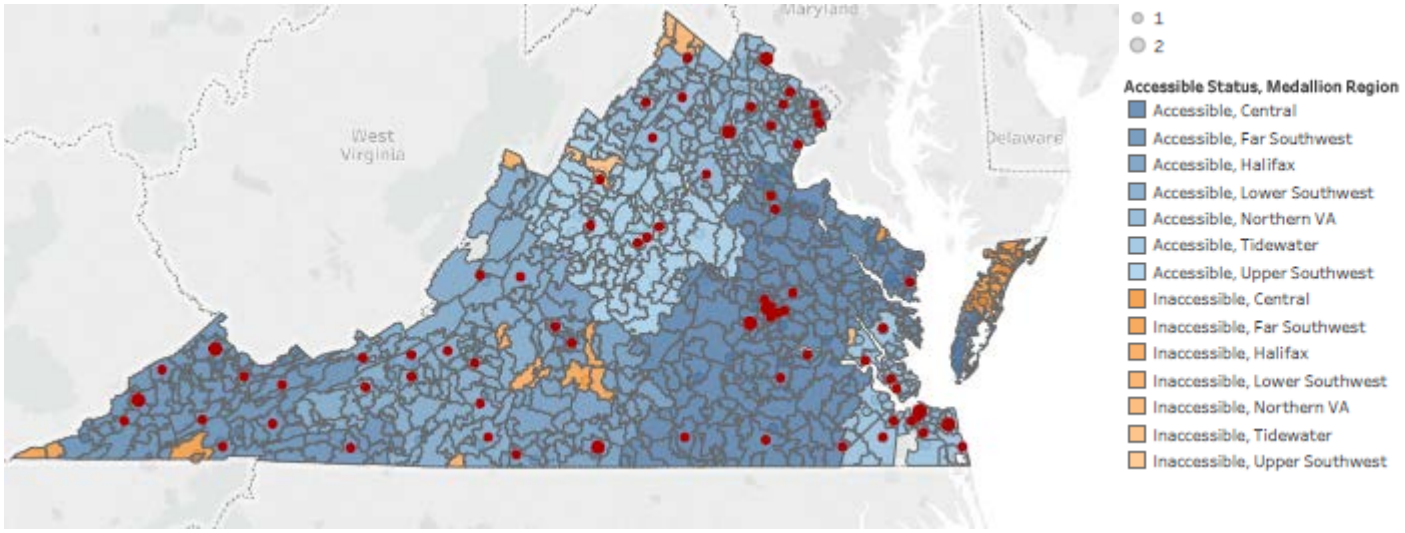
The table below summarizes the total number of the ARTS network and percentage increase since the implementation of ARTS.

Figure 16: Office Based Opioid Treatment Providers

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	103	NEW
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	77	↑ 1850%
Partial Hospitalization Program (ASAM 2.5)	0	13	NEW
Intensive Outpatient Program (ASAM 2.1)	49	72	↑ 47%
Opioid Treatment Program	6	29	↑ 383%
Office-Based Opioid Treatment Provider	0	162	NEW

Network Adequacy by ASAM Level of Care[15]

Figure 17: ASAM Level 4.0 Acute Inpatient



[15] Note: Maps provided by the Department of Medical Assistance Services and reflect providers as of November 2017. The map is based on zip codes that have at least two providers within 30 miles driving of an urban area or 60 miles driving of a rural area.

Figure 18: ASAM Level 3 Residential

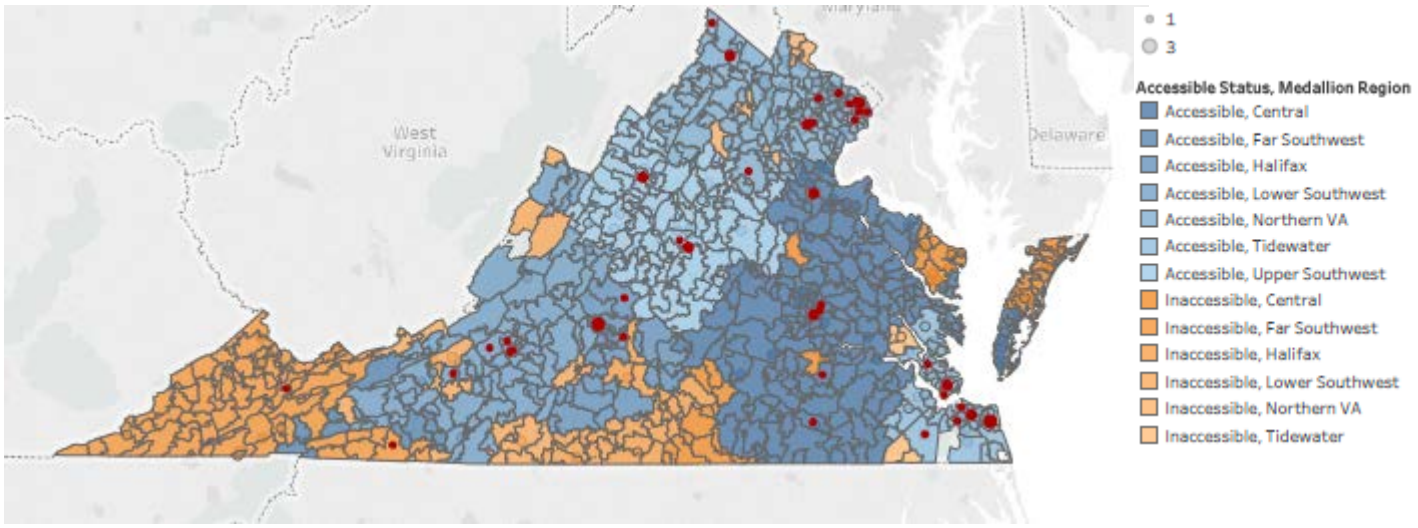


Figure 19: ASAM Level 2.5 Partial Hospitalization

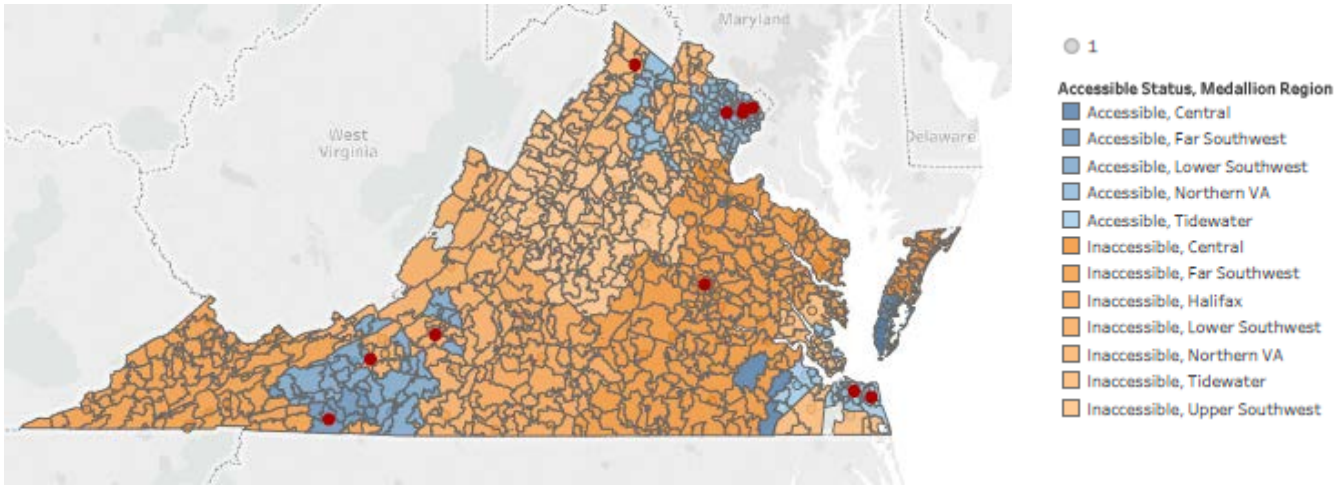


Figure 20: ASAM Level 2.1 Intensive Outpatient

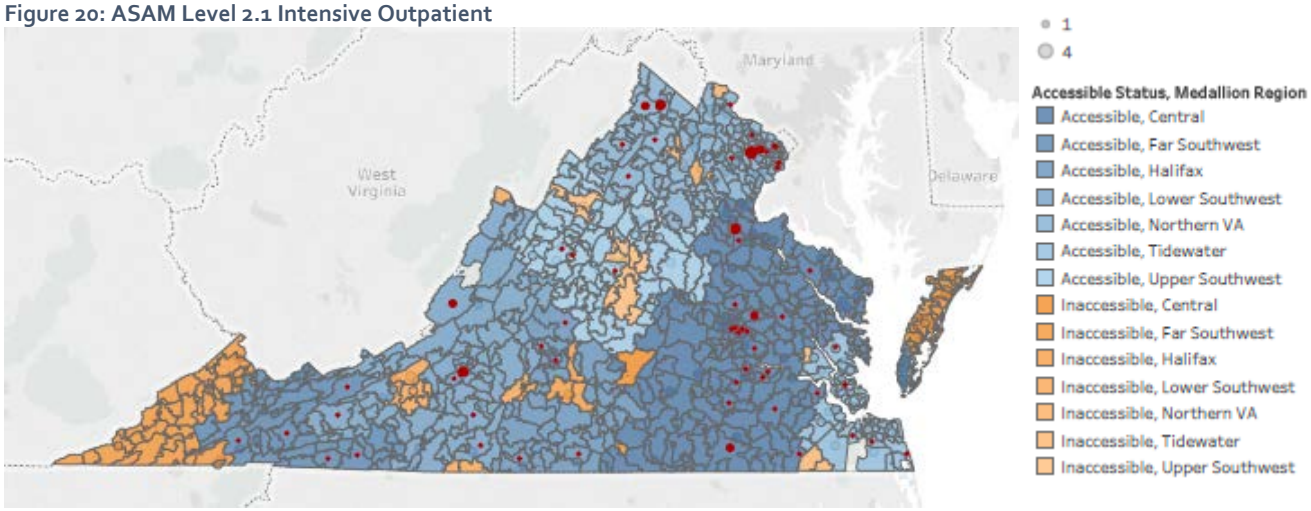


Figure 21: Office Based Opioid Treatment Programs

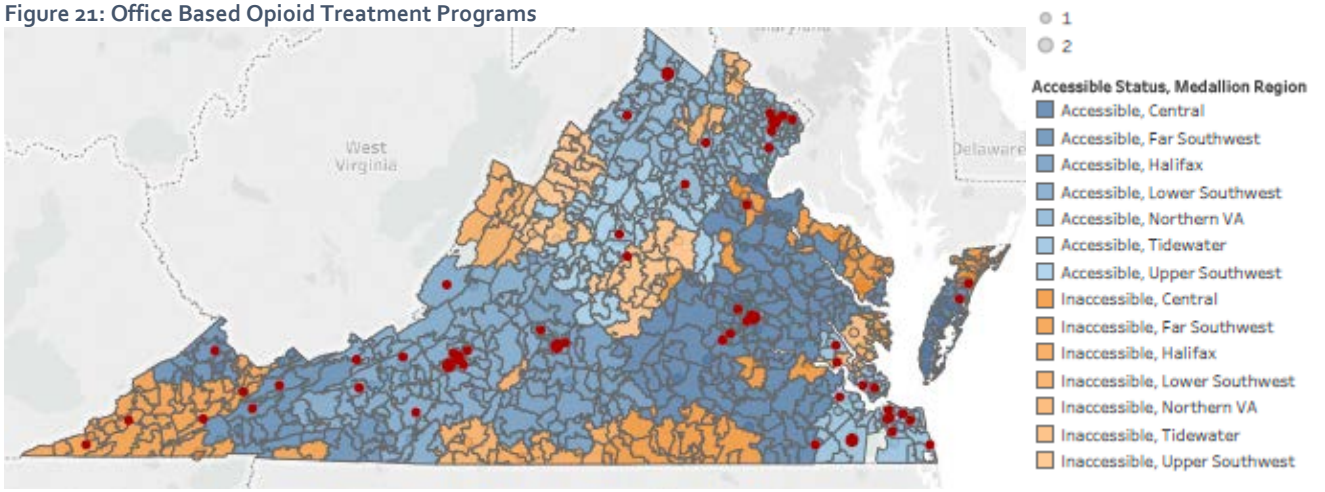


Figure 22: Opioid Treatment Programs

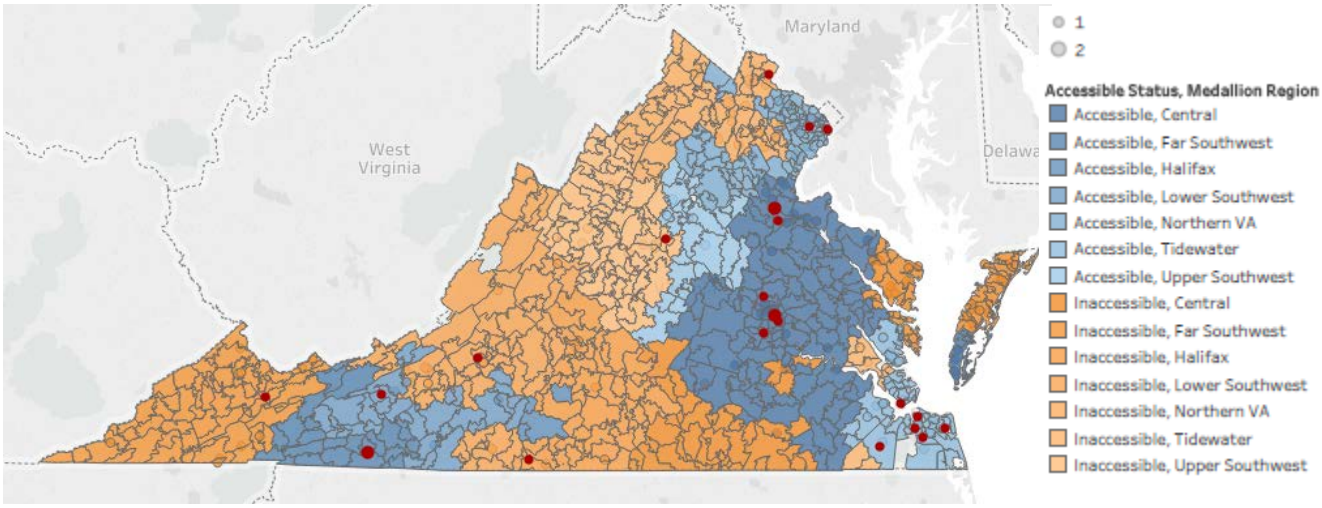
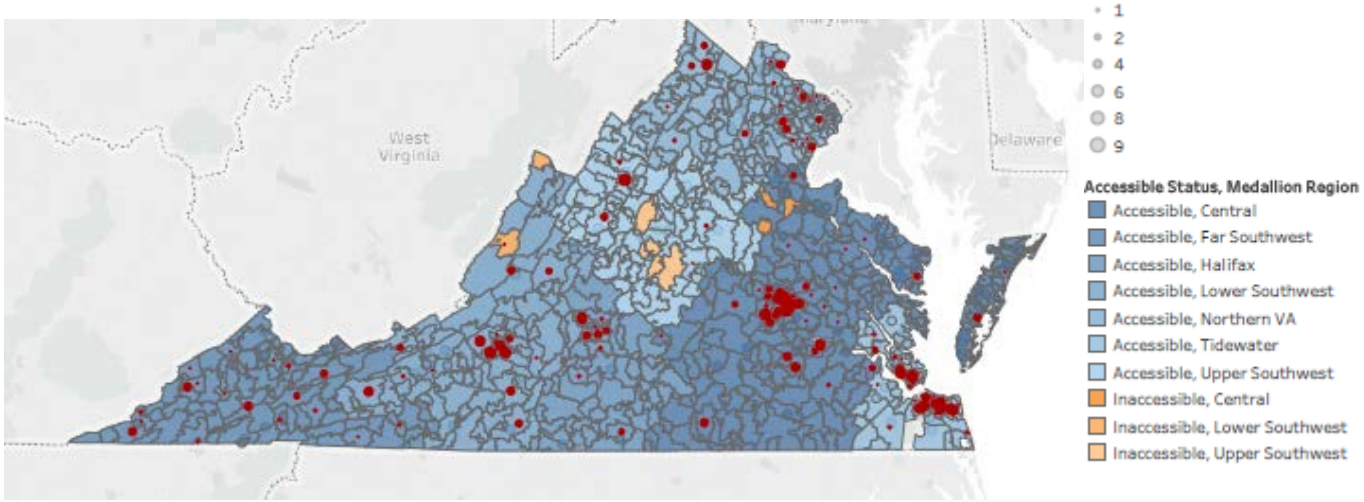


Figure 23: In-Network Buprenorphine Waivered Practitioners



DMAS completed the final list of network providers for posting on the Virginia Department of Health website using google maps[16]. This is a valuable resource for providers in locating network providers for the transition of care.

Figure 24: ARTS In-Network Provider Mapping Tool

Virginia's Medicaid program has an enhanced substance use disorder treatment benefit - Addiction and Recovery Treatment Services (ARTS). The ARTS benefit provides treatment for those with substance use disorders across the state. The ARTS benefit expands access to a comprehensive continuum of addiction treatment services for all enrolled members in Medicaid, FAMIS, FAMIS MOMS and the Governor's Access Plan (GAP),

including expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential substance use disorder treatment.

Click on the **map** for more information about the ARTS Provider Network. Visit the **website** for handouts of Medicaid ARTS Providers in each region.

PERFORMANCE METRICS

Residential Treatment Services

Virginia Medicaid recipients that are short-term residents in an ASAM Level 3 facility will receive all medically necessary services within the CMS required thirty (30) days average length of stay (ALOS). Residential services are provided in a DBHDS-licensed facility that has been issued an ASAM Level of Care certification for Levels 3.1, 3.3, 3.5, and/or 3.7, credentialed and enrolled by an MCO or the BHSA as a network provider. The table below shows the total weighted ALOS by the total number of bed days for all levels of care divided by the total number of admissions. The ALOS meets the CMS requirements for residential treatment services.

[16] https://www.google.com/maps/d/viewer?mid=1px9XvltnM7rXZ6vrTgXgPGIHTew&hl=en&ll=37.81633144363703%2C-80.57419543505449&z=7

Figure 25: Average Length of Stay in Residential Treatment Facilities

ASAM Level	Program	All Medicaid members		
	Service Name	Admissions	Average LOS (day)	Total LOS
3.1	Clinically managed low intensity residential services	73	15.5	1129
3.5	Clinically managed high intensity residential services (Adult); Clinically managed medium intensity residential services (Adolescent)	70	15.1	1057
3.7*	Clinically managed high intensity residential services (Adult); Clinically managed medium intensity residential services (Adolescent)	88	5.4	479
Overall ASAM 3	Residential treatment services	231	11.5	2665

* For 3.1 and 3.5 services, no gaps across claims were allowed for defining a single stay. For 3.7 services, 3-day interval or less was allowed between claim date for a single stay.

ARTS Quality Measures

The following CMS measures for SUD Demonstration Waivers will be reported on the 2nd quarterly report 2019 for the Medallion 3.0 managed care plans. This will allow more time for the claims to adjudicate to be captured in these measures. The CCC Plus health plans will not report on these measures until 2nd Quarter 2020 to have a full year of data.

Figure 26: CMS Measures for SUD Demonstration Waivers

Source	Measure	Collection Mechanism
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/encounter data
NQF #1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	Electronic clinical data/clinical paper chart review
NQF #2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims/encounter data
NQF #0648	Timely Transmission of Transition Record	Electronic clinical data/clinical paper chart review
PQA	Use of Opioids at High Dosage in Persons Without Cancer (PQA)	Claims/encounter data
PQA	Use of Opioids from Multiple Providers in Persons Without Cancer (PQA)	Claims/encounter data

PQA	Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer (PQA)	Claims/encounter data

Monthly Deliverables

DMAS requires the managed care health plans and the BHSA to submit monthly deliverables, including comprehensive quality control procedures. All deliverable submissions must conform to the specifications documented in the DMAS ARTS Technical Manual, including all documented formatting requirements. It is the DMAS contracted health plans' and BHSA's responsibility to comply with these specifications. Any submission that does not comply with these specifications may be rejected by DMAS in total or in part. The MCO and the BHSA are required to correct and re-submit deliverables as necessary to comply with the reporting requirements set forth in the DMAS ARTS Technical Manual.

DMAS worked closely with the managed care health plans and the BHSA during this reporting period. The data submitted was not consistent and DMAS followed up with several clarifications to the DMAS ARTS Technical Manual.

The DMAS ARTS Technical Manual requires the managed care health plans and the BHSA to report on the following measures by the 15th of each month: Patient Utilization Management and Safety Program (PUMS) Members; Appeals and Grievances; ARTS Service Authorizations; Call Center Statistics; ARTS Provider Network; and Provider Network Change Affecting Member Access to Care.

Patient Utilization Management and Safety Program (PUMS)

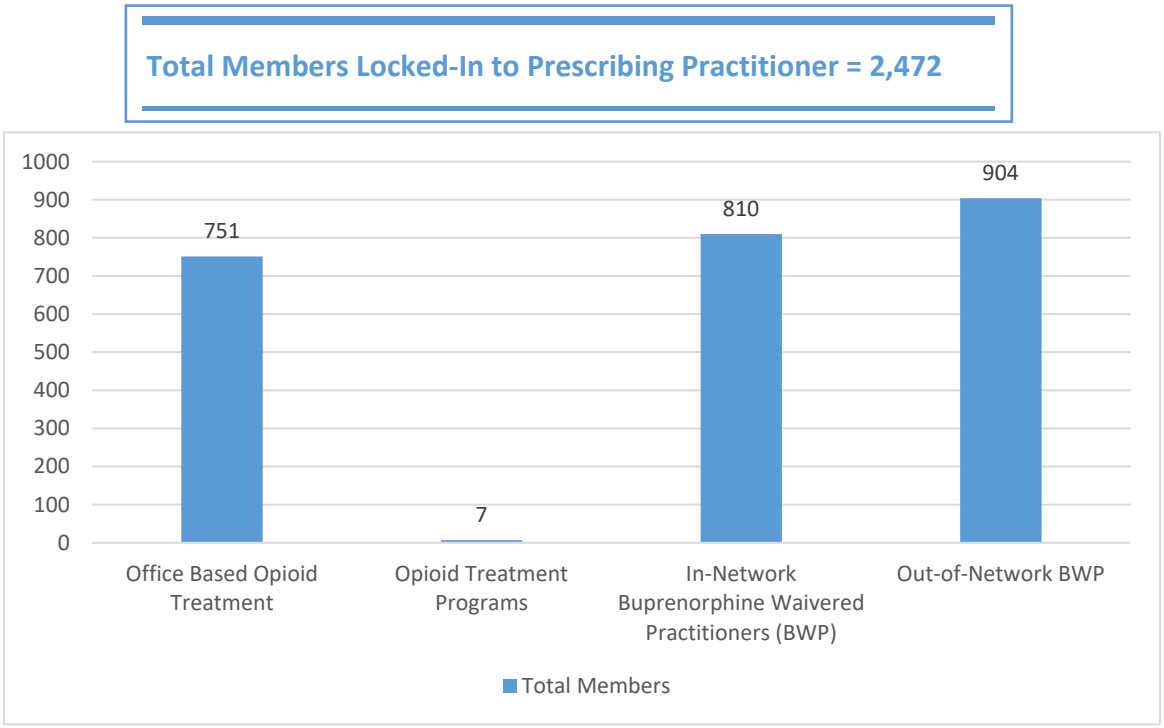
The managed care health plans are expected to report on their members who are assigned to PUMS within the past 30 days from the reporting month. The table below includes only the Medallion 3.0 managed care health plans as the CCC Plus managed care health plans implemented later in this demonstration year.

The reasons that members are placed into PUMS include:

1 = Buprenorphine Containing Product: Therapy in the past thirty (30) days – AUTOMATIC LOCK-IN *If on monoproduct (indicating pregnancy), refer to case management.*
***Exclude members using Butrans and Belbuca only when used for the treatment of pain.*
2 = High Average Daily Dose: > one hundred and twenty (120) cumulative morphine milligram equivalents (MME) per day over the past ninety (90) days,
3 = Opioids and Benzodiazepines concurrent use – at least one (1) Opioid claim and fourteen (14) day supply of Benzo (in any order),
4 = Doctor and/or Pharmacy Shopping: > three (3) prescribers OR > three (3) pharmacies writing/filling claims for any controlled substance in the past sixty (60) days,
5 = Use of a Controlled Substance with a History of Dependence, Abuse, or Poisoning/Overdose: Any use of a controlled substance in the past sixty (60) days with at least two (2) occurrences of a medical claim for controlled Substance Abuse or Dependence in the past three hundred and sixty-five (365) days,

6 = History of Substance Use, Abuse or Dependence or Poisoning/Overdose: Any member with a diagnosis of substance use, substance abuse, or substance dependence on any new claim in any setting (e.g., ED, pharmacy, inpatient, outpatient, etc.) within the past sixty (60) days.*
**No prior claims in the previous 2 months or 60-day time frame*

Figure 27: Total Members Locked-In to Prescribing Practitioner



Appeals and Grievances

The managed care health plans and the BHSA are to report the total number of appeals submitted by a provider on behalf of a member as well as appeals submitted by a member. The appeals that are unresolved will show in the Ending Balance and will be reported on the following month.

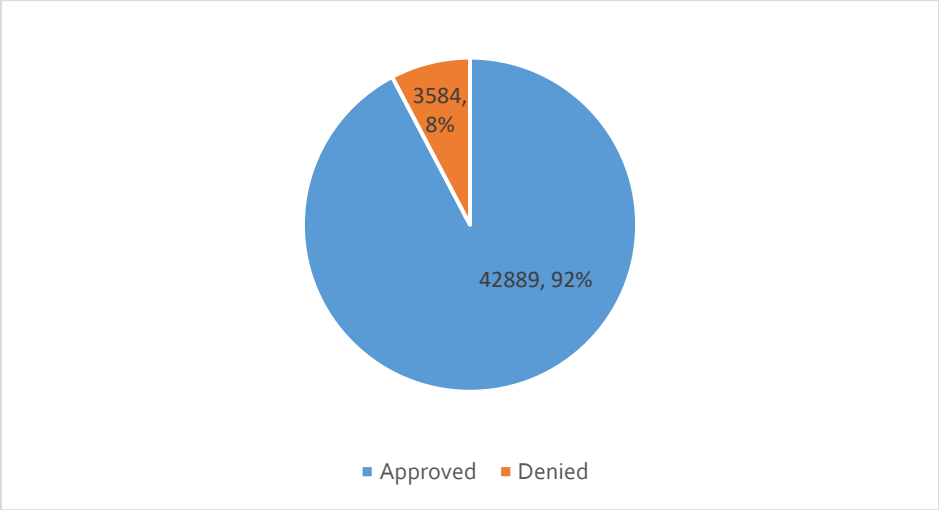
Figure 28: ARTS Appeals by Provider and Member

ARTS Appeals by Provider	**# Opened**	**123**
	# Closed	90
	Ending Balance	33
ARTS Appeals by Member	# Opened	116
	# Closed	109
	Ending Balance	7

ARTS Service Authorizations and Registrations

The managed care health plans and the BHSA are required to report on all ASAM Level Service Authorizations, Registrations (for Substance Use Case Management and Substance Abuse Peer Support only) that were approved / denied / pended during the previous calendar month.

Figure 29: Total Number of Service Authorizations and Registrations



MCO Call Center Statistics

This report includes only calls related to ARTS (any substance use disorder related call). "Calls Abandoned" are the number of calls where the caller disconnects while on hold waiting for an agent.

Figure 30: ARTS Provider and Member Call Totals

ARTS Member Calls	**# of Calls**		**7,099**
	# Abandoned		348
	% Abandoned	5% or less	4.9%
ARTS Provider Calls	**# of Calls**		**9,749**
	# Abandoned		189
	% Abandoned	5% or less	1.9%
Total Calls	**# of Calls**		**16,848**
	# Abandoned		537
	% Abandoned	5% or less	3.2%

OUTREACH/ INNOVATION ACTIVITIES TO ASSURE ACCESS

DMAS implemented a multi-faceted approach to educate members, various stakeholders, advocates, providers, and health plans about ARTS. In preparation for the development of the enhanced substance use disorder benefit, DMAS compiled a workgroup including the DHP, DBHDS, VDH, managed care organizations (MCOs), stakeholders and providers, to design a transformed model for addiction and recovery treatment which is based on the American Society of Addiction Medicine (ASAM) standards.

In addition, DMAS was in regular communication with Virginia's Executive Branch officials, including the Governor's Office, regarding progress and challenges in developing the program. In addition, efforts were made to inform Virginia's Legislative Branch, the General Assembly, via weekly correspondence. With the approval of the waiver in December 2016, DMAS has continued to provide outreach and education, some independently and some with our stakeholders or business partners.

In partnership with DBHDS and VDH, DMAS provided extensive training for providers and stakeholders on the ARTS benefit as well as best practices in working with individuals with substance use disorders. The trainings that have occurred starting in the beginning prior to ARTS implementation and continued post implementation include:

Figure 31: ARTS Training for Providers and Stakeholders

12 DMAS "ARTS 101" in-person sessions across the Commonwealth

- Over **800** providers attended
- An additional **140** providers attended ARTS webinars

VDH Addiction Disease Management trainings

- Over **750** physicians, nurse practitioners, physician assistants, behavioral health clinicians, and practice administrators attended

DBHDS ASAM patient placement criteria training

- Over **500** providers attended

10 "ARTS provider manual trainings"

- Over **800** providers attended

In 2017, DMAS held four Provider Association stakeholder meetings, which included over 40 provider associations to provide feedback on the program development as well as inform members of the ARTS benefit. DMAS presented on the ARTS benefit at numerous provider association conferences, including: Office of Children's Services /Comprehensive Services Act , Medical Society of Virginia, National Association of Social Workers – Virginia Chapter, Virginia Association of Community Services Boards (CSBs), the CSB Mental Health and Substance Abuse Councils, Virginia Association of Family Physicians, Virginia Association of

Medication Assisted Recovery Programs, Virginia Association of Pharmacy and Virginia and Network of Private Providers. DMAS also participated in several regional behavioral health summit meetings to promote the ARTS program and opportunities for providers to collaborate and expand services.

DMAS held weekly technical assistance conference calls for ARTS providers which started the first week in April 2017. DMAS, the managed care health plan and BHSA representatives held these calls and answered questions from the participants as well as provided updates and announcements as needed. DMAS ceased the ARTS technical assistance calls in the Fall of 2017 due to low participation.

Another avenue for outreach has been the email address for the public to make inquiries about ARTS[17]. DMAS staff monitor this email inbox daily. Most inquiries are from providers and the weekly average is 30 emails. DMAS reminds callers at each provider call and presentation conducted that this email address is for providers and members. DMAS has notified the public through public notices to use the email box to make recommendations about the project and to suggest outreach strategies as well.

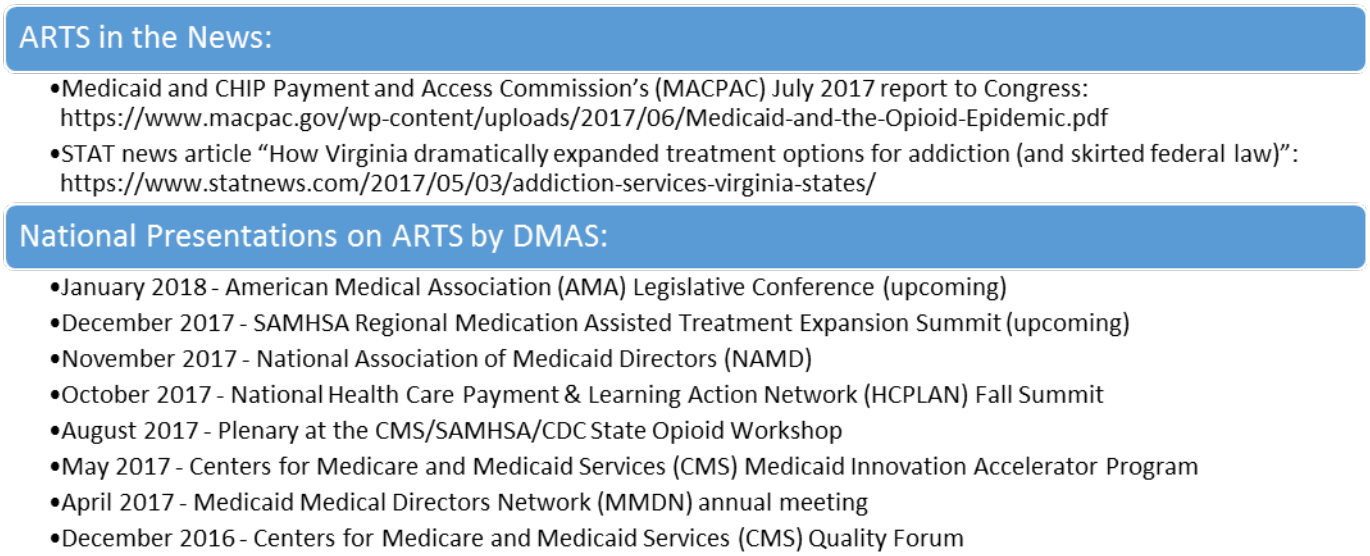
An additional approach has been the DMAS-established ARTS webpage on the DMAS website[18]. The webpage includes specific sections for providers and other stakeholders as well as upcoming trainings, credentialing information, posting of the demonstration waiver and Special Terms and Conditions, as well as other helpful information.

Figure 32: ARTS Website

DMAS staff has also received national recognition of the ARTS program. Below is a summary for this reporting period:

[17] Email address for the public to make inquiries about ARTS: SUD@dmas.virginia.gov
[18] ARTS webpage on the DMAS website: http://www.dmas.virginia.gov/Content_Pgs/bh-home.aspx

Figure 33: ARTS National Recognition Summary



In November of 2017, DMAS implemented the Redcap Survey for the Preferred Office Based Opioid Treatment (OBOT). This tool allows OBOT providers real time access to update their clinic's availability information and to add or remove staff from their provider roster. The REDCap tool is in two sections. The first section, Demographics, gathers information such as intake phone numbers, number of open "slots" for new patients, and appointment wait time for new patients. The second section, add/remove providers, gathers information on all Buprenorphine waivered and Licensed Behavioral Health Care providers. OBOTs may add new providers to their roster as well as remove those providers no longer associated with the facility.

Once an OBOT completes the Redcap survey, DMAS tabulates the findings and shares with the Medicaid Health Care Plans. The Demographics and Capacity report is for use by Addiction Recovery Treatment Services (ARTS) Care Coordinators with the individual health plans to identify available treatment sites and to facilitate member access to care. The Pharmacy Managers with the individual health plans should use the Provider Data report, with their PBM or claims processor, to manage PUMS lock-in groups. The provider report allows health plans to update information so unnecessary service authorizations are not required of Buprenorphine Waivered Providers practicing in OBOT facilities.

COLLECTION AND VERIFICATION OF UTILIZATION AND ENROLLMENT DATA

DMAS requires the managed care health plans and the BHSA to submit monthly deliverables, including comprehensive quality control procedures. All deliverable submissions must conform to the specifications documented in the DMAS ARTS Technical Manual, including all documented formatting requirements. It is the DMAS contracted health plans' and BHSA's responsibility to comply with these specifications. See Monthly Deliverables Section of this Report.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix B of this Report, an updated budget neutrality workbook for the 2017 year that includes established baseline and member months data that meets all the reporting requirements for monitoring budget neutrality.

CONSUMER ISSUES

DMAS implemented the Preferred OBOT model for members to receive evidence-based Medication Assisted Treatment with medication, counseling and psychosocial supports that result with best outcomes in recovery. Despite the efforts of the Preferred OBOTs, which are accepting new patients, hundreds of consumers continued to see out-of-network providers while the managed care health plans paid for the buprenorphine products. Many of the low-income consumers were not receiving the counseling or care coordination and were paying cash for the clinics to see the practitioner. The managed care health plans, in an effort to transition members to higher quality care, began denying coverage of the buprenorphine prescriptions prescribed by out-of-network providers beginning November 2017. This resulted in numerous provider concerns who were out-of-network and several of their patients contacting DMAS and the managed care health plans with concerns of having to transition to an in-network provider. DMAS and the managed care health plans worked with members to get them transitioned to in-network providers. DMAS also worked with the out-of-network providers on steps to become a network provider.

CONTRACTOR REPORTING REQUIREMENTS

DMAS developed revisions of its contract requirements for the managed care health plans and the BHSA, Medicaid state plan, state regulations and DMAS provider manuals, to establish standards of care for ARTS that incorporate industry standard benchmarks from the ASAM Criteria for defining medical necessity criteria, covered services and provider qualifications.

The managed care health plans and the BHSA contracts were modified to incorporate ASAM requirements into provider credentialing and networking, utilization management and service coordination processes to ensure that service provision is reviewed based on the ASAM Criteria and that care coordination structures match the ASAM Criteria. The managed care health plans and the BHSA contracts also added the requirement for dashboard reporting. This reporting period focused on finalizing the credentialing process with ARTS providers licensed within the scope of practice as defined by Virginia state licensure authorities. The managed care health plans and the BHSA continued to utilize, as required by contract, a standardized provider credentialing checklist developed by DMAS for Opiate Treatment Programs (OTPs) and Office Based Opioid Treatment (OBOT) providers, Intensive Outpatient Programs (ASAM Level 2.1), Partial Hospitalization Programs (ASAM Level 2.5) and Residential Treatment Services (ASAM Level 3.1, 3.3, 3.5, and 3.7) that align with the ASAM Criteria. State licensure requirements for Outpatient

Services (ASAM Level 1.0), OTP, Intensive Outpatient (ASAM Level 2.1), and Partial Hospitalization (ASAM Level 2.5) currently align with ASAM Criteria.

DMAS required that each provider of ARTS residential services be assessed to meet the provider competencies and capacities described in the ASAM Criteria for the requisite level or sublevel of care prior to participating in the Virginia Medicaid program under the ARTS demonstration. The following processes will be implemented to verify that ARTS residential treatment service providers deliver care consistent with the ASAM Criteria:

- All DBHDS-licensed residential treatment services will provide a self-attestation to DMAS as comporting with ASAM Level 3.1, 3.3, 3.5 and/or 3.7.
- DMAS will contracted with a vendor, who has extensive expertise in the ASAM Criteria to conduct site visits to verify the self-attestation and certify residential treatment providers as ASAM Level 3.1, 3.3, 3.5 and/or 3.7 programs based on site visits.
- Providers received site visit reports from the vendor verifying that their programs meet ASAM criteria for Level 3.1, 3.3, 3.5, and/or 3.7 that in turn was also shared with the health plans and Magellan of Virginia as a requirement to become credentialed as residential treatment providers.

LESSONS LEARNED

DMAS continues to receive positive feedback from providers and the health plans on the transparency, outreach and willingness to engage feedback for a successful implementation and resolution of any concerns. DMAS posted a third update to the provider manual after receiving additional public comments. This update clarified the documentation requirements for ASAM Levels of Care as well as separated the Opioid Treatment Services into a separate supplement. The supplement addressed care coordination for Opioid Use Disorder and the requirements for documentation and reimbursement. The goal is to make the program information as clear as possible for providers. DMAS learned there was some confusion about the types of licenses need by ASAM Level of Care so worked with DBHDS Office of Licensing to create a document with specific licensing numbers to crosswalk to the ASAM Level of Care.

During this reporting period, DMAS received several claims and networking issues reported by providers. One lesson learned is that more work was needed pre-implementation with the managed care health plans and the BHSA for on-site testing and system readiness reviews to ensure most issues are caught prior to implementation. DMAS relied on self-reports that the systems were tested and functioning appropriately.

DMAS held the weekly technical assistance calls as well as the ARTS stakeholder meetings to allow opportunities for providers, stakeholders and health plans to have opportunities to identify issues and strategize for program improvements. DMAS has learned the value in working with all stakeholders, including the Governor's office, in advocating for the program as this has proved to be both challenging, and yet effective.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS has contracted with an independent evaluation by academic researchers at Virginia Commonwealth University (VCU) to evaluate if the delivery system transformation is effective in improving health outcomes and decreasing health care costs and utilization. The Executive Summary for the first five months of implementation is listed below. The copy of the full report is located in the Exhibits section of this report.

Executive Summary

Virginia implemented the Addiction and Recovery Treatment Services (ARTS) program in April, 2017 to increase access to treatment for Medicaid members with opioid or other substance use disorders. The Department of Medical Assistance Services contracted with Virginia Commonwealth University School of Medicine to conduct an independent evaluation of the ARTS program.

The objective of this report is to describe changes in substance use disorder treatment utilization, expenditures, and access during the first 5 months of ARTS. The major findings from this report are as follows:

Supply of Treatment Providers

There have been substantial increases in the number of practitioners and facilities providing addiction treatment services to Medicaid members, including residential treatment facilities, opioid treatment programs, and providers authorized to prescribe buprenorphine. The number of outpatient practitioners billing for ARTS services more than doubled.

Gaps in access to some service providers – especially residential facilities and Office-Based Opioid Treatment clinics – remain in some areas of the state, including the Far Southwest and other rural areas.

Increased Spending and Utilization on Addiction Treatment Services

During the first five months of the ARTS program, almost 14,000 Medicaid members used addiction-related services, a 40 percent increase from the year before.

Spending on paid claims for addiction-related services amounted to almost $10 million during the first five months of ARTS, a 32 percent increase from the prior year.

Treatment rates for members with substance use or opioid use disorders increased by more than 50 percent. Treatment rates are higher for those with an opioid use disorder diagnosis (51 percent) than for those with alcohol use disorders (28 percent).

ARTS added coverage for residential treatment and medically managed intensive inpatient services for substance use disorders, although outpatient treatment is by far the most frequently used service.

The use of buprenorphine to treat opioid use disorders increased substantially during the first five months of ARTS, although many members using buprenorphine do not have any opioid use disorder diagnosis and are not getting other services consistent with professional guidelines.

Decreased Hospital Emergency Department Use Related to Substance Use Disorders

The number of emergency department visits related to substance use disorders decreased by 31 percent during the first five months of ARTS while the number of members with a visit decreased by 14 percent.

Total spending on emergency department visits related to substance use declined by 14 percent to about $16 million during the first 5 months of ARTS.

Decreased Prescribing for Opioid Pain Medications

The number of prescriptions for opioid pain medications among Medicaid members decreased by 28 percent during the first five months of ARTS, while the number of prescriptions for non-opioid pain relievers increased by 2 percent.

Regional Variation

Spending on services related to substance use disorder treatment increased the most in the Southside region (77 percent), and increased the least in the Northern region (six percent).

The Far Southwest includes 52 percent of all buprenorphine prescriptions in the state despite having only eight percent of Medicaid members. Yet, buprenorphine users in the Far Southwest are much less likely to be receiving other treatment services compared to buprenorphine users in other parts of the state.

Emergency department visits and opioid prescribing rates are highest in the Far Southwest region, and lowest in the Northern region.

Despite much lower increases in spending on substance use disorder treatment, Northern Virginia had the largest decrease in emergency department visits compared to other Virginia regions.

Workforce Development and New Models of Care Delivery

Addiction disease management training sessions sponsored by the Virginia Department of Health led to increases in the provision of addiction treatment services after six months among those who attended the training, as well as improved prescribing patterns for controlled substances.

New care delivery models through ARTS, especially the Office-Based Opioid Treatment program, seek to improve the quality and effectiveness of addiction treatment services, although utilization of such clinics has been low compared to other outpatient providers.

CONCLUSION

DMAS successfully implemented the ARTS program. During the first eight months of implementation, DMAS continued to work with providers, managed care health plans and the BHSA to work through identified issues and helping to foster the lines of communication between the providers and the health plans. DMAS continues to monitor and review the ARTS Network and working with stakeholders to increase access to areas in need of providers.

FFCY

BACKGROUND

Youth in foster care face a number of issues when they are released from state custody, not the least of which is access to health care. The Former Foster Care Medicaid eligibility group provides an opportunity for this population to continue receiving full Medicaid coverage until age 26, which gives these youth time to transition into managing the responsibilities of living independently.

On March 23, 2010, the Affordable Care Act (ACA) was signed into law, making a number of changes to Medicaid eligibility effective January 1, 2014. To further the overall goal of expanding health coverage, the ACA included section 2004, which added a new mandatory Medicaid eligibility group at section 1902(a)(10)(A)(i)(IX) of the Act to provide an opportunity for former foster care youth to obtain Medicaid coverage until age 26 from the state responsible for the individual's foster care. DMAS initially received approval from CMS to cover former foster care youth who received their foster care and Medicaid in Virginia as well as youth who received their foster care and Medicaid from another state but who are now living in Virginia.

In November 2016, CMS notified states that they could no longer cover the former foster care youth who received their services from another state but are now living in Virginia under the Medicaid state plan authority. States who wished to continue coverage for this population could do so under a Medicaid Section 1115 Demonstration waiver.

In May 2017, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to former foster care youth who were enrolled in Medicaid and foster care in another state and who are now living in Virginia and are applying for Virginia Medicaid. Approval of the waiver amendment was received on September 22, 2017. DMAS staff are currently identifying next steps to ensure continued enrollment and improved health outcomes for these individuals.

GOALS

Virginia's overall goal for the FFCY benefit is to serve foster care youth with the access to health services they need, through amending the GAP Demonstration Waiver.

The goals of the former foster care youth demonstrations are twofold:

- Increase and strengthen coverage of former foster care youth who were in Medicaid and foster care in a different state; and
- Improve health outcomes for these youth.

ELIGIBILITY AND BENEFIT INFORMATION

Individuals eligible in this demonstration group are those former foster care youth who: (1) were in the custody of another state or American Indian tribe, (2) were receiving foster care and Medicaid services until discharge from foster care upon turning age 18 or older, (3) are not eligible in a mandatory Medicaid coverage group, and (4) are under the age of 26.

Former Foster Care youth receive the full Medicaid benefit package, including long-term supports and services, if medically necessary.

ENROLLMENT COUNTS FOR YEAR TO DATE

The state provides, as Appendix B of this Report, enrollment counts for FFCY members for the 2017 year. As of December 2017, there were 86 FFCY members.

OPERATIONAL UPDATES

The waiver amendment to add the former foster care youth from out of state was approved in September 2017. Since approval, there have been no policy or administrative difficulties in operation for this piece of the demonstration waiver. There have been no challenges or issues.

PERFORMANCE METRICS

While no evaluation has been completed since the demonstration was approved in September 2017, it is anticipated that providing coverage to this population will lead to better health outcomes and increased access to care. There have been no appeals filed to-date related to this population.

OUTREACH/ INNOVATION ACTIVITIES TO ASSURE ACCESS

No formal outreach activities have been completed to date for this population. Advocacy organizations who work with this population have indicated that they currently stress the importance of enrolling in coverage for both youth who received their foster care and Medicaid from another state as well as those who received their services in Virginia prior to aging out of foster care. CMS has confirmed that DMAS is not required to develop an outreach plan for the FFCY component of the waiver.

COLLECTION AND VERIFICATION OF UTILIZATION AND ENROLLMENT DATA

This waiver amendment was approved in September 2017. Due to the relatively short time between amendment approval and end of this demonstration year, there has been no verification of utilization and enrollment data.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix B of this Report, an updated budget neutrality workbook for the 2017 year that includes established baseline and member month's data that meets all the reporting requirements for monitoring budget neutrality.

CONSUMER ISSUES

Benefits are provided through the state's fee for service and managed care delivery systems. No complaints or issues have been identified to date.

CONTRACTOR REPORTING REQUIREMENTS

No contracts needed to be amended when the Former Foster Care Youth component was added to this waiver. These youth were previously covered under the Medicaid State Plan; therefore, no changes needed to be made when the waiver was approved.

RECOVERY NAVIGATORS

The Former Foster Care Youth component of this waiver does not utilize Recovery Navigators.

LESSONS LEARNED

This demonstration was approved in September 2017. There is nothing to report at this time.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

The Evaluation plan is being developed at this time. No evaluation activities have taken place and there are no interim findings.

CONCLUSION

The demonstration was implemented as a measure to continue Medicaid coverage for former foster care youth who received their services in another state but who are now living in Virginia. This group was formerly covered in Virginia under the State Plan. The change in the authority mechanism did not necessitate any changes to how these the application process for these individuals or how they receive Medicaid coverage. Because the approval of the amendment to the demonstration waiver was granted less than six months ago, evaluation activities are still in the development stage. However, it is anticipated that utilization and enrollment data will support that the goals of improved health outcomes and increased access to care are being met for this population.

ENCLOSURES

Appendix A – GAP Outreach Chart
Appendix B – GAP, ARTS, and FFCY Budget Neutrality Reports for Demonstration Year 3
ARTS VCU Evaluation First Five Months
Reference Cited

STATE CONTACT(S)

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GAP
Bridging the Mental Health Coverage Gap in Virginia

ARTS
Addiction and Recovery Treatment Services

FFCY
Former Foster Care Youth

Appendix A – GAP Outreach Chart

DATE	EVENT	AUDIENCE	ITEM	FOCUS: GAP	FOCUS: Recovery Navigators	#ATTENDED	COMMENTS	PRESENTER
1/23/2017	Stand Down Event	Low Income Veterans	GAP Flyer	Yes	No	Unknown	Disseminated GAP flyers to the Dept. of Veterans Affairs to share at their Stand Down event in Washington D.C.	DMAS Staff
2/1/2017	Department of Corrections	Department of Corrections staff	GAP Flyer	Yes	Yes	8	Presented regarding GAP, application process, and overall benefit package.	Magellan Staff
2/2/2017	Resource	Library in Roanoke	GAP Flyer	Yes	Yes	Unknown	Posted flyers on a resource bulletin board	Magellan Staff
2/28/2017	Jail Outreach	Returning citizens in re-entry program	GAP Flyer	Yes	Yes	10	Spoke to a group of inmates in a reentry program to offer information about GAP and Recovery Navigation and warm line resources.	Magellan Staff
3/3/2017	NAMI Virginia e-Newsletter	NAMI VA	Announcement	Yes	No	Approx. 4300	Announced the Final 2017 legislative updated that included the GAP FPL increase to 100%	NAMI VA Staff
3/7/2017	Email	Virginia Hospital & Healthcare Association	Website link and documents	Yes	No	Unknown	Shared GAP information with the Virginia Hospital and Healthcare Association	DMAS Staff

3/10/2017	SMI Screener and Application Training	VADOC Officials	Training presentation	Yes	No	90	Trained VADOC Mental Health staff on how to conduct and submit GAP SMI screenings and applications for returning citizens	DMAS, Cover VA, and Magellan Staff
3/15/2017	Meeting with Chesterfield County Sheriff's Office	Chesterfield County Sherriff's Office	GAP information	Yes	Yes	1	Discussed conducting GAP screenings and applications at the Chesterfield County Jail	DMAS and Magellan Staff
3/29/2017	Department of Corrections	Department of Corrections	GAP Flyer	Yes	Yes	7	Provided information about application progress, benefit package, warm line, Recovery Navigation, and support.	Magellan Staff
7/6/2017	Training	MCO Health Plans	Peer Supports	Yes	Yes	50	DMAS presentation for MCO plans regarding peer services. Magellan System of Care Director and Recovery Navigator highlighted the benefit of having peers involved in the GAP program and shared a success story. Magellan Recovery Navigator shared his lived experience, the importance of peer supports, and key aspects of his work as a peer in the field.	DMAS Staff, Magellan Systems of Care Director, Magellan Recovery Navigator
7/19/2017	Training	Magellan Clinical staff	GAP	Yes		30	DMAS Staff, Magellan Systems of Care	Magellan Senior Trainer

							Director, Magellan Recovery Navigator	
7/26/2017	E blast Communication	DMAS	GAP	Yes		40 CSB's	DMAS drafted a communication to be sent to the entire Virginia Community Services Board Stakeholder Group for dissemination as a reminder about the GAP screening and submission process.	DMAS Staff
7/27/2017	Conference Call	DBHDS	GAP	Yes	No	2	DMAS led a conference call with Department of Behavioral Health and Developmental Services Jail Diversion Program Coordinator and Forensic Mental Health Consultant regarding survey she is leading with Community Service Board, Consumer Driven Agencies, Parole, Jails and Dept. of Corrections. DBHDS staff reviewed sharing the survey results with GAP staff to evaluate barriers, gaps, current discharge processes, and reentry.	DMAS staff, DBHDS staff
8/3/2017	In person presentation	Incarcerated Individuals	GAP	Yes	Yes	10	Spoke to a group of inmates in a re-entry	Magellan Staff

							program who are about to be released Presented information about applying for GAP and covered Recovery Navigation & Warmline.	
8/17/2017	Conference Presentation	Homeless service providers, nonprofit agencies, community services board, preferred pathway providers	GAP	Yes	Yes	35	DMAS staff presented information regarding GAP overview, covered services, Peer Supports, upcoming changes to FPL increase and the addition of ARTS services for GAP members.	DMAS Staff; Magellan Recovery Navigator
8/22/2017	Governor McAuliffe's Reentry Resource Fair	Individuals newly released from incarceration	GAP	Yes		100	DMAS staff spoke with individuals in the Metro Richmond area who have been released from incarceration and are looking for resources to assist with transition back into the community. Staff discussed GAP overview and provided outreach and educational flyers.	DMAS Staff
8/23/2017	Webinar	Enroll VA eligibility staff	GAP	Yes	Yes	10	DMAS staff presented information regarding GAP overview, covered	DMAS Staff

							services, Peer Supports, upcoming changes to FPL increase and the addition of ARTS services for GAP members. DMAS staff reviewed application process for GAP.	
9/5/2017	Training	Piedmont Access to Health Services (FQHC)	GAP	Yes		10	DMAS staff provided outreach and educational materials to FQHC staff regarding GAP overview, covered services, application process, and key aspects of the process.	DMAS Staff
9/7/2017	Training	Central Virginia Health Services (FQHC)	GAP	Yes	Yes	6	DMAS Staff met with clinical team at Central Virginia Health Services, which has 15 site locations across Virginia. Reviewed the SMI application process and barriers to timely screenings for their locality.	DMAS Staff
9/12/2017	Meeting	Magellan Clinical Staff	GAP	Yes		4	DMAS staff met with Magellan Clinical Management regarding coordination of care, barriers, and recovery	DMAS Staff

							navigation and reviewed importance of care coordination.	
9/21/2017	Presentation	Hospitals, Health Care Systems Administrators	GAP/ARTS	Yes	Yes	25	DMAS Staff presented on CCC Plus, GAP, and ARTS updates. DMAS staff focused on GAP overview	DMAS Staff
10/21/2017	NAMI Walk	Providers, members, potential members, community	GAP	Yes		500	Staffed a presentation booth with GAP information regarding eligibility, enrollment, benefits, and resources.	DMAS
10/26/2017	Dept. of Corrections Deep Meadow Facility	Incarcerated members	GAP	Yes		100	Resource Fair for incarcerated members and vendors to provide helpful information to make transition successful. Magellan Recovery Navigator attended and had 35 individuals request follow up information about GAP.	Magellan
10/27/2017	Region 10 Consumer Advocacy Council	Region 10 Members and Case Managers	GAP	Yes	Yes	100	Resource Fair for to provide helpful information to make transition successful. Magellan Recovery Navigator attended and had 35 individuals request	Magellan

							follow up information about GAP.	
10/30/2017	VCU Psychology Class	Undergraduate students	GAP	Yes	Yes	30	Provided overview of GAP, history, enrollment and current statistics on demographics, diagnosis, and geographic region of members. Discussed covered benefits, Peer Supports, and Recovery Navigation	DMAS
11/1/2017	Horizon Behavioral Health CSB	Crisis Stabilization Unit and Detox Treatment Team	GAP	Yes	Yes	16	Presented to treatment teams to give details about Recovery Navigation to better their understanding of the service and increase collaboration in connecting with GAP member enrolled in their services.	Magellan
11/10/2017	Dept. of Corrections Resource Event	Incarcerated Individuals at Deep Meadow Correctional Facility	GAP	Yes	Yes	50	Recovery Navigators shared information about transition back to the community, GAP application process and benefits, and warm line.	Magellan
11/14/2017	Eleventh Annual Greater Richmond Project Homeless Connect	Homeless Individuals	GAP	Yes	Yes	500	Staffed a presentation booth with GAP information regarding eligibility,	DMAS, Magellan

							enrollment, benefits, and resources.	
11/15-16/2017	VAPRA Conference	Individuals in recovery and providers	GAP	Yes	Yes	150	Staffed a presentation booth with GAP information regarding eligibility, enrollment, benefits, and resources	DMAS, Magellan
11/15-16/2017	Louisa County Reentry	Individuals	GAP	Yes	Yes	15	Presented GAP information regarding eligibility, enrollment, benefits, and resources.	Magellan
12/5/2017	New Life Church for Celebrate Recovery	Individuals	GAP	Yes	Yes	20	Presented GAP information regarding eligibility, enrollment, benefits, and resources.	Magellan
12/7/2017	Central Virginia Regional Jail resource fair	Incarcerated Individuals at Central Virginia Regional Jail	GAP	Yes	Yes	45	Staffed a presentation booth with GAP information regarding eligibility, enrollment, benefits, and resources	Magellan

Appendix B – GAP, ARTS, and FFCY Budget Neutrality Reports for Demonstration Year 3

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00 (CY14)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01 (CY 15)	DY 02 (CY16)	DY 03 (CY 17)	DY 04 (CY18)	DY 05 (CY19)	TOTAL WOW
Non-LTC Disabled Adults with SMI										
Pop Type:	**Medicaid**									
Eligible Member Months	4.9%	6	1,008,513	4.9%	953,344	943,384	1,107,365	1,161,072	1,217,384	
PMPM Cost	4.6%	6	$1,731.41	4.6%	$1,969.68	$2,103.43	$2,104.05	$2,200.84	$2,302.08	
Total Expenditure			$1,746,150,082		$ 1,877,781,807	$ 1,984,339,966	$ 2,329,955,835	$ 2,555,334,146	$ 2,802,515,829	$ 11,549,927,583

Without the proposed 1115 Demonstration waiver, individuals who would otherwise be served through the GAP program are assumed to progress further along the mental illness spectrum and obtain a disability determination, thereby qualifying for full-Medicaid benefits under current Virginia eligibility levels.

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00 (CY14)	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01 (CY 15)	DY 02 (CY16)	DY 03 (CY 17)	DY 04 (CY18)	DY 05 (CY19)	TOTAL WOW
SUD Waiver Services Recipients										
Pop Type:	**Medicaid**									
Eligible Member Months					-	-	220	879	922	
PMPM Cost					$ -	$ -	$ 2,529.58	$ 2,656.06	$ 2,788.86	
Total Expenditure					$ -	$ -	$ 556,507	$ 2,334,675	$ 2,571,330	$ 5,462,512
										$ 11,555,390,095

The proposed 1115 waiver assumes hypothetical costs equal to the projected costs of the waiver. That is, in the absence of this demonstration, costs equal to the projected PMPM would have been incurred.

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS								
			DEMONSTRATION YEARS (DY)					TOTAL WW
ELIGIBILITY GROUP	DY 00 (CY 14)	DEMO TREND RATE	DY 01 (CY 15)	DY 02 (CY 16)	DY 03 (CY 17)	DY 04 (CY 18)	DY 05 (CY 19)	
Pop Type:	**Medicaid**		**Non-LTC Disabled Adults with SMI**					
Eligible Member Months	1,008,513	4.9%	916,442	850,698	968,760	971,771	1,008,252	
PMPM Cost	$ 1,731.41	4.6%	$ 1,969.68	$ 2,103.43	$ 2,104.05	$ 2,200.84	$ 2,302.08	
Total Expenditure	$ 1,746,150,082		$ 1,805,096,706	$ 1,789,381,674	$ 2,038,323,421	$ 2,138,712,200	$ 2,321,076,467	**$ 10,092,590,467**

With the proposed 1115 Demonstration waiver, individuals served through the GAP program are assumed to be diverted from obtaining a disability determination and thereby qualifying for full-Medicaid benefits under current Virginia eligibility levels.

			DY 01 (CY 15)	DY 02 (CY 16)	DY 03 (CY 17)	DY 04 (CY 18)	DY 05 (CY 19)	
Pop Type:	**Expansion**		**GAP Population**					
Eligible Member Months	-		36,902	92,686	138,605	189,301	209,132	
PMPM Cost	$ 650.00	3.70%	$ 416.05	$ 430.22	$ 394.70	$ 417.82	$ 433.28	
Total Expenditure	$ -		$ 15,353,077	$ 39,875,371	$ 54,707,937	$ 79,094,364	$ 90,613,270	**$ 279,644,020**

The 1115 Demonstration waiver initially provided a limited coverage benefit to individuals with severe mental illness at or below 60% FPL and has been amended to include those at or below 100% FPL. Actual costs of GAP members were used as the DY 01 through DY 03 costs for this population.

Former Foster Care Transfers from Out of State									
Pop Type:	**Expansion**								
Eligible Member Months		2.1%	56	91	813	830	847		
PMPM Cost	$ 261.29	5.00%	$ 430.34	$ 462.90	$ 484.07	$ 508.28	$ 533.69		
Total Expenditure	$ -		$ 24,099	$ 42,124	$ 393,551	$ 421,869	$ 452,035	**$**	**1,333,678**

In Demonstration Year 03 (CY2017) DMAS changed methodology for identifying the Former Foster Care Transfers from Out of State. DMAS includes those in the eligibility aid category for former foster care recipients who had no enrollment as a foster care child or as a Medicaid or CHIP child before their 19th birthday.

SUD Waiver Services Recipients									
Pop Type:	**Expansion**								
Member Count			-	-	220	879	922		
PMPM Cost	$ 6,709.50	5.00%	$ -	$ -	$ 2,529.58	$ 2,656.06	$ 2,788.86		
Expenditure			$ -	$ -	$ 556,507	$ 2,334,675	$ 2,571,330	**$**	**5,462,512**
								$	**10,379,030,677**	**TOTAL WW COSTS**

Residential Treatment for Adults with Substance Abuse Disorder provided by facilities with 16+ beds is paid through both fee-for-service and managed care. DMAS calculates the expenditures with actual fee-for-service payments plus an estimated PMPM times the number of member months of recipients in managed care. Because there were only 4 fee-for-service member months in the calendar year, DMAS included another 3 payments made in January of 2018 to get a more accurate estimate of the PMPM to apply to the managed care member months.

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01 (CY 15)	DY 02 (CY 16)	DY 03 (CY 17)	DY 04 (CY 18)	DY 05 (CY 19)	
Medicaid Populations						
Non-LTC Disabled Adults with SMI	$ 1,877,781,807	$ 1,984,339,966	$ 2,329,955,835	$ 2,555,334,146	$ 2,802,515,829	$ 11,549,927,583
Medicaid Populations						
SUD Waiver Services Recipients	$ -	$ -	$ 556,507	$ 2,334,675	$ 2,571,330	$ 5,462,512
TOTAL	$ 1,877,781,807	$ 1,984,339,966	$ 2,330,512,342	$ 2,557,668,821	$ 2,805,087,159	**$ 11,555,390,095**

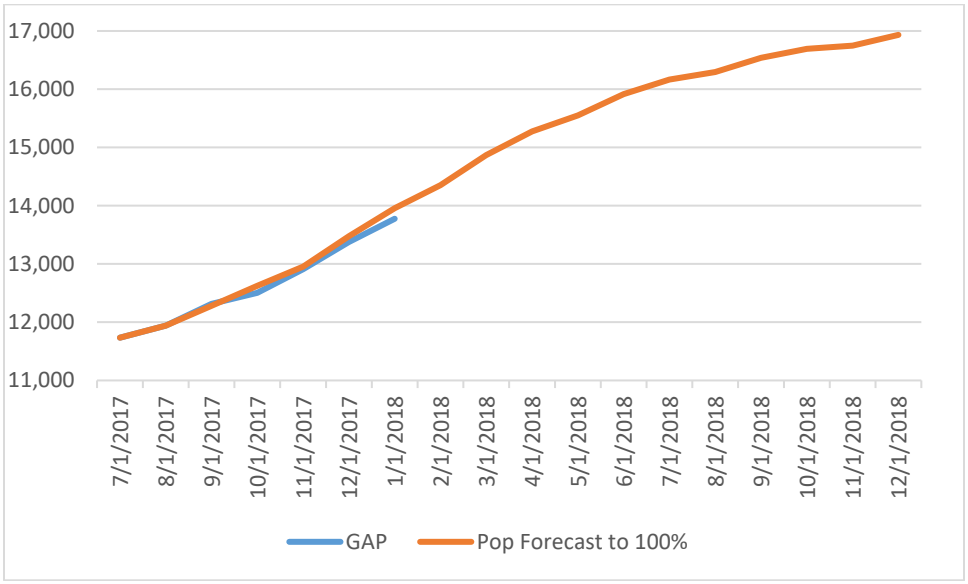
With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01 (CY 15)	DY 02 (CY 16)	DY 03 (CY 17)	DY 04 (CY 18)	DY 05 (CY 19)	
Medicaid Populations						
Non-LTC Disabled Adults with SMI	$ 1,805,096,706	$ 1,789,381,674	$ 2,038,323,421	$ 2,138,712,200	$ 2,321,076,467	$ 10,092,590,467
Expansion Populations						
GAP Population	$ 15,353,077	$ 39,875,371	$ 54,707,937	$ 79,094,364	$ 90,613,270	$ 279,644,020
Expansion Popoulations						
Former Foster Care Transfers from Out of State	$ 24,099	$ 42,124	$ 393,551	$ 421,869	$ 452,035	$ 1,333,678
Expansion Popoulations						
SUD Waiver Services Recipients	$ -	$ -	$ 556,507	$ 2,334,675	$ 2,571,330	$ 5,462,512
TOTAL	$ 1,820,473,882	$ 1,829,299,168	$ 2,093,981,416	$ 2,220,563,108	$ 2,414,713,102	**$ 10,379,030,677**
VARIANCE	$ 57,307,924	$ 155,040,798	$ 236,530,926	$ 337,105,713	$ 390,374,057	**$ 1,176,359,418**

GAP TRACKING PROJECTIONS

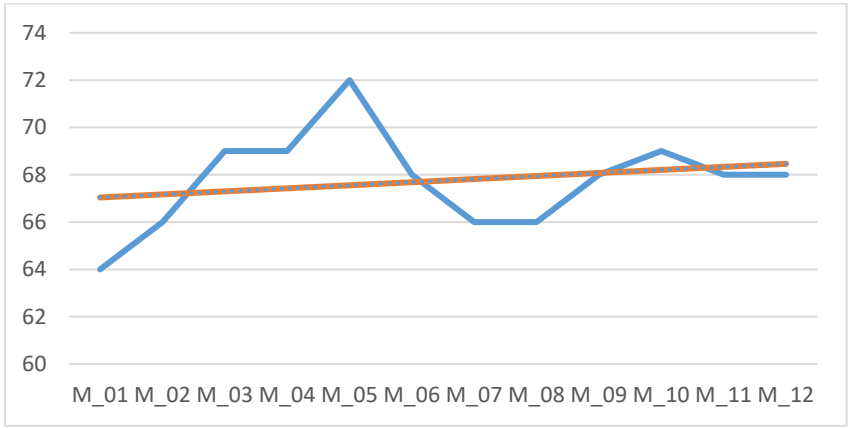
		Program																
SortMth	Month	45608	45609	49601	Month Total	POP	Medical	Admin	Total	PMPM	Payment Weeks	Weighted Exp	Weighted PMPM				GAP	Pop Forecast to 100%
7	January 2017	$622,049	$2,482,114	$127,621	$3,231,784	9,947	$3,104,162	$127,621	$3,231,784	$324.90	4	$3,501,099	$351.98			7/1/2016	7,991	7,991	
8	February 2017	$666,260	$3,086,467	$131,619	$3,884,346	10,086	$3,752,728	$131,619	$3,884,346	$385.12	4	$4,208,042	$417.22			8/1/2016	8,265	8,265	
9	March 2017	$815,877	$3,782,935	$149,804	$4,748,615	10,467	$4,598,811	$149,804	$4,748,615	$453.67	5	$4,115,467	$393.18			9/1/2016	8,780	8,780	
	Quarter Total	$2,104,185	$9,351,516	$409,044	$11,864,745	30,500	$11,455,701	$409,044	$11,864,745	$389.01	13	$11,864,745	$389.01			10/1/2016	9,059	9,059	
10	April 2017	$705,886	$3,021,734	$145,615	$3,873,235	10,821	$3,727,620	$145,615	$3,873,235	$357.94	4	$4,196,004	$387.76			11/1/2016	9,362	9,362	
11	May 2017	$750,000	$3,337,168	$147,153	$4,234,321	11,077	$4,087,168	$147,153	$4,234,321	$382.26	4	$4,587,181	$414.12			12/1/2016	9,734	9,734	
12	June 2017	$802,177	$3,232,118	$155,603	$4,189,898	11,425	$4,034,294	$155,603	$4,189,898	$366.73	4	$4,539,056	$397.29			1/1/2017	9,947	9,947	
	Quarter Total	$2,258,063	$9,591,020	$448,371	$12,297,454	33,323	$11,849,082	$448,371	$12,297,454	$369.04	12	$13,322,241	$399.79			2/1/2017	10,086	10,086	
1	July 2017	$877,196	$4,083,100	$161,548	$5,121,844	11,734	$4,960,296	$161,548	$5,121,844	$436.50	5	$4,438,931	$378.30			3/1/2017	10,467	10,467	
2	August 2017	$740,795	$3,377,316	$147,006	$4,265,117	11,940	$4,118,111	$147,006	$4,265,117	$357.21	4	$4,620,543	$386.98			4/1/2017	10,821	10,821	
3	September 2017	$1,244,060	$4,087,406	$169,969	$5,501,436	12,314	$5,331,466	$169,969	$5,501,436	$446.76	5	$4,767,911	$387.19			5/1/2017	11,077	11,077	
	Quarter Total	$2,862,052	$11,547,822	$478,523	$14,888,397	35,988	$14,409,874	$478,523	$14,888,397	$413.70	14	$13,824,940	$384.15			6/1/2017	11,425	11,425	
4	October 2017	$876,425	$3,588,479	$157,733	$4,622,637	12,505	$4,464,904	$157,733	$4,622,637	$369.66	4	$5,007,856	$400.47			7/1/2017	11,734	11,734	
5	November 2017	$822,232	$3,991,868	$168,684	$4,982,785	12,911	$4,814,101	$168,684	$4,982,785	$385.93	4	$5,398,017	$418.09			8/1/2017	11,940	11,940	
6	December 2017	$990,620	$4,868,668	$192,633	$6,051,920	13,378	$5,859,288	$192,633	$6,051,920	$452.38	5	$5,244,997	$392.06			9/1/2017	12,314	12,280	
	Quarter Total	$2,689,278	$12,449,015	$519,049	$15,657,342	38,794	$15,138,292	$519,049	$15,657,342	$403.60	13	$15,657,342	$403.60			10/1/2017	12,505	12,626	
																11/1/2017	12,911	12,954	
																12/1/2017	13,378	13,475	
																1/1/2018	13,776	13,956	
																2/1/2018		14,354	
																3/1/2018		14,869	
																4/1/2018		15,277	
																5/1/2018		15,551	
																6/1/2018		15,916	
																7/1/2018		16,167	
																8/1/2018		16,296	
																9/1/2018		16,539	
																10/1/2018		16,693	
																11/1/2018		16,749	
																12/1/2018		16,933	189,301
																1/1/2019		17,042	
																2/1/2019		17,057	
																3/1/2019		17,206	
																4/1/2019		17,281	
																5/1/2019		17,283	
																6/1/2019		17,419	
																7/1/2019		17,480	
																8/1/2019		17,480	
																9/1/2019		17,626	
																10/1/2019		17,697	
																11/1/2019		17,708	
																12/1/2019		17,853	209,132

GAP TRACKING PROJECTIONS (CONT.)



FFCY TRACKING PROJECTIONS

	From GAP Waiver Former Foster Care.sas								67.03826
									0.129404
		Member Months	Yearly Total	Month	EXPENDITURES	PMPM	Yearly Total	Yearly PMPM	
	M_01	64		2017-01	$38,663.68	$604.12			67.03826
	M_02	66		2017-02	$29,734.10	$450.52			67.16766
	M_03	69		2017-03	$30,984.60	$449.05			67.29707
	M_04	69		2017-04	$40,600.26	$588.41			67.42647
	M_05	72		2017-05	$33,853.02	$470.18			67.55587
	M_06	68		2017-06	$30,781.70	$452.67			67.68528
	M_07	66		2017-07	$34,725.54	$526.14			67.81468
	M_08	66		2017-08	$29,155.99	$441.76			67.94408
	M_09	68		2017-09	$32,405.76	$476.56			68.07349
	M_10	69		2017-10	$31,691.49	$459.30			68.20289
	M_11	68		2017-11	$31,074.17	$456.97			68.33229
	M_12	68	813	2017-12	$29,880.56	$439.42	$393,550.87	$484.07	68.4617
									2.1%



RESIDENTIAL SUD 16+ BEDS

							Actual FFS Expenditures											
	Fee For Service																	
	16+_BED_	ELIGCAT	REMIT_MT	SVC_MT	EXPENDS	Members	Total		PMPM									
	N	BD	2017-11	2017-06	$11,805.00	1					With a little more data (January Paid amounts) we can get a better cost per person							
	N	QMBD	2017-12	2017-11	$94.74	1					Y	SMI	2018-01	2017-10	$5,115.50	1		
	Y	LICA	2017-12	2017-11	$2,361.00	1					Y	SMI	2018-01	2017-11	$5,509.00	1		
	Y	SMI	2017-12	2017-11	$4,054.55	3	**$6,416**	4	$1,603.89		Y	SMI	2018-01	2017-12	$787.00	1		**$2,546.72**
																		$4,120.72
	Managed Care																	
	16+_BED_	Reported_ month	Members															
	N	2017-09	2				Estimated											
	N	2017-10	11				PMPM * MCO											
	N	2017-11	11				Recipients											
	N	2017-12	3															
	Y	2017-06	1															
	Y	2017-07	15			Reported												
	Y	2017-08	25			recipients												
	Y	2017-09	43			from												
	Y	2017-10	39			encounters												
	Y	2017-11	61															
	Y	2017-12	32			216	**$550,092**											

DIVISION OF STATE DEMONSTRATION AND WAIVERS (DSDW) BUDGET NEUTRALITY ANALYSIS

Division of State Demonstration and Waivers (DSDW) Budget Neutrality Analysis

	DY 01 January 12, 2015 - December 31, 2015 12 Months	DY 02 January 1, 2016 - December 31, 2016 12 Months	DY 03 January 1, 2017 - December 31, 2017 12 Months	DY 04 January 1, 2018 - December 31, 2018 12 Months	DY 05 January 1, 2019 - December 31, 2019 12 Months	Total
Without Waiver (WOW)	$ 1,877,781,807	$ 1,984,339,966	$ 2,330,512,342	$ 2,557,668,821	$ 2,805,087,159	**$ 11,555,390,095**
With Waivers (WW)	$ 1,820,473,882	$ 1,829,299,168	$ 2,093,981,416	$ 2,220,563,108	$ 2,414,713,102	**$ 10,379,030,677**
WOW minus WW	**$ 57,307,924**	**$ 155,040,798**	**$ 236,530,926**	**$ 337,105,713**	**$ 390,374,057**	**$ 1,176,359,418**

HISTORIC DATA

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Non-LTC Disabled Adults with SMI	SFY 2010	SFY 2011	SFY 2012	SFY 2013	SFY 2014	5-YEARS
TOTAL EXPENDITURES	$ 1,152,815,523	$ 1,327,142,595	$ 1,323,507,206	$ 1,507,211,170	$ 1,667,366,289	$ 6,978,042,782
ELIGIBLE MEMBER MONTHS	814,944	859,896	874,128	945,144	984,912	
PMPM COST	$ 1,414.59	$ 1,543.38	$ 1,514.09	$ 1,594.69	$ 1,692.91	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		15.12%	-0.27%	13.88%	10.63%	9.66%
ELIGIBLE MEMBER MONTHS		5.52%	1.66%	8.12%	4.21%	4.85%
PMPM COST		9.10%	-1.90%	5.32%	6.16%	4.59%

Other Data	HY 1	HY 2	HY 3	HY 4	HY 5	5-YEARS
TOTAL EXPENDITURES	$ 75,403,373	$ 105,400,535	$ 117,311,422	$ 110,121,194	$ 108,883,807	$ 517,120,330
ELIGIBLE MEMBER MONTHS	176,926	207,616	219,846	172,353	167,514	
PMPM COST	$ 426.18	$ 507.67	$ 533.61	$ 638.93	$ 650.00	
TREND RATES						5-YEAR
			ANNUAL CHANGE			AVERAGE
TOTAL EXPENDITURE		39.78%	11.30%	-6.13%	-1.12%	9.62%
ELIGIBLE MEMBER MONTHS		17.35%	5.89%	-21.60%	-2.81%	-1.36%
PMPM COST		19.12%	5.11%	19.74%	1.73%	11.13%

Non-LTC Disabled Adults with SMI

1. Unduplicated individuals were identified using diagnosis set run against FFS and Encounter claims. Recipients with indicators of LTC were excluded.

2. All paid claims (FFS, Capitation) were pulled for identified individuals.

3. In prior years where some claim types were not available, average cost per person for that service was obtained and multiplied by the number of indentified identified in the cohort for the year.

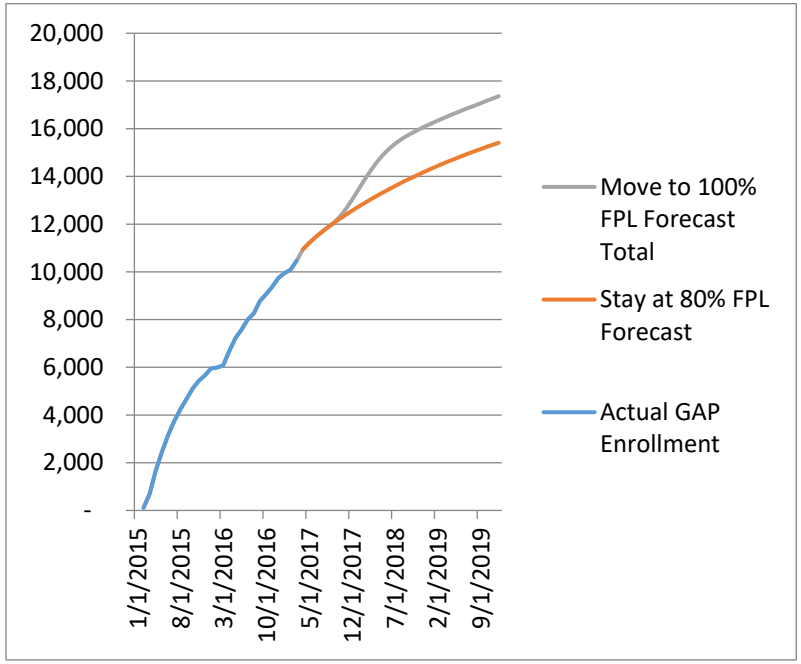
OLD PROJECTIONS

	Actual GAP Enrollment	Stay at 80% FPL Forecast	80% to 100% FPL Forecast	Move to 100% FPL Forecast Total	Cumulative Member Months Per Year					
1/1/2015					-					
2/1/2015	112			112	112					
3/1/2015	696			696	808					
4/1/2015	1671			1,671	2,479					
5/1/2015	2464			2,464	4,943					
6/1/2015	3154			3,154	8,097					
7/1/2015	3734			3,734	11,831					
8/1/2015	4225			4,225	16,056					
9/1/2015	4665			4,665	20,721					
10/1/2015	5103			5,103	25,824					
11/1/2015	5428			5,428	31,252					
12/1/2015	5650			5,650	36,902	36,902	92,686	137,517	180,526	201,650
1/1/2016	5951			5,951	5,951					
2/1/2016	5987			5,987	11,938					
3/1/2016	6073			6,073	18,011					
4/1/2016	6687			6,687	24,698					
5/1/2016	7222			7,222	31,920					
6/1/2016	7575			7,575	39,495					
7/1/2016	7991			7,991	47,486					
8/1/2016	8265			8,265	55,751					
9/1/2016	8780			8,780	64,531					
10/1/2016	9059			9,059	73,590					
11/1/2016	9362			9,362	82,952					
12/1/2016	9734			9,734	92,686	92,686				
1/1/2017	9947			9,947	9,947					
2/1/2017	10086			10,086	20,033					
3/1/2017	10467			10,467	30,500					
4/1/2017		10,934		10,934	41,434					
5/1/2017		11,199		11,199	52,633					
6/1/2017		11,436		11,436	64,069					
7/1/2017		11,650		11,650	75,719					
8/1/2017		11,848		11,848	87,567					
9/1/2017		12,035		12,035	99,603					
10/1/2017		12,214	80	12,294	111,896					
11/1/2017		12,386	235	12,621	124,517					
12/1/2017		12,552	448	13,000	137,517	137,517				

OLD PROJECTIONS (CONT.)

1/1/2018		12,713		696	13,409	13,409			
2/1/2018		12,869		952	13,821	27,230			
3/1/2018		13,021		1,192	14,213	41,442			
4/1/2018		13,168		1,399	14,567	56,010			
5/1/2018		13,311		1,564	14,875	70,885			
6/1/2018		13,451		1,686	15,137	86,021			
7/1/2018		13,586		1,768	15,354	101,375			
8/1/2018		13,718		1,821	15,539	116,914			
9/1/2018		13,846		1,853	15,699	132,613			
10/1/2018		13,970		1,871	15,841	148,454			
11/1/2018		14,092		1,882	15,974	164,428			
12/1/2018		14,210		1,888	16,098	180,526	180,526		
1/1/2019		14,325		1,893	16,218	16,218			
2/1/2019		14,437		1,896	16,333	32,552			
3/1/2019		14,546		1,899	16,445	48,997			
4/1/2019		14,653		1,902	16,555	65,552			
5/1/2019		14,756		1,904	16,660	82,212			
6/1/2019		14,857		1,906	16,763	98,975			
7/1/2019		14,955		1,908	16,863	115,838			
8/1/2019		15,051		1,908	16,959	132,797			
9/1/2019		15,144		1,919	17,063	149,859			
10/1/2019		15,234		1,931	17,165	167,025			
11/1/2019		15,322		1,942	17,264	184,289			
12/1/2019		15,408		1,953	17,361	201,650	201,650		

OLD PROJECTIONS (CONT.)



SUD ESTIMATE EXPLANATION

	Members	Member Months	PMPM	Total Funds	State Funds	Federal Funds
CY2017	546	628	$6,709.50	$4,213,566	$2,106,783	$2,106,783
CY2018	764	879	$7,044.98	$6,192,533	$3,096,267	$3,096,267
CY2019	802	922	$7,397.22	$6,820,240	$3,410,120	$3,410,120
CY2020	842	968	$7,767.08	$7,518,538	$3,759,269	$3,759,269
CY2021	884	1,017	$8,155.44	$8,294,082	$4,147,041	$4,147,041

We expect today we would have 970 adult members per year using Substance Use Treatment Centers if Available through all of CY 2017

970

The Waiver is starting April 1, after the first quarter of the year

75%

Utilization will grow at 5% per year

5%

75% will use 16 bed or greater facilities

75%

	Percent of Waiver Participants	Days Utilization	
Pregnant Women	15%	60	9.000
Other Adults	85%	30	25.500
Weighted Average for Member Months per Participant			**1.150**

Utilization will be 15% at the higher $400 per day rate and 85% at $180 per day for an average of $213 per day or $6,390 per month

	15%	
$400.00	$60.00	
$180.00	$153.00	
	$213.00	Average Cost per day
	$6,390	Average Cost per Month

And this Cost per day will grow at 5% per year

5%

SA SERVICES CHANGES

	Estimated Total Expenditures Without SUD Changes	SUD Services Changes	New Estimated Total Expenditures		Member Months	
CY17	$61,351,825	$604,150	$61,955,975			
CY18	$83,520,297	$1,537,100	$85,057,398			
CY19	$96,745,841	$1,897,407	$98,643,248			
CY17	$446.14	$4.39	$450.53		137,517	
CY18	$409.31	$8.51	$471.16		180,526	
CY19	$433.28	$9.41	$489.18		201,650	
			0.038234659			

VCU ARTS Evaluation Update
Addiction & Recovery Treatment Services

Treatment for Addiction Disorders Increases During First Three Months of New Medicaid Program

September 2017

Overview

Over 1,100 Virginians died from opioid overdoses in 2016, nearly doubling since 2011.[1] Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or had pain reliever dependence.[2]

Virginia implemented the Addiction and Recovery Treatment Services (ARTS) program in April, 2017 to increase access to treatment for Medicaid members with opioid or other substance use disorders. ARTS benefits cover a wide range of addiction treatment services which are based on American Society of Addiction Medicine criteria.[3] ARTS services include the following: inpatient detoxification, residential treatment, partial hospitalization, intensive outpatient programs, opioid treatment and case management. ARTS services are carved into existing Medicaid managed care plans to support full integration of behavioral and physical health.

ARTS Evaluation

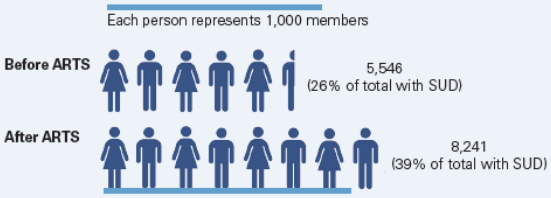
The Department of Medical Assistance Services contracted with Virginia Commonwealth University to conduct an independent evaluation of the ARTS program. This brief highlights developments across the first three months of the evaluation period, from April 1st, 2017 to July 1st, 2017.

Key Findings

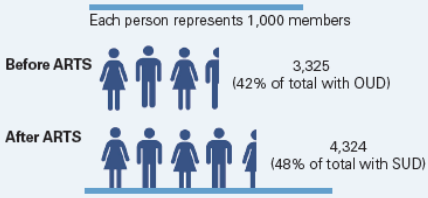
- Treatment rates among Medicaid members with substance use disorders (SUD) increased by 50% in the first 3 months of ARTS compared to a similar time period in 2016.
- Rates of pharmacotherapy for members with an opioid use disorder (OUD) vary by region. The Eastern region experienced the largest improvement with a 79% increase in the number of members treated.
- The number of outpatient practitioners providing OUD services to Medicaid members more than doubled, from 300 practitioners to 691 during the first 3 months of ARTS.

ARTS Narrows the Treatment Gap

Members receiving treatment for any substance use disorder (SUD)



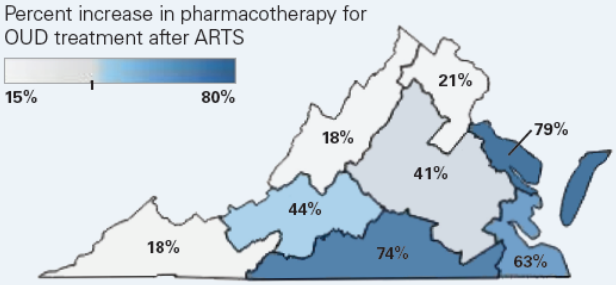
Members receiving pharmacotherapy for opioid use disorder (OUD)



Over 8,000 Medicaid members received some kind of treatment for a substance use disorder (SUD) during April through June, 2017 (the first three months of ARTS).[a] This means 39% of Medicaid members with a SUD diagnosis were receiving treatment for their addiction after ARTS was implemented, a 50% increase from April through June, 2016. Among Medicaid members with an opioid use disorder (OUD), 48% received pharmacotherapy during the first three months of ARTS (4,324 members), a 30% increase compared to a year earlier. Treatment for alcohol use disorders also increased substantially, more than doubling during the first three months of ARTS (see Appendix A for more details).

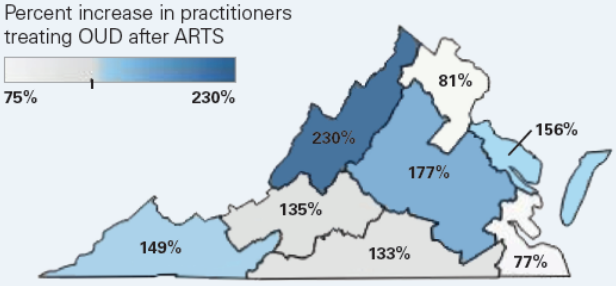
VCU Health Behavior and Policy
School of Medicine

Pharmacotherapy for Opioid Use Disorders is Increasing



Pharmacotherapy for OUD treatment increased in all regions of Virginia after ARTS implementation. The largest increase in the number of members receiving pharmacotherapy for OUD was 79% in the Eastern region. Rates of receiving any treatment among members with SUD varies by region, from a low of 25% in Hampton Roads to a high of 63% in Southwest (see Appendix B for details).

Number of OUD Outpatient Practitioners More than Doubled



The total number of outpatient practitioners providing SUD services to Medicaid members more than doubled, from 667 to 1,603 after ARTS implementation. Similarly, the number of OUD practitioners increased from 300 practitioners before ARTS to 691 practitioners during the first three months of ARTS. All regions in Virginia experienced an increase in the number of providers, ranging from a 77% increase in the Hampton Roads region to a 230% increase in the Valley region (see Appendix C for more details).

Conclusions

During the first three months, ARTS has reduced the treatment gap for SUD by increasing the number of practitioners providing services for SUD, and by increasing the number of Medicaid members receiving pharmacotherapy for an OUD. Future reports will examine whether the treatment gap for SUD narrows even further, and provide more detail on the types of services being received.[b]

This report was prepared by the ARTS evaluation team at the Virginia Commonwealth University (VCU) Department of Health Behavior and Policy and the Department of Family Medicine and Population Health. VCU staff include **Peter Cunningham**, Ph.D., **Andrew Barnes,** Ph.D., **Heather Saunders**, MSW, **Lauryn Saxe Walker**, RN, MPH, **Yaou Sheng**, MPH, **Sebastian Tong**, M.D. MPH, **E. Marshall Brooks**, Ph.D., and **Rebecca A. Aycock**, Ph.D. The evaluation team would like to thank the Department of Medical Assistance Services for providing their technical expertise on the Medicaid claims data and the ARTS program.

[1]Virginia Department of Health. Fatal Drug Overdose Quarterly Report: 1st Quarter 2017.; 2017. http://www.vdh.virginia.gov/content/uploads/sites/18/2016/04/Fatal-Drug-Overdoses-Quarterly-Report-Q1-2017_Updated.pdf. [2]Medicaid and CHIP Payment and Access Commission (MACPAC). Report to Congress on Medicaid and CHIP June 2017: Chapter 2- Medicaid and the Opioid Epidemic. 2017. [3]American Society of Addiction Medicine (ASAM). What is the ASAM Criteria. Resources. https://www.asam.org/resources/the-asam-criteria/about.2017

[a]Medicaid members with SUD are defined as having any diagnosis of opioid, alcohol, or other addiction disorder (other than tobacco) for any medical encounter or prescription drug paid for by Medicaid. Estimates reported include members covered by GAP and FAMIS programs, although these members do not receive the full spectrum of ARTS services. Treatment is defined as any level of service as defined by the American Society of Addiction Medicine guidelines, pharmacotherapy, case management and office-based outpatient treatment. [b]These results are based on claims submitted between April and June, 2017. As some claims may not have been submitted or paid for at the time of analysis, actual utilization may be higher than the estimates shown. The total numbers of Medicaid members with SUD and OUD are likely higher than those reported here. The claims data used in this report relies on providers coding that a member has a SUD including OUD. Providers have not always screened and then coded for SUD diagnoses in the past, especially before ARTS, when treatment was not available. The conclusions in this report are the authors, and no official endorsement by the VCU School of Medicine or Virginia Department of Medical Assistance Services is intended or should be inferred.

Appendix A1

Change in treatment gap for Medicaid members with substance use disorders

	Before ARTS Apr-June, 2016	First Three Months of ARTS Apr-June, 2017	Percent Change
All Substance Use Disorders (SUD)			
Total Medicaid members with SUD	21,121	21,117	0
Receiving any treatment	5,546	8,241	+49
Receiving pharmacotherapy	3,426	4,433	+29
Percent receiving any treatment	26%	39%	+50
Opioid Use Disorders (OUD)			
Total Medicaid members with OUD	7,883	8,992	+14
Receiving any treatment	4,030	5,539	+37
Receiving pharmacotherapy	3,325	4,324	+30
Percent receiving any treatment	51%	62%	+22
Alcohol Use Disorders (AUD)			
Total Medicaid members with AUD	7,426	6,590	-11
Receiving any treatment	749	1,539	+102
Receiving pharmacotherapy	120	133	+11
Percent receiving treatment	10%	23%	+130

[1]Members with both OUD and AUD are included in OUD.

Appendix A2

Change in treatment gap for **GAP** members with substance use disorders

	Before ARTS Apr-June, 2016	First Three Months of ARTS Apr-June, 2017	Percent Change
All Substance Use Disorders (SUD)			
Total Medicaid members with SUD	1,120	1,570	+40
Receiving any treatment	490	886	+81
Receiving pharmacotherapy	234	614	+162
Percent receiving any treatment	44%	56%	+29
Opioid Use Disorders (OUD)			
Total Medicaid members with OUD	450	895	+99
Receiving any treatment	261	702	+169
Receiving pharmacotherapy	200	578	+189
Percent receiving any treatment	58%	78%	+34
Alcohol Use Disorders (AUD)			
Total Medicaid members with AUD	433	467	+8
Receiving any treatment	151	142	-6
Receiving pharmacotherapy	37	40	+8
Percent receiving treatment	35%	30%	-13

[1]GAP refers to the Governor's Access Plan. [2]Members with both OUD and AUD are included in OUD.

Appendix A3

Change in treatment gap for **FAMIS** members with substance use disorders

	Before ARTS Apr-June, 2016	First Three Months of ARTS Apr-June, 2017	Percent Change
All Substance Use Disorders (SUD)			
Total Medicaid members with SUD	127	137	+8
Receiving any treatment	24	44	+83
Receiving pharmacotherapy	9	10	+11
Percent receiving any treatment	19%	32%	+68
Opioid Use Disorders (OUD)			
Total Medicaid members with OUD	18	14	-22
Receiving any treatment	9	12	+33
Receiving pharmacotherapy	9	10	+11
Percent receiving any treatment	50%	86%	+72
Alcohol Use Disorders (AUD)			
Total Medicaid members with AUD	22	23	+5
Receiving any treatment	1	2	+100
Receiving pharmacotherapy	0	0	0
Percent receiving treatment	5%	9%	+80

[1]FAMIS refers to the Family Access to Medical Insurance Security program. [2]Members with both OUD and AUD are included in OUD.

Appendix B

Change in treatment gap for Medicaid members by Virginia region

	Members with disorder (n) Apr-June, 2016	Members receiving treatment (n) Apr-June, 2016	Percent receiving treatment (%) Apr-June, 2016	Members with disorder (n) Apr-June, 2017	Members receiving treatment (n) Apr-June, 2017	Percent receiving treatment (%) Apr-June, 2017
Members with SUD who received any type of treatment						
Total for state	21,121	5,546	26	21,117	8,241	39
Central	4,765	1,116	23	4,751	1,638	34
Eastern	343	78	23	361	146	40
Hampton Roads	4,659	601	13	4,069	1,032	25
Northern	2,698	606	22	2,520	823	33
Southside	1,361	249	18	1,537	466	30
Southwest	3,164	1,745	55	3,443	2,164	63
Valley	1,227	325	26	1,254	515	41
West Central	2,887	816	28	3,169	1,445	46
Members with OUD who received any type of treatment						
Total for state	7,883	4,030	51	8,992	5,539	62
Central	1,588	701	44	1,749	925	53
Eastern	112	51	46	145	93	64
Hampton Roads	1,274	296	23	1,211	552	46
Northern	854	409	48	836	520	62
Southside	367	131	36	558	253	45
Southwest	2,137	1,609	75	2,485	1,927	78
Valley	460	214	47	479	287	60
West Central	1,081	610	56	1,517	970	64
Members with OUD who received Pharmacotherapy						
Total for state	7,883	3,325	42	8,992	4,324	48
Central	1,588	409	26	1,749	576	33
Eastern	112	39	35	145	70	48
Hampton Roads	1,274	170	13	1,211	277	23
Northern	854	346	41	836	417	50
Southside	367	102	28	558	177	32
Southwest	2,137	1,539	72	2,485	1,820	73
Valley	460	187	41	479	220	46
West Central	1,081	525	49	1,517	755	50

Appendix C

Change in number of practitioners by Virginia region

	Before ARTS Apr-June, 2016	First Three Months of ARTS Apr-June, 2017	Percent Change
Outpatient practitioners providing SUD services			
Total for state	667	1,603	+140
Central	137	337	+146
Eastern	19	41	+116
Hampton Roads	142	318	+124
Northern	113	193	+71
Southside	53	155	+193
Southwest	62	172	+177
Valley	57	135	+137
West Central	82	252	+207
Outpatient practitioners providing OUD services			
Total for state	300	691	+130
Central	57	158	+177
Eastern	9	23	+156
Hampton Roads	57	101	+77
Northern	48	87	+81
Southside	24	56	+133
Southwest	35	87	+149
Valley	20	66	+230
West Central	48	113	+135

Reference Cited

1. CMS State Medicaid Director letter, #15-003: https://www.medicaid.gov/federal-policy-guidance/downloads/SMD15003.pdf

2. Substance Abuse and Mental Health Services Administration, *Racial/Ethnic Differences in Mental Health Service Use among Adults*. HHS Publication No. SMA-15-4906. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Retrieved January 17, 2018, from https://www.samhsa.gov/data/sites/default/files/MHServicesUseAmongAdults/MHServicesUseAmongAdults

3. Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry.* 2010 Oct;49(10):980-9. PMID: 20855043. Retrieved January 17, 2018, from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml#part_154790

4. Email address for the public to make inquiries about GAP: BridgetheGAP@dmas.virginia.gov

5. GAP webpage on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/gap.aspx

6. Cover Virginia's website: http://www.coverva.org/gap.cfm

7. Magellan website link for provider communication: http://magellanofvirginia.com/for-providers-va/communications.aspx

8. Magellan training page for providers: http://magellanofvirginia.com/for-providers-va/provider-training.aspx

9. Magellan GAP specific webpage: http://www.magellanofvirginia.com/for-members/governor's-access-program-(gap).aspx

10. Syed, Samina T., Ben S. Gerber, and Lisa K. Sharp. "Traveling Towards Disease: Transportation Barriers to Health Care Access." *Journal of community health* 38.5 (2013): 976–993. *PMC*. Web. 1 Feb. 2018

11. Data extracted from Kaiser Family Foundation Opioid Overdose Deaths, http://www.kff.org/other/state-indicator/opioid-overdose-deaths-by-raceethnicity and the Virginia Department of Health's Office of the Chief Medical Examiner, http://www.vdh.virginia.gov/medical-examiner/forensic-epidemiology.

12. MACPAC June 2017 Report to Congress on Medicaid and CHIP. https://www.macpac.gov/publication/medicaid-and-the-opioid-epidemic/

13. ARTS training webinar: http://www.magellanofvirginia.com/for-providers/arts-information/

14. ARTS webpage on the DMAS website: http://www.dmas.virginia.gov/Content_Pgs/bh-home.aspx

15. Note: Maps provided by the Department of Medical Assistance Services and reflect providers as of November 2017. The map is based on zip codes that have at least two providers within 30 miles driving of an urban area or 60 miles driving of a rural area.

16. DMAS completed the final list of network providers for posting on the Virginia Department of Health website using google maps: https://www.google.com/maps/d/viewer?mid=1px9XvltnM7rXZ6vrTgXgPGIHTew&hl=en&ll=37.816331443637 03%2C-80.57419543505449&z=7

17. Email address for the public to make inquiries about ARTS: SUD@dmas.virginia.gov

18. ARTS webpage on the DMAS website: http://www.dmas.virginia.gov/Content_Pgs/bh-home.aspx