Virginia Department of Medical Assistance Services

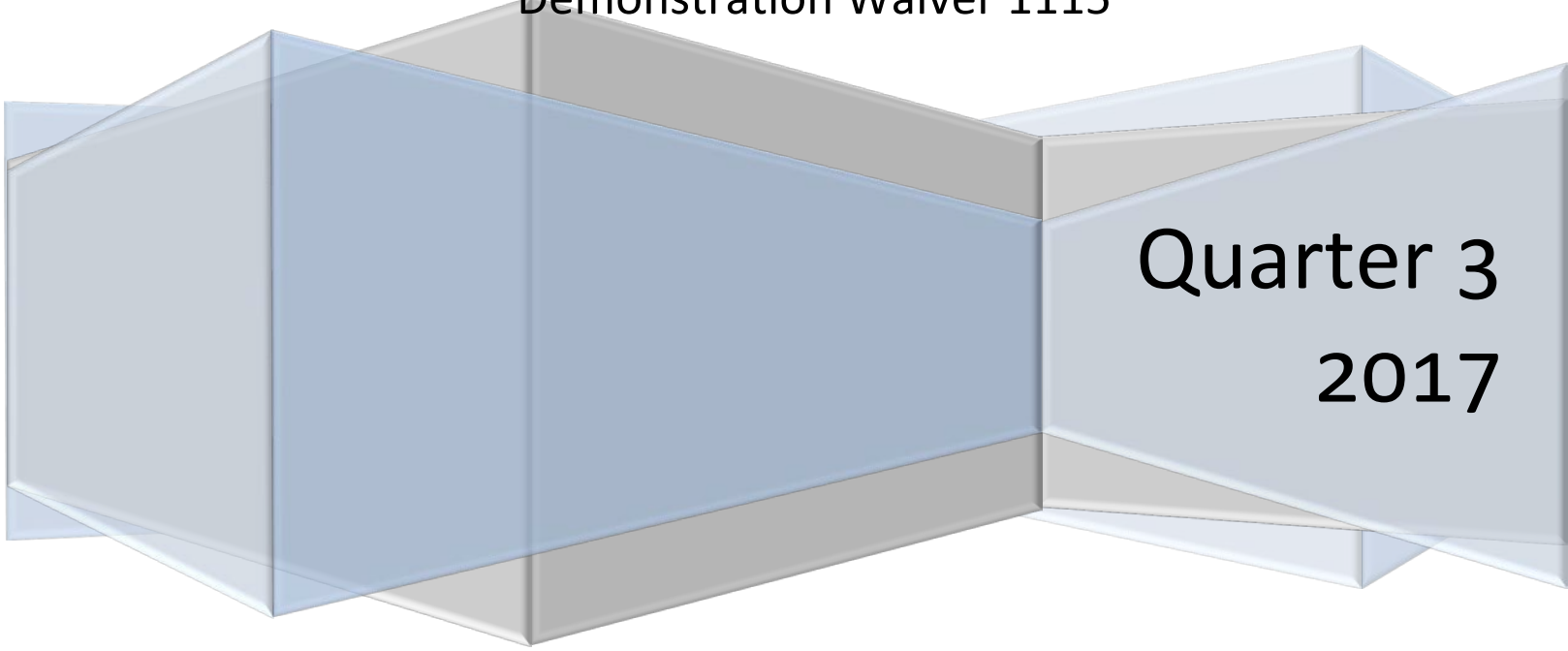
The Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation

Section 1115 Quarterly Report
Project 11 – W- 00297/3

Demonstration Waiver 1115
Demonstration Year: 3 (1/01/2017 – 12/31/2017)
Demonstration Quarter: 3 (07/01/2017 – 09/30/2017) Approval Period: January 12, 2015 through December 31, 2019

Project 11 – W- 00297/3

Demonstration Waiver 1115



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* is a ten step plan that expands access to care, improves care for veterans and for individuals with serious mental illnesses (SMI), and enhances 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 GAP Demonstration includes 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 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) .

This report highlights progress made during Quarter Three of the third year of the GAP Demonstration as well as the State's implementation of the system transformation of the substance use disorder treatment services: Addiction and Recovery Treatment Service (ARTS).

BACKGROUND

GAP

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, therefore addressing the severity of their condition. With treatment and supports, 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.

ARTS

Virginia's 1.1 million members enrolled in Medicaid are disproportionately impacted by the substance use epidemic. Over 1,100 Virginians died from opioid overdoses in 2016, nearly doubling since 2011. Nationally, Medicaid members are four times more likely than people with private insurance to have ever used heroin or had pain reliever dependence. 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 member's enrolled in Medicaid, made a recommendation to increase access to treatment for opioid addiction for Virginia's Medicaid members by increasing Medicaid reimbursement rates. Thus DMAS developed a large stakeholder and provider workgroup to work in collaboration to develop the comprehensive benefit for substance use disorder treatment services: ARTS, which implemented on April 1, 2017.

GOALS

GAP

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.

ARTS

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:

Improve quality of care and population health outcomes for the Medicaid population.

- Improve quality of addiction treatment (as measured by performance on identified quality measures).
- Reduce prescription opioid drug abuse (measured by Pharmacy Quality Assurance opioid performance measures).
- Decrease fatal and non-fatal drug overdoses among Medicaid members.

Increase Medicaid members' access to and utilization of community-based and outpatient addiction treatment services.

- Increase the percentage of Medicaid members living in communities with an adequate supply of clinicians offering addiction treatment services to Medicaid members.
- Increase the quantity of community-based and outpatient addiction treatment services used by Medicaid members with SUD.

Decrease utilization of high-cost Emergency Department and hospital services by Medicaid members with SUD.

- Decrease ED visits, inpatient admissions, and readmissions to the same level of care or higher for a primary diagnosis of SUD.
- Decrease inappropriate utilization for other physical and behavioral health care services for other conditions such as chronic diseases and serious mental illness.

Improve care coordination and care transitions for Medicaid members with SUD.

- Improve the coordination of addiction treatment with other behavioral and physical health services.
- Improve care transitions to outpatient care, including hand-offs between levels of care within the SUD care continuum and linkages with primary care upon discharge.

Increase the number and type of health care clinicians providing SUD services to Medicaid members with SUD.

- Increase number of addiction treatment providers providing all ASAM Levels of Care in each region of the Commonwealth.
- Increase the number of buprenorphine-waivered physicians and the number of physicians providing Medication Assisted Treatment.
- Increase the number of clinicians with substance abuse training and the number of behavioral health clinicians providing addiction treatment .

ELIGIBILITY AND BENEFIT INFORMATION

GAP

The Virginia GAP Demonstration Waiver eligibility guidelines are as follows:

Figure 1

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 80% of Federal Poverty Level (FPL)
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 growing success 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.

ARTS

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. DMAS has also began the regional implementation of the CCC Plus (Managed Long Term Support Services Managed Care Plans) starting August 1, 2017. All health plans and Magellan of Virginia are covering the full range of ARTS services.

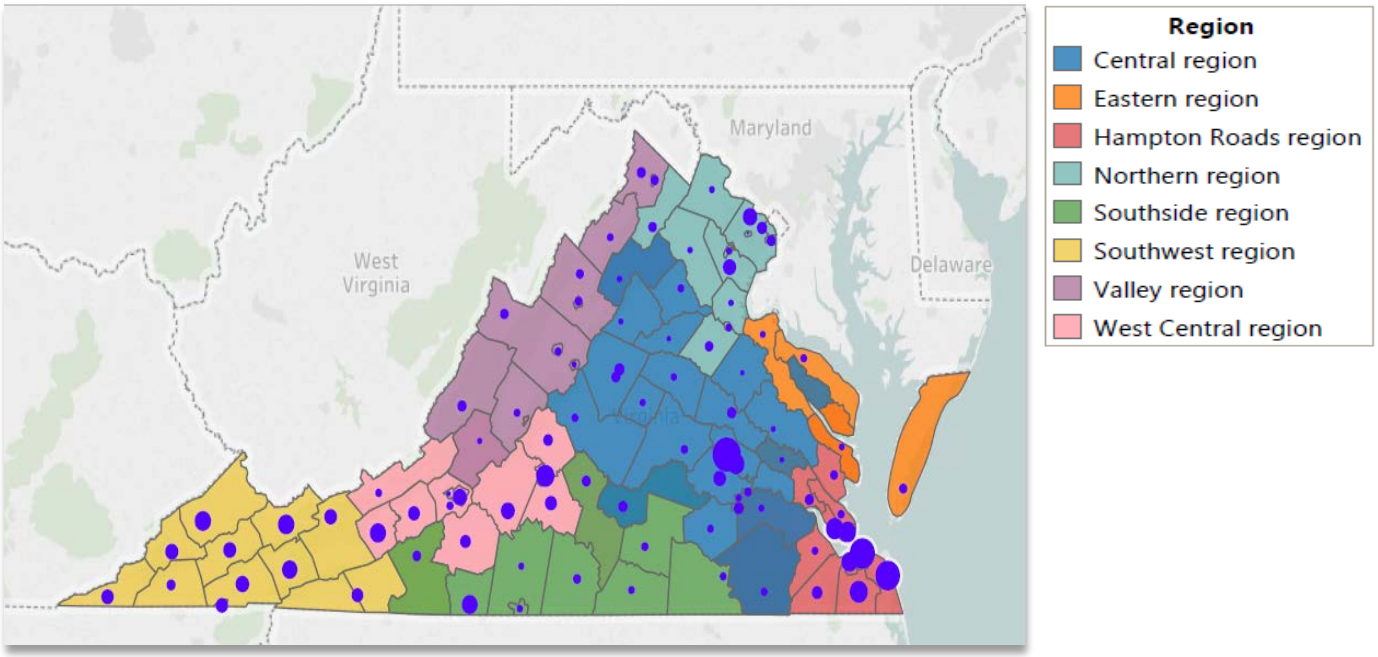
Expansion of the administration of community-based addiction and recovery treatment services	• Transition through the DMAS contracted managed care organizations (MCOs) including Medallion 3.0, Commonwealth Coordinated Care (CCC) and CCC Plus. • The DMAS contracted Behavioral Health Services Administrator (BHSA), Magellan of Virginia, will cover ARTS for those members who are enrolled in the full coverage Fee-For-Service (FFS) and members enrolled in the GAP benefit thus providers will continue to bill Magellan for these FFS enrolled members only.
Expansion of Community-based addiction and recovery treatment services for all members	• Residential Treatment, • Partial Hospitalization, • Intensive Outpatient Treatment, • Medication Assisted Treatment/Opioid Treatment Services (includes individual, group counseling and family therapy and medication administration), and • Substance Use Case Management.
Allowing for coverage of inpatient detoxification and inpatient substance use disorder treatment for all members	• For all full-benefit Medicaid and FAMIS enrolled members. • DMAS is expanding coverage of residential detoxification and residential substance use disorder treatment for all full-benefit Medicaid enrolled members.

ENROLLMENT COUNTS FOR QUARTER AND YEAR TO DATE

GAP Member Population

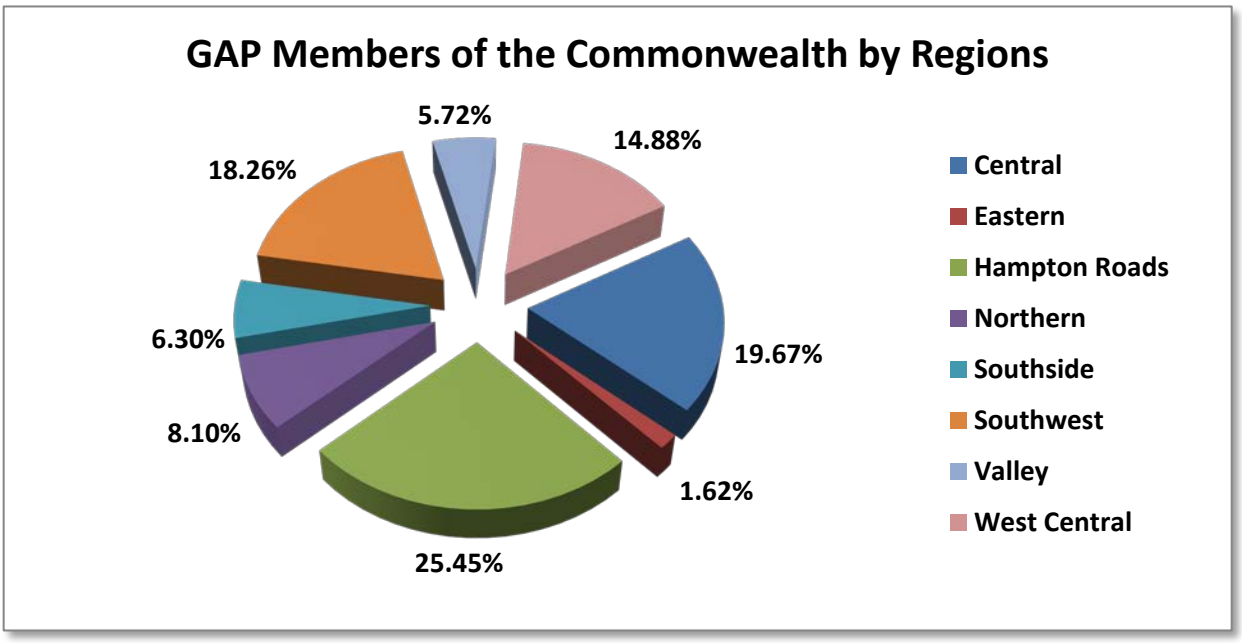
The Department of Medical Assistance Services currently provides coverage to approximately 995,992 enrolled in Medicaid. Approximately 2% of these beneficiaries are enrolled in GAP. In the following figures and tables, the population displayed includes GAP members categorized by location, race/ethnicity, gender, age group and primary diagnosis.

Figure 2: GAP Enrollment, Third Quarter



The GAP Demonstration continues to steadily grow in membership. For the quarter ending on September 30, 2017 there were 12,494 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, 3rd Quarter



The figure above displays the geographic distribution of the GAP population, broken down by regions in the third quarter. As highlighted in the figure, the Hampton Roads region continues to house the largest concentration of GAP members at 3,180 with the Central (2,457 members) and Southwest (2,281 members) regions closely following.

Figure 4: GAP Enrollment, Third Quarter

Demonstration Population	Total Number of members Quarter Ending 9/30/2017	Total Number of members Quarter Ending 6/31/2017	Members Enrolled Since 01/12/2015
GAP Members Enrolled	12,494	11,730	16,939

As shown in Figure 4, there have been 16,939 unique members enrolled since the implementation of the Demonstration. The difference between the unique members' number and the currently enrolled number may be associated with financial eligibility requirements in 2015 and 2016 as well as those that did not successfully complete the eligibility renewal/re-enrollment process.

Figure 5: GAP Members by Race and Ethnicity in the Third Quarter

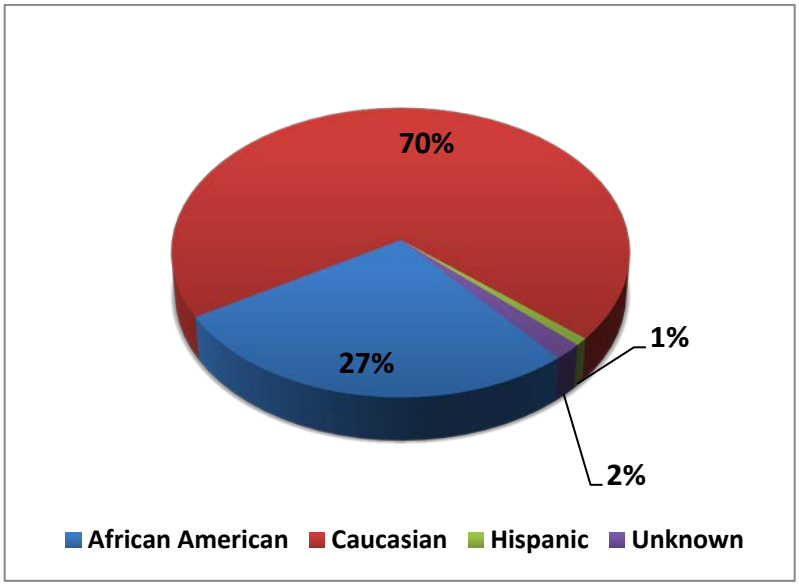
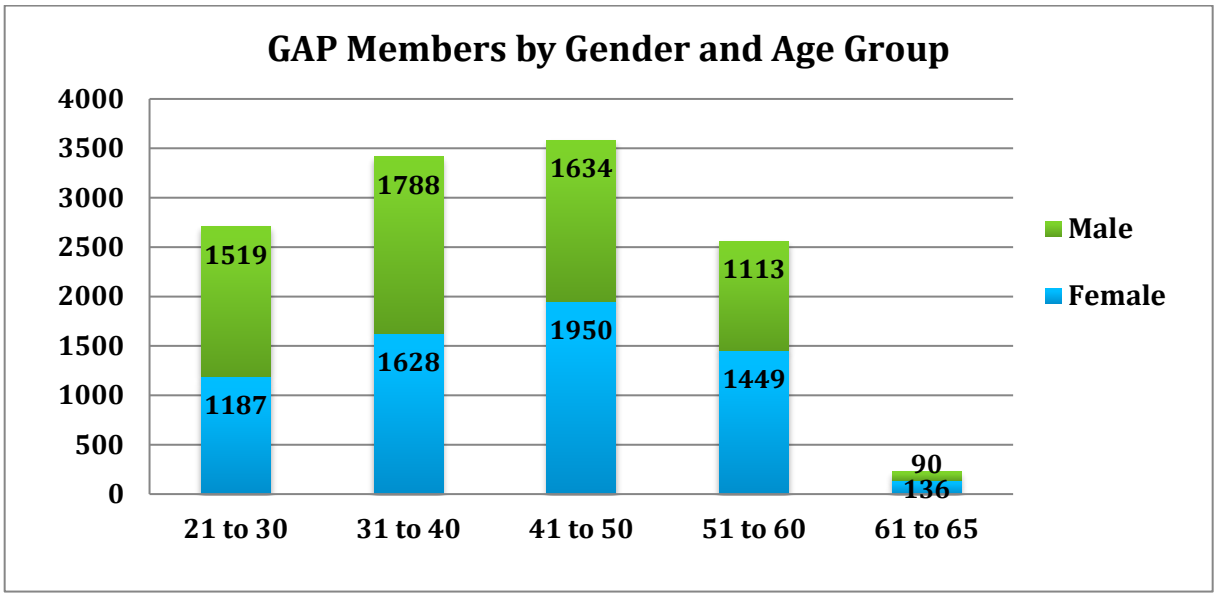


Figure 5 displays the distribution of the four primary race and ethnic groups of the GAP population. Approximately seventy percent (69.76%) of the GAP population are Caucasian, 27.54% of the GAP population are African American, roughly 2% did not elect to identify their race ethnicity and roughly 1% of the GAP population is Hispanic.

Figure 6: Male and Female GAP Members by Age Group, 3rd Quarter



The age demographics of GAP members remain relatively equal across all eligible age groups with the exception of members over the age of 61. Figure 6 displays the distribution of GAP members by gender and age group, details age and gender demographics among the GAP member population. When comparing gender characteristics of the GAP population, there are more females enrolled in GAP than males (51% and 49%, respectfully), and the 41-50 age group remains the largest population of GAP members at 28.7%.

Figure 7: Primary Diagnosis in the Third Quarter

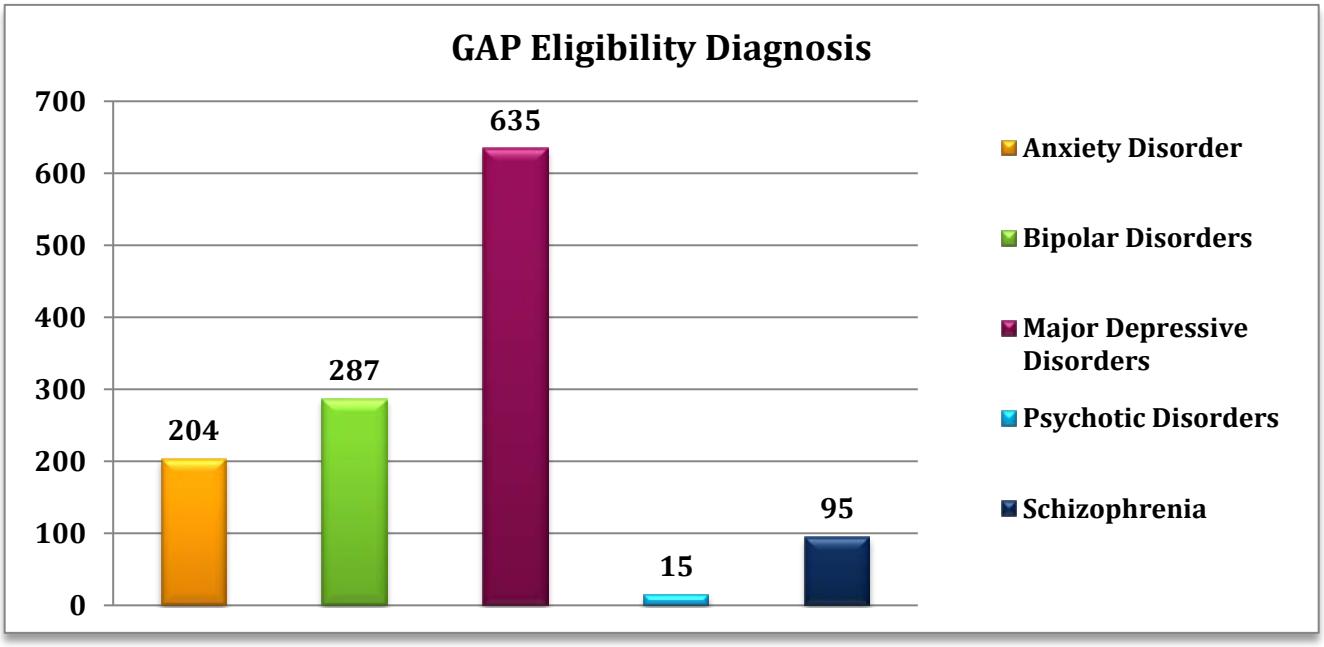


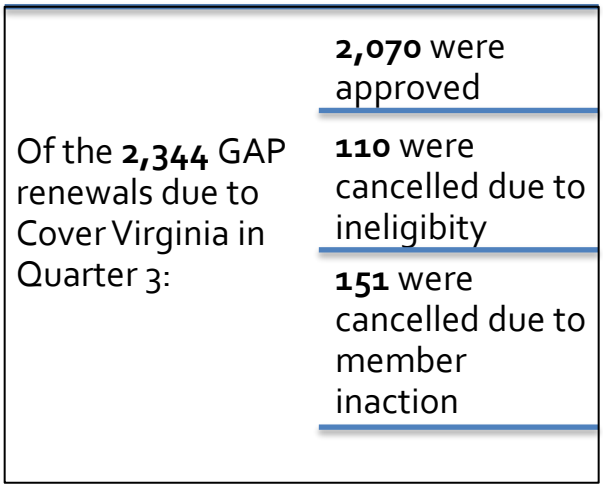
Figure 7 displays the distribution of GAP members (1,236 of 12,494) and their primary diagnosis for eligibility in quarter 3. The primary diagnoses remain fairly equal from quarter 2 to quarter 3, with approximately fifty-one percent (51%) of members diagnosed with Major Depression, followed by twenty-one (23.22%) of members diagnosed with a Bipolar Disorder, 16.50 % diagnosed with an Anxiety Disorders such as Posttraumatic Stress Disorder, approximately 8% diagnosed with Schizophrenia, and 1% diagnosed with a Psychotic Disorder.

Using the sample of the GAP population displayed in figure 7, Table one represents the distribution of GAP members (402 members) with approved service authorizations for services such as Case Management, Crisis Intervention and Stabilization, Psychosocial Rehabilitation, etc., per primary diagnosis in the third quarter. Among the diagnosis groups, approximately 51% received GAP Case Management, 24.88% received Crisis Intervention Services, 17.41% received Crisis Stabilization services, 5.47% receive Substance Intensive Outpatient, roughly 1.00% received Psychosocial Rehabilitation services, along with only 1% of GAP members in the second quarter receiving Psychotherapy services for 45 minutes. It should be noted that the numbers for Psychotherapy services only reflect authorization dates from 7/1/2017-7/25/2017. As of 7/26/2017 service authorization is no longer required for Psychotherapy for GAP members.

Table 1: Service Authorizations by GAP Eligibility Primary Diagnosis in the 3rd Quarter

Service Authorization Category	Counts of GAP Members
Crisis Intervention	**100**
Anxiety Disorder	10
Bipolar Disorders	21
Major Depressive Disorders	51
Psychotic Disorders	10
Schizophrenia	8
Crisis Stabilization	**70**
Anxiety Disorder	5
Bipolar Disorders	20
Major Depressive Disorders	42
Psychotic Disorders	3
Psychosocial Rehabilitation	**2**
Major Depressive Disorders	2
GAP Case Management	**205**
Anxiety Disorder	28
Bipolar Disorders	47
Major Depressive Disorders	92
Psychotic Disorders	8
Schizophrenia	30
Substance Intensive Outpatient	**22**
Anxiety Disorder	3
Bipolar Disorders	3
Major Depressive Disorders	14
Psychotic Disorders	1
Schizophrenia	1
Psychotherapy, 45-minutes	**3**
Anxiety Disorder	1
Major Depressive Disorders	2
Grand Total	**402**

Figure 8: Cover Virginia Renewals in the Third Quarter



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 Quarter 3.

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 Quarter three, Magellan attempted to contact 76 members who were facing cancellation to ensure they were aware they needed to complete financial renewal paperwork. Cover Virginia reported to DMAS during Quarter 3 that these outreach attempts are very helpful in increasing renewal completion.

ARTS

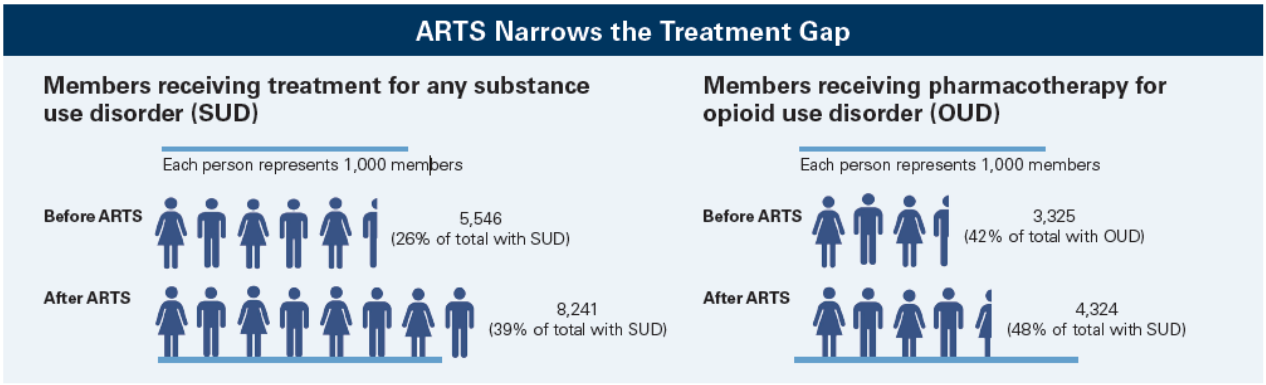
The Department of Medical Assistance Services (DMAS) provides substance use disorder treatment services and co-occurring substance use and mental health disorder treatment services to all 1.1 million members enrolled in Medicaid, FAMIS, FAMIS MOMS and GAP.

DMAS contracted with Virginia Commonwealth University (VCU) to conduct an independent evaluation of the ARTS program. This brief highlights developments across the first three months of the evaluation period, from April 1, 2017 to July 1, 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.

Figure 9: Members Receiving Treatment Services



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). 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.

Figure 10: Member Receiving Pharmacotherapy for OUD

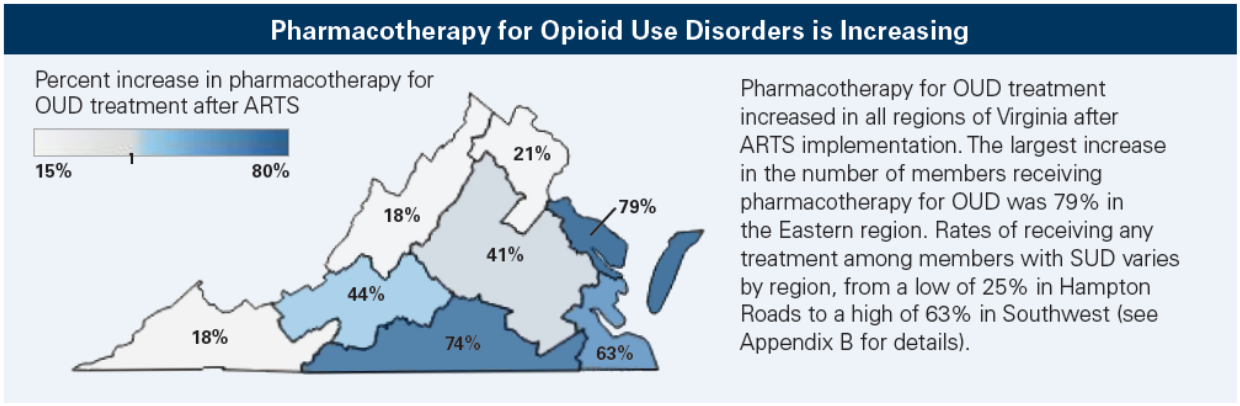
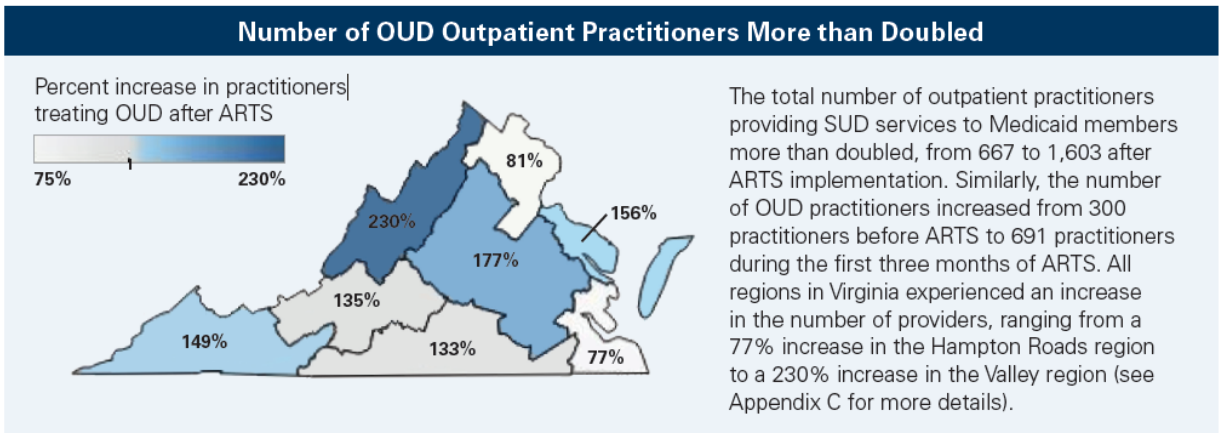


Figure 11: Members Receiving Outpatient Counseling for OUD



DMAS also implemented the Peer Services benefit this quarter, effective July 1, 2017. The provision of Peer Support Services facilitates Recovery from both serious mental health conditions and substance use disorders. Recovery is a process in which people are able to live, work, learn and fully participate in their communities. Peer Support Services are delivered by trained and certified peers who have been successful in the recovery process and can extend the reach of treatment beyond the clinical setting into an individual's community and natural environment to support and assist an individual with staying engaged in the recovery process. Peer support services are an evidence-based model of care which consists of a qualified peer support provider who assists individuals with their recovery. The experiences of peer support providers, as consumers of mental health and substance use services, can be an important component in the delivery of a comprehensive mental health and substance use service delivery system.

Peer Support Services and Family Support Partner Services shall be an added service under Mental Health (MH) service settings for individuals with mental health disorders and under the Addiction and Recovery Treatment Services (ARTS) settings for individuals with substance use disorders and co-occurring substance use and mental health disorders.

The ARTS Peer Support Services is covered as follows:

- Magellan of Virginia for GAP and fee for service enrolled members;
- Medallion 3.0 and Commonwealth Coordinated Care (CCC) Programs for their enrolled members.
- CCC Plus Programs for their enrolled members beginning with the CCC Plus regional implementations beginning August 1, 2017.

This quarter focused on the training of Peer Support Services and provider recruitment activities.

OUTREACH/ INNOVATION ACTIVITIES TO ASSURE ACCESS

GAP

DMAS continued to implement a multi-faceted approach to educate potential members, families, advocates, providers and other stakeholders about GAP. During Quarter 3, DMAS continued Phase II of the GAP outreach plan focusing on increasing awareness of the Demonstration.

DMAS has been involved with House Bill 2183 Workgroup to assist with Department of Corrections / local and regional jails to decrease barriers to individuals who are incarcerated at time of release. The workgroup continued to meet in Quarter 3 to draft recommendations, as following: (1) drafting a screening form for jail intake staff to identify potential Medicaid/GAP applicants; (2) create an electronic data match for DMAS and Department of Juvenile Justice and the Compensation board, and (3) developing communication process to notify local agencies when member is incarcerated. The Workgroup discussed using COVER VA as a central processing location for applications and discussed how this has worked well for GAP members. 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.

In an effort to increase GAP members' renewal application completion process and care coordination with such a transient population, DMAS and Magellan continued to work to ensure 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 health 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 comparison to all Medicaid members documented as eligible for receiving or have received a TracFone, approximately 1.00% (11/24,334) of members is a GAP recipient. More importantly, out of the 11 recipients that are participating in the SafeLink program only three members have phones that are ready for use. Therefore, roughly less than 1% of the GAP population is receiving the benefits associated with the SafeLink Program. GAP Staff will continue to meet with Magellan to discuss the details related to the SafeLink program and how to increase availability and usage.

Last year, 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 for 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 7 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 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, Magellan has hosted weekly conference calls for GAP providers and beneficiaries. As the volume of questions from GAP providers decreased, providers were invited to join the general Magellan provider call and GAP was added to the agenda to allow for any GAP specific questions, comments or concerns. DMAS and Magellan staff hosts these calls and answer questions from the provider network as well as provide 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: BridgetheGAP@dmas.virginia.gov . 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. This quarter, most of the emails received came from providers; most inquires involved questions regarding covered services and procedure codes. Additionally, providers are utilizing the email to request presentations and print materials.

DMAS' also maintains a GAP webpage on the DMAS website: http://www.dmas.virginia.gov/Content_pgs/gap.aspx. 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.

The GAP webpage received 6709 page views, of which 5189 were unique page views between July 1, 2017 and September 30, 2017. DMAS staff receives weekly reports and the GAP webpage is averaging approximately 550-600 views per week. During the month of September, page views increased significantly. DMAS staff updated educational flyers and outreach materials during this Quarter and worked on changing format of the webpage to increase ease of finding information for members, families, and providers.

Cover Virginia's website (http://www.coverva.org/gap.cfm) includes a webpage dedicated to GAP and outlines the financial eligibility criteria and application process. It also includes a picture of the GAP ID card.

Magellan's website has a link for provider communication, http://magellanofvirginia.com/for-providers-va/communications.aspx , where they have posted notices to providers about GAP.

They also have a training page for providers (http://www.magellanofvirginia.com/for-providers-va/training.aspx. They have also developed a GAP specific webpage, http://www.magellanofvirginia.com/for-members/governor's-access-program-(gap).aspx for members, their family members and advocates.

ARTS

DMAS has continued outreach efforts in the 3rd Quarter through a multi-faceted approach to educate members about the ARTS and Peer Support Services benefit available to them as well as various stakeholders, advocates, providers and health plans about ARTS. DMAS continues to meet with the Stakeholder workgroup including the DHP, DBHDS, VDH, managed care organizations (MCOs), stakeholders and providers, to keep informed of any post implementation issues as well as continue to promote the program, credentialing of provider with the MCOs and Magellan of Virginia work through issues post implementation.

In partnership with DBHDS and VDH, DMAS continue to provide training for providers and stakeholders on the ARTS benefit as well as Peer Support Services. VDH continues the practitioner trainings for best practices in working with individuals with substance use disorders. The trainings have included outreach to the judicial system for court ordered treatment and impact of ARTS services to benefit those requiring treatment services;

DMAS help two ARTS Coordinator meetings with the MCO staff and continued the monthly Chief Medical Officer (CMO). DMAS staff participated in 9 stakeholder/association meetings as well. DMAS has also participated in several regional behavioral health summit meetings to promote the ARTS program and opportunities for providers to collaborate and expand services.

DMAS continued to hold weekly technical assistance conference calls for ARTS providers which started the first week in April 2017. DMAS, MCO and Magellan staff hosts these calls and answer questions from the participants as well as provided updates and announcements as needed.

Another avenue for outreach has been the email address for the public to make inquiries about ARTS: SUD@dmas.virginia.gov . This email inbox is monitored daily by DMAS staff. Most inquiries are from providers as well as the MCOs. The weekly average continues to be around 30 emails. DMAS reminds callers at each provider call and presentation conducted that this email address is for providers and members. DMAS has also drafted update to the ARTS provider manual and posted on Town Hall for public comment and shared with the provider associations for feedback.

Finally, DMAS has updated the ARTS webpage on the DMAS website for easier navigation: http://www.dmas.virginia.gov/Content_pgs/bh-home.aspx. 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.

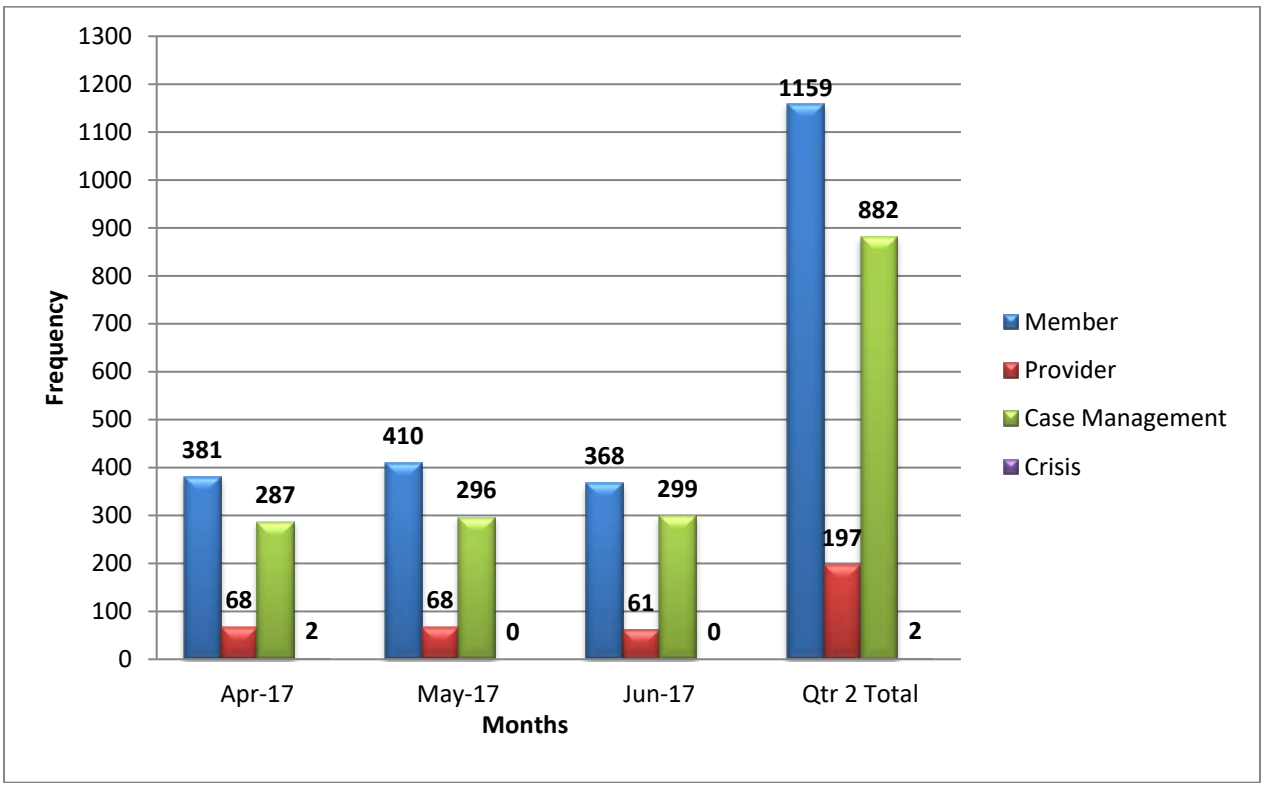
COLLECTION & VERIFICATION OF UTILIZATION DATA & ENROLLMENT DATA

GAP

DMAS collects and reviews data from contractors (Magellan and Cover Virginia) and uses data from its MMIS 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 12 below reflects the types of calls they receive:

Figure 12: BHSA Call Center Data, Quarter 3

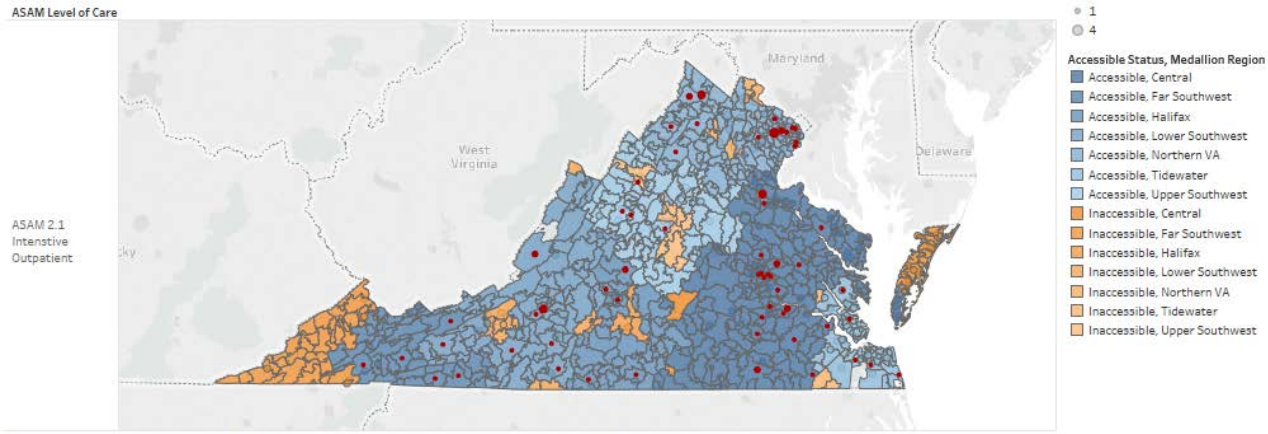


Each quarter, it is notable that there are more contacts from GAP members than from providers. It does appear that members are becoming more engaged in their treatment and service planning by attempting to access and use their benefits. Members may contact Magellan for physical health care referrals and resources, as well as behavioral health care resources. This reflects the need for care coordination in order to access services and demonstrates that the integrated model appears to be successful.

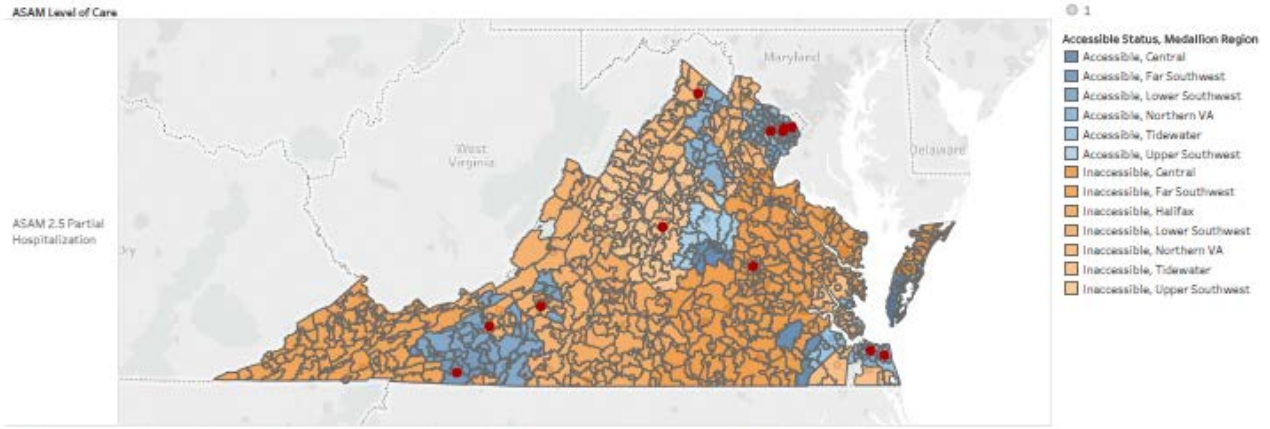
ARTS

DMAS has collected data submitted from the managed care organizations and the behavioral health services administrator (BHSA) on network and service authorizations for ARTS services. The Special Terms and Conditions (STCs) require the state to report for residential levels of care, at least one sublevel level of care is required to be available to recipients upon implementation within each MCO and the BHSA network. The STCs also require access standards and timeliness requirements, including number of days to first ARTS service at appropriate level of care after referral, will be specified in the ARTS Network Development Plans and the ARTS Network Readiness Plans and referenced in the managed care organization and administrative service organization contracts. The following tables show the network adequacy for the 3rd quarter as well as service authorization requests and approval trends for the 3rd quarter post implementation. DMAS continues to work with the Office of Data Analytics for service utilization.

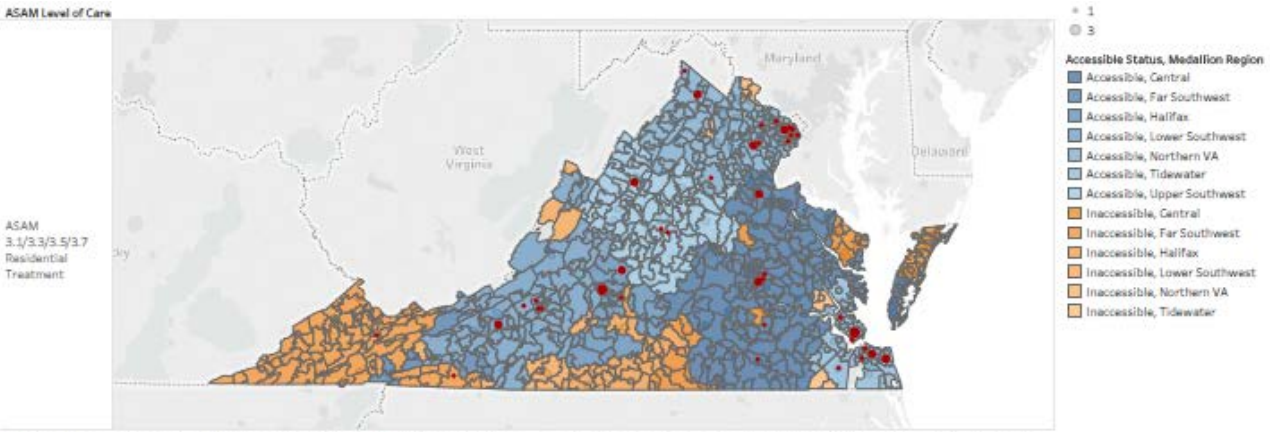
Figure 13 ARTS Network by ASAM Level of Care



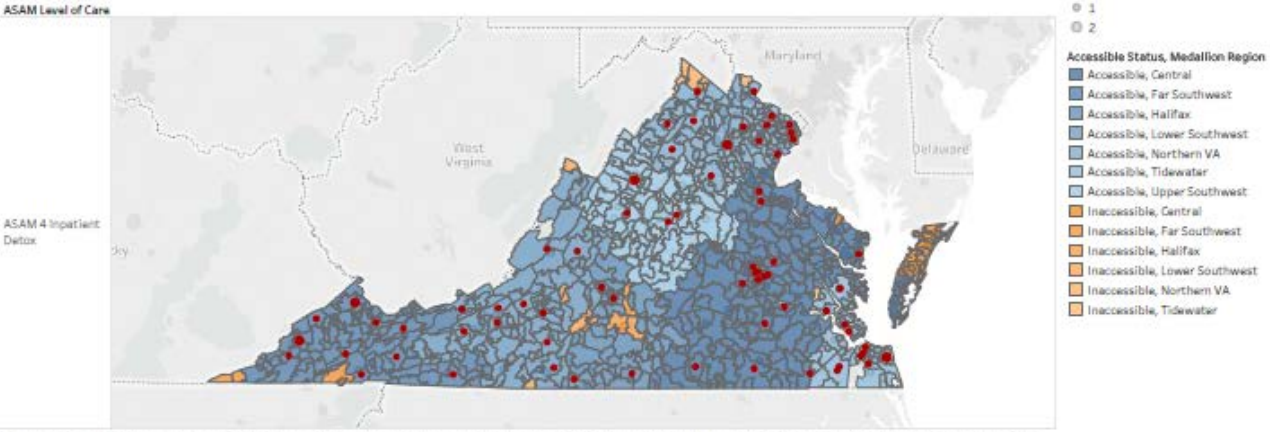
Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers. The data is filtered on Provider Record Validation Status, File Submission Date and the National Provider Identifier (NPI) of the provider. The Provider Record Validation Status filter keeps VALID. The File Submission Date filter keeps 08/20/2017.



Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers. The data is filtered on Provider Record Validation Status, File Submission Date and the National Provider Identifier (NPI) of the provider. The Provider Record Validation Status filter keeps VALID. The File Submission Date filter keeps 08/20/2017.



Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers. The data is filtered on Provider Record Validation Status, File Submission Date and the National Provider Identifier (NPI) of the provider. The Provider Record Validation Status filter keeps VALID. The File Submission Date filter keeps 08/20/2017.



Map based on Longitude (generated) and Latitude (generated) and Latitude (generated) broken down by ASAM Level of Care. For pane Latitude (generated): Color shows details about Color and Region. Details are shown for Member Zip Code. For pane Latitude (generated) (2): Size shows distinct count of providers. The data is filtered on Provider Record Validation Status, File Submission Date and the National Provider Identifier (NPI) of the provider. The Provider Record Validation Status filter keeps VALID. The File Submission Date filter keeps 08/20/2017.

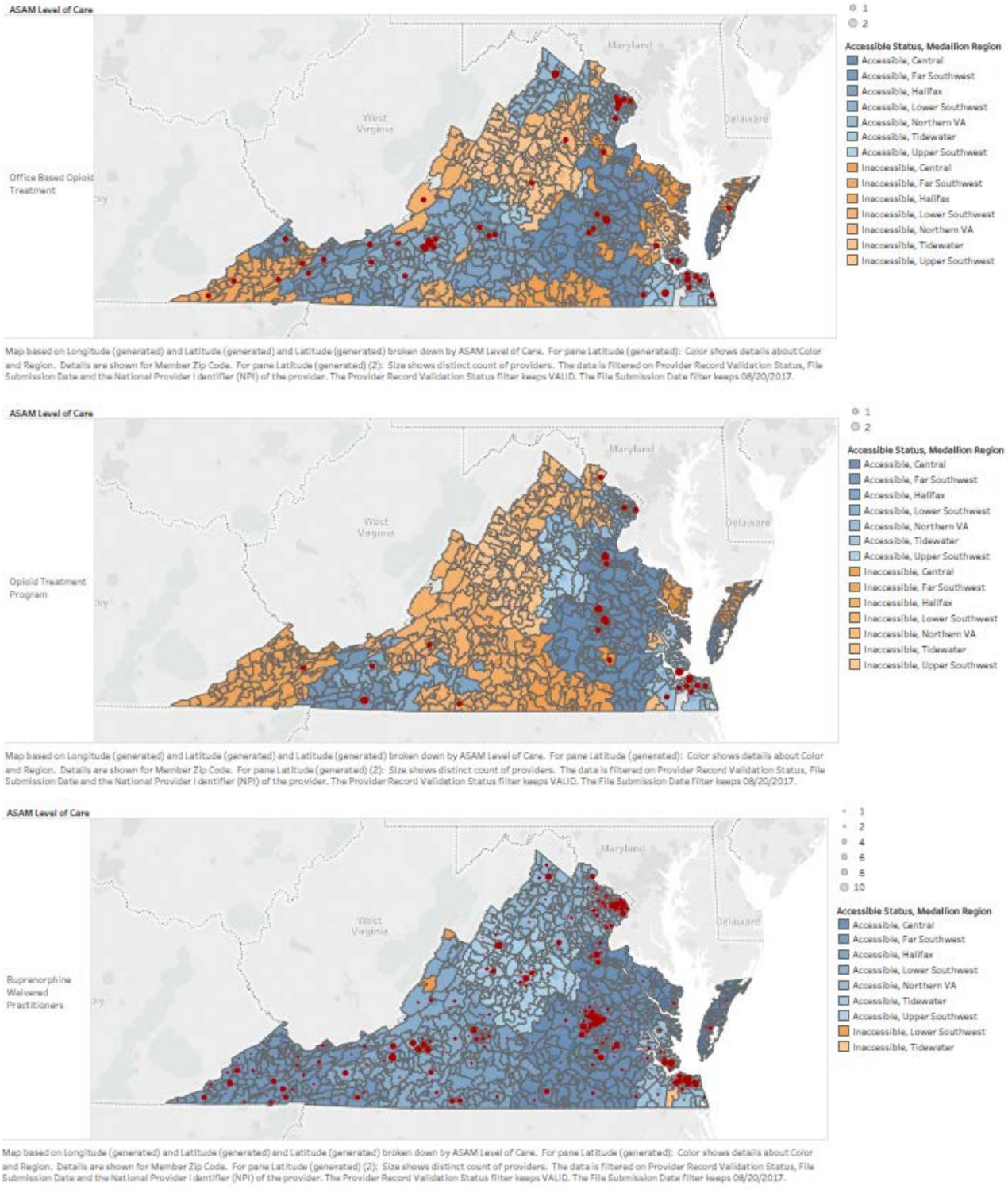


Figure 14 ARTS Service Authorization Totals by ASAM Level of Care

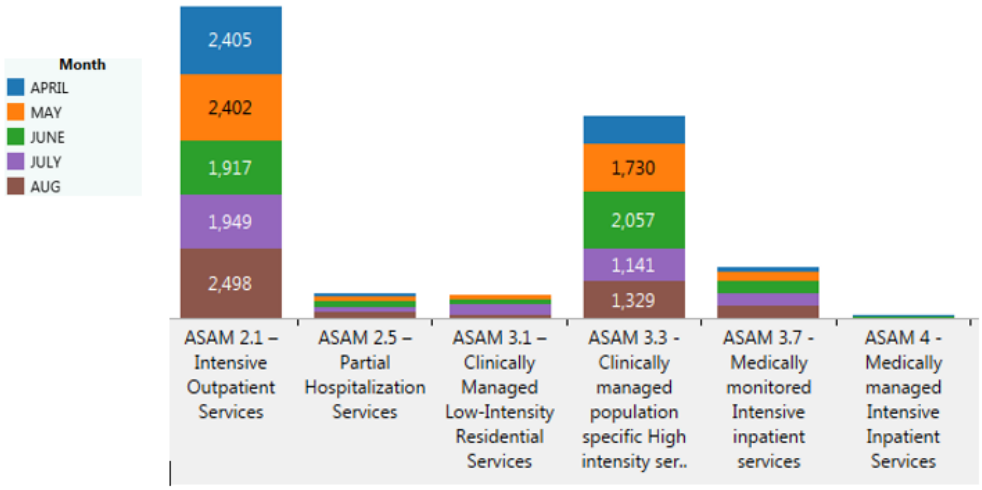
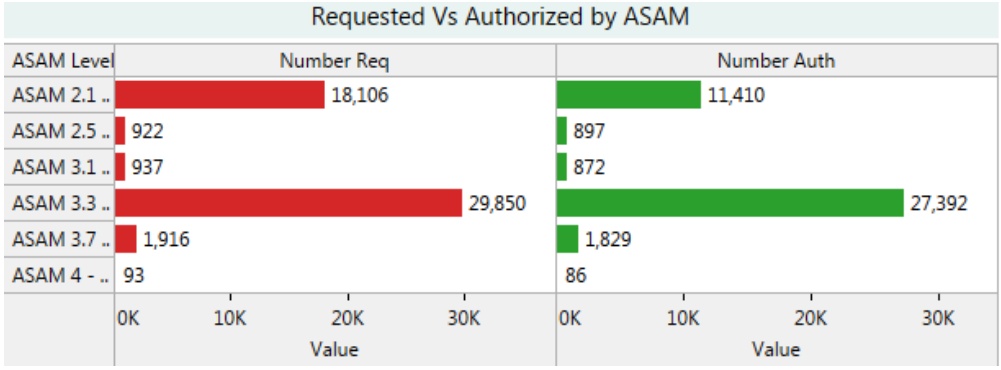


Figure 15 ARTS Service Authorization Units Requested vs Authorized by ASAM Level of Care

The data below shows that providers are submitting more units for Intensive Outpatient Services that they are able to support through the ASAM Criteria. This service did not require a service authorization prior to ARTS. The health plans and Magellan of Virginia is provider outreach and training to providers regarding ASAM Criteria.



OPERATIONAL/POLICY/SYSTEMS/FISCAL DEVELOPMENT ISSUES

GAP

At the time of reporting, there are limited significant operational, systems, or fiscal developmental issues to disclose for the second quarter. Since the launch of the Demonstration, DMAS continues to ensure that all systems are working together for the success of the Demonstration.

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 are effective for GAP member 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 to update outreach materials.

During Quarter Three, DMAS staff revised the GAP Regulations to account for program changes mandated by the 2017 General Assembly. Changes are: increasing the eligibility from 80 – 100% of the Federal Poverty Level effective 10/1/2017; adding partial day hospitalization and residential treatment services for substance use disorder, and; changing Recovery Navigation, provided by the BHSA, to a Peer Support Services provided by licensed private providers. The Final proposed packaged has now been submitted to the Office of the Attorney General for review. DMAS is also working with the Centers for Medicare and Medicaid to amend the waiver to reflect these requested changes.

ARTS

During Quarter three, the second three months' post ARTS implementation, DMAS continued monitored activity with health plans and Magellan of Virginia to determine if there were any significant operational, policy, systems, or fiscal developmental issues. There were claim issues identified by providers and reported to DMAS. DMAS has been working with the health plans and Magellan of Virginia extensively to update systems to correct for appropriate claims processing as well as providing technical assistance to providers if billing incorrectly. The MCOs and Magellan of Virginia continue to work on system updates to correct claims denying incorrectly and adjust these claims as system is corrected. DMAS continues to promote the health plans ARTS Care Coordinators, who are licensed practitioners, to help field clinical concerns and questions.

DMAS worked on several documents to notify the providers of the required staff to perform the multidimensional assessment, development of the individual service plan and completion of the service authorization form. DMAS developed another document to notify providers how the health plans and Magellan of Virginia respond for service authorization notifications. These were posted online and shared with providers via blast email.

DMAS also received feedback from providers and the health plans that there were discrepancies in determining the ASAM Level of Care consistently. This creating some 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 reached out and provided training 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 held a meeting with health plans and residential treatment providers to discuss ASAM Criteria and how to best meet the needs of the pregnant members. DMAS developed a clarification memorandum on ASAM Criteria for residential treatment and shared via email to providers and posted online.

Finally, DMAS is strongly encouraging the health plans to assign members receiving buprenorphine to a Preferred OBOT Provider or any other in-network providers if a Preferred OBOT Provider is not available and accessible. The health plan will cover all the members' addiction treatment services (e.g., physician visit, lab tests, counseling, medication, etc.) instead of members needing to pay out of pocket at out-of-network providers. This increased access to Preferred OBOT Providers will ensure that the member receives the counseling and "high touch" care coordination that will result in the best outcomes. Medicaid health plans have the contractual authority to deny coverage of buprenorphine prescribed by out-of-network providers and will not pay for buprenorphine prescribed by out-of-network providers beginning November 1, 2017. This will hopefully decrease members seeking prescription from out—of-network providers and paying cash for visit to obtain prescriptions and not also receive the evidenced based care to also be receiving counseling.

FINANCIAL/BUDGET NEUTRALITY DEVELOPMENT ISSUES

There are no financial/budget neutrality developmental issues to date noted for GAP nor ARTS. Please see attached budget neutrality spreadsheets.

CONSUMER ISSUES

GAP

DMAS continues to hear that members are experiencing wait times to access appointments for SMI screenings, particularly in the Hampton Roads region. DMAS will be targeting this region for increased outreach and education during Quarter 4. DMAS continues to collaborate with Magellan and follow up regarding with these allegations so DMAS can investigate this concern further. Magellan continues assist members with accessing other screening entities to avoid delays in the application process. Members have reported barriers to getting appointments from providers who are unsure of what GAP is. DMAS has been working closely with Magellan to ensure that provider referrals given to members are viable. GAP providers are accepting new patients and DMAS continues to monitor barriers for screening entities and communicate regularly with Magellan regarding this during weekly conference calls.

ARTS

The only concern noted by consumers at this time is getting access to in-network providers for buprenorphine prescriptions. The health plans have sent member notices with contact numbers to help members locate in-network providers. If there are no in-network providers, the health plans and Magellan will continue to cover buprenorphine prescriptions for out of network

prescribers. DMAS is working with the health plans and Magellan of Virginia to ensure that any issues that may surface are documented and resolved.

CONTRACTOR REPORTING REQUIREMENTS

GAP

Last year, DMAS worked with Magellan to identify broad categories as well as some initial specific data elements to be reported. Broad categories included the following: care coordination, peer supports/Recovery Navigator Services, warm line and routine utilization. DMAS receives weekly reports from Cover Virginia to address the GAP eligibility applications being processed, number of calls received, amount of outgoing mail sent, and information regarding financial renewal. During Quarter 3, DMAS continued to receive all necessary reports from contractors using the data elements detailed above.

DMAS in exploring using predicative modeling tools to assist in identifying GAP members with the highest level of need. GAP staff members 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 settings. The information related to pharmaceutical codes and prescription cost may give insight to and suggest higher levels of medical vulnerability and needs for coordination of health and mental health services in the GAP population. DMAS staff would like to utilize the predictive modeling data to increase care coordination for GAP members who are at high risk with limited behavioral health services.

ARTS

DMAS developed revisions of its contract requirements for the health plans and Magellan of Virginia, Medicaid state plan, state regulations and 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 health plans and Magellan of Virginia 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 health plans and Magellan of Virginia 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 health plans and Magellan of Virginia 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 each provider of ARTS residential services to 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.

DMAS is in the Request for Proposal process to secure a new vendor to perform the ASAM site visits for residential treatment providers. DMAS has 4 provider applications pending.

DMAS's physician review panel continues to review the applications for OBOT providers to ensure they meet the ASAM Criteria. There are now 57 OBOT providers approved during this reporting period. DMAS notified the health plans and Magellan of Virginia of those residential treatment providers and OBOT providers who were approved to finalize their credentialing process.

This reporting period, each health plan and Magellan of Virginia submitted their ARTS Network Development Plan describing current ARTS network and their plan to develop a more comprehensive network for each ASAM level of care in each region. Also, each health plan and Magellan of Virginia submitted an ARTS Network Readiness Plan describing its ARTS services network by region and specifying which ASAM levels of care will have adequate numbers of providers and which levels of care will require further provider development.

The table below represents the current network by ASAM Level of Care and change in numbers of Medicaid enrolled providers for this reporting period.

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS	% Increase in Providers
Inpatient Detox (ASAM 4.0)	Unknown	75	**NEW**
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	76	**1850%**
Partial Hospitalization Program (ASAM 2.5)	0	12	**NEW**
Intensive Outpatient Program (ASAM 2.1)	49	81	**80%**
Opioid Treatment Program	2	29	**483%**
Office-Based Opioid Treatment Provider	0	57	**NEW**

DMAS is working to complete the final list of network providers for posting on the Virginia Department of Health website using google maps. This will be a valuable resource for providers in locating network providers for the transition of care.

RECOVERY NAVIGATORS

GAP

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 board. GAP members are being automatically referred for Recovery Navigation services at time of crisis stabilization request to increase ability for the recovery navigator to be able to initiate support while member is still in the facility and assist with transition back into the community and assist with putting supports in place to make discharge successful.

In Quarter 3, there was an average of 139 members enrolled in Recovery Navigation. There is an average of 27 new enrollees per month to Recovery Navigation. The average number of days in Recovery Navigation is 146. There was an average of 14 calls to the "Warmline", 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 from Quarter 3:

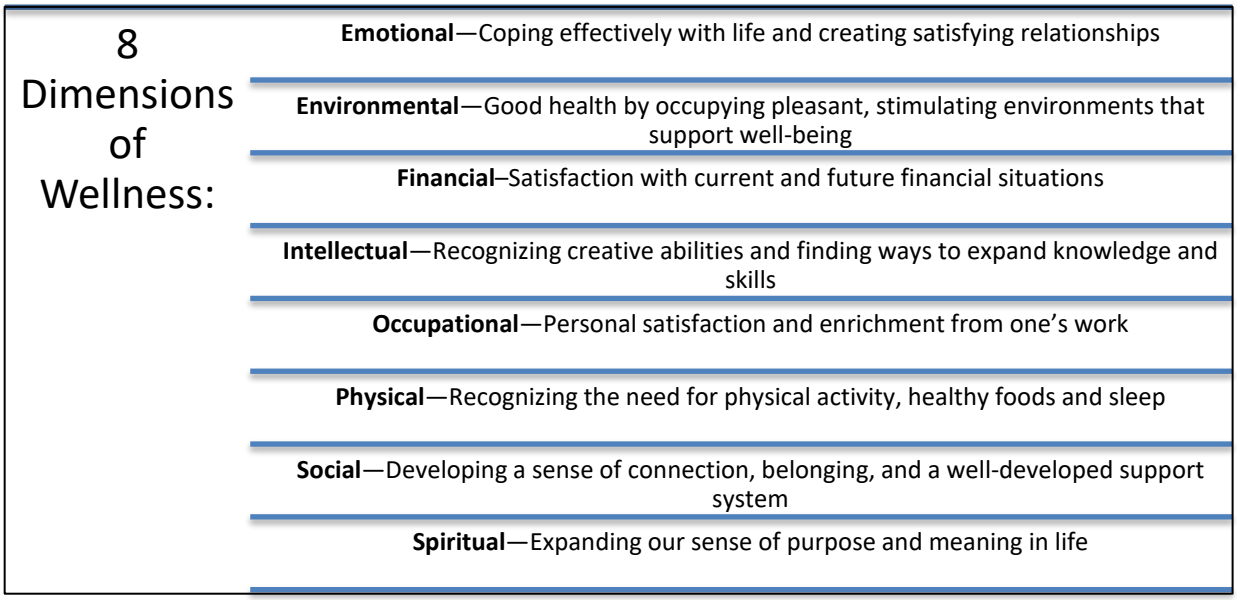
> *A 32-year-old female GAP member presented with diagnosis of Bipolar Disorder and Posttraumatic Stress Disorder. She was experiencing symptoms of depression after the*

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 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 16



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 15 describes each dimension.

Magellan is considering the use of the Temple University Collaborative Participation Survey results to assist in capturing the promotion of recovery and quality of life is a major focus of recovery navigation transformation efforts. 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.

PEER SUPPORTS: MENTAL HEALTH AND ADDICTION AND RECOVERY TREATMENT SERVICES

GAP

Effective 7/1/2017 GAP members are eligible to receive Mental Health Peer Supports and Addiction and Recovery Treatment Services Peer Supports. These services are evidence based services provided by certified, professionally qualified and trained Peer Recovery Specialists. Services are non-clinical, peer to peer activities that empower individuals to improve their health, recovery, resiliency, and wellness.

GAP members are not able to receive both Recovery Navigation support and Peer Supports at the same time. If a GAP enrollee elects to transition out of Recovery Navigation services through Magellan and receive MH or ARTS Peer Support Services, the recovery navigator should assist with the transition from BHSA-provided peer support navigation. The transition period may last up to 30 consecutive calendar days and address discharging from recovery navigator services and engagement in peer support services.

During Quarter 3, there have been no service authorizations for GAP members receiving Peer Supports services. There are 5 credentialed providers for this level of care in Magellan's network. DMAS anticipated a slow start up for this level of care.

ARTS

ARTS does not cover Peer Navigators but is covering Peer Support Services for individuals with a substance use disorder or co-occurring mental health and substance use disorder. DMAS finalized the Peer Attestation Forms and Peer Registration Forms and shared with providers, the health plans and Magellan of Virginia. DMAS finalized the Peer Support Services regulations and submitted to the Virginia Town Hall for public comment and to begin processing. The public comment period ends November 2, 2017. DMAS also completed several provider trainings on Peer Support Services this reporting period. There are no service authorizations for Peer Services to date.

DMAS will continue to partner with Magellan on outreach regarding this level of care.

LESSONS LEARNED

GAP

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.

ARTS

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 has posted the ARTS manual online for public comment and also separated the Opioid Treatment Services section to a Supplement. The goal is to make the program information as clear as possible for providers.

During this reporting period, DMAS continued to receive several claims and networking issues reported by providers. DMAS is working with Magellan of Virginia and the MCOs to resolve issues and they are being identified.

DMAS continues to have the weekly technical assistance calls as well as the monthly 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.

DEMONSTRATION EVALUATION

GAP

DMAS previously used 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.

Due to the issues with data collection and analysis, the evaluation panel did not meet this quarter. The panel has been on hiatus while staff works on resolving the reporting issues. In anticipation of the Waiver Amendment approval, this panel will end.

ARTS

DMAS continues to meet regularly with the Virginia Commonwealth University (VCU) research team and finalized the first quarterly report. This analysis shows the increase in provider access

for members with Opioid Use Disorder as well as any Substance Use Disorder. The analysis is available in the Appendix of this report.

CONCLUSION

GAP

DMAS staff were able to make great progress on outreach and education during this quarter. DMAS staff partnered with stakeholders, Community Services Boards, SMI screening entities, and members to gain a better understanding of the barriers and successes to serving members across Virginia. During Quarter 3, DMAS implemented MH Peer Supports and ARTS Peer Supports for GAP members and are monitoring network capacity and member utilization of this service as it begins to be used. DMAS continues to be committed to increasing access to healthcare to the criminal justice system's returning citizens with significant behavioral health and medical needs and recognize how access to care impacts recidivism. New outreach material has been completed and will begin to be disseminated to newly returning citizens after release from incarceration. DMAS is also committed to continue strong collaboration with its contractors to develop higher confidence in the data process as well as identifying additional opportunities to better serve our members throughout Demonstration year 3.

ARTS

DMAS successfully implemented the ARTS program. During the second quarter post implementation, DMAS continued to work with providers, health plans and Magellan of Virginia to work through identified issues and helping to foster the lines of communication between the providers and the health plans. DMAS is also committed to finalizing the review of the ARTS Network and working with stakeholders to increase access to areas in need of providers.

FORMER FOSTER CARE MEMBERS

In May 2018, 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 applying for Virginia Medicaid. These youths were previously covered through the State Plan for Medical Assistance, but based on guidance from CMS, it was determined that in order for the authority to cover these youths to continue, it would need to be done through a section 1115 Medicaid demonstration waiver. 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.

ENCLOSURES

Outreach Appendix
ARTS VCU Evaluation Quarter 1

STATE CONTACT(S)

If there are any questions about the contents of this report, please contact:

Sherry Confer
Behavioral Health Manager
Sherry.Confer@dmas.virginia.gov

Appendix-Outreach Chart

DATE	EVENT	AUDIENCE	ITEM	FOCUS: GAP	FOCUS: Peer Support	#ATTENDED	COMMENTS	PRESENTER
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	Magellan provided additional training to afterhours clinical staff who handle GAP calls and authorizations that may be received after the Virginia office is closed to ensure they understand covered benefits.	Magellan Senior Trainer
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		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	DMAS staff, DBHDS staff

							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.	
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 services, Peer Supports, upcoming changes to FPL increase and the addition of ARTS services for GAP members. DMAS staff reviewed application process for GAP.	DMAS staff
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 navigation and reviewed importance of care coordination.	DMAS staff
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

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

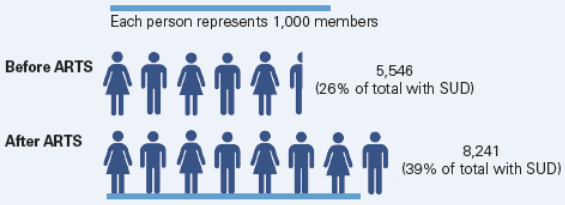
The Department of Medical Assistance Services contracted with Virginia Commonwealth University to conduct an independent evaluation of the ARTS program. This brief highlights developments across the first three months of the evaluation period, from April 1st, 2017 to July 1st, 2017.

Key Findings

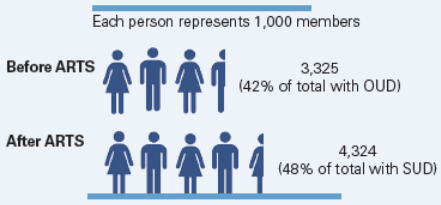
- Treatment rates among Medicaid members with substance use disorders (SUD) increased by 50% in the first 3 months of ARTS compared to a similar time period in 2016.
- Rates of pharmacotherapy for members with an opioid use disorder (OUD) vary by region. The Eastern region experienced the largest improvement 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)



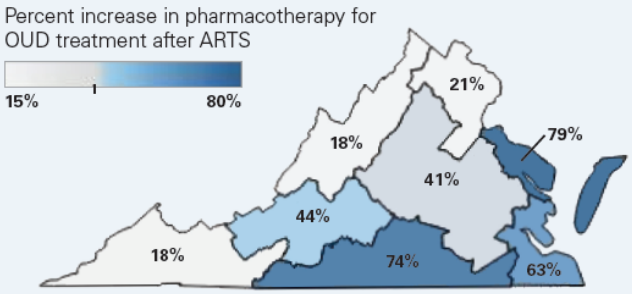
Members receiving pharmacotherapy for opioid use disorder (OUD)



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).

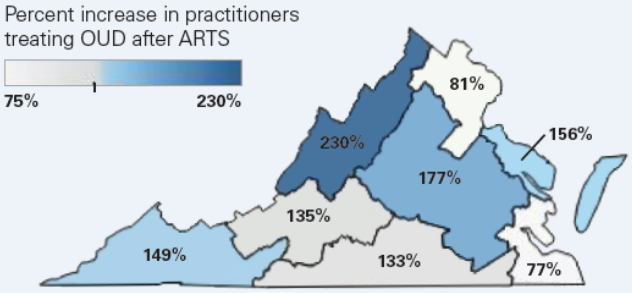
VCU Health Behavior and Policy
School of Medicine

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