

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 Quarterly Report

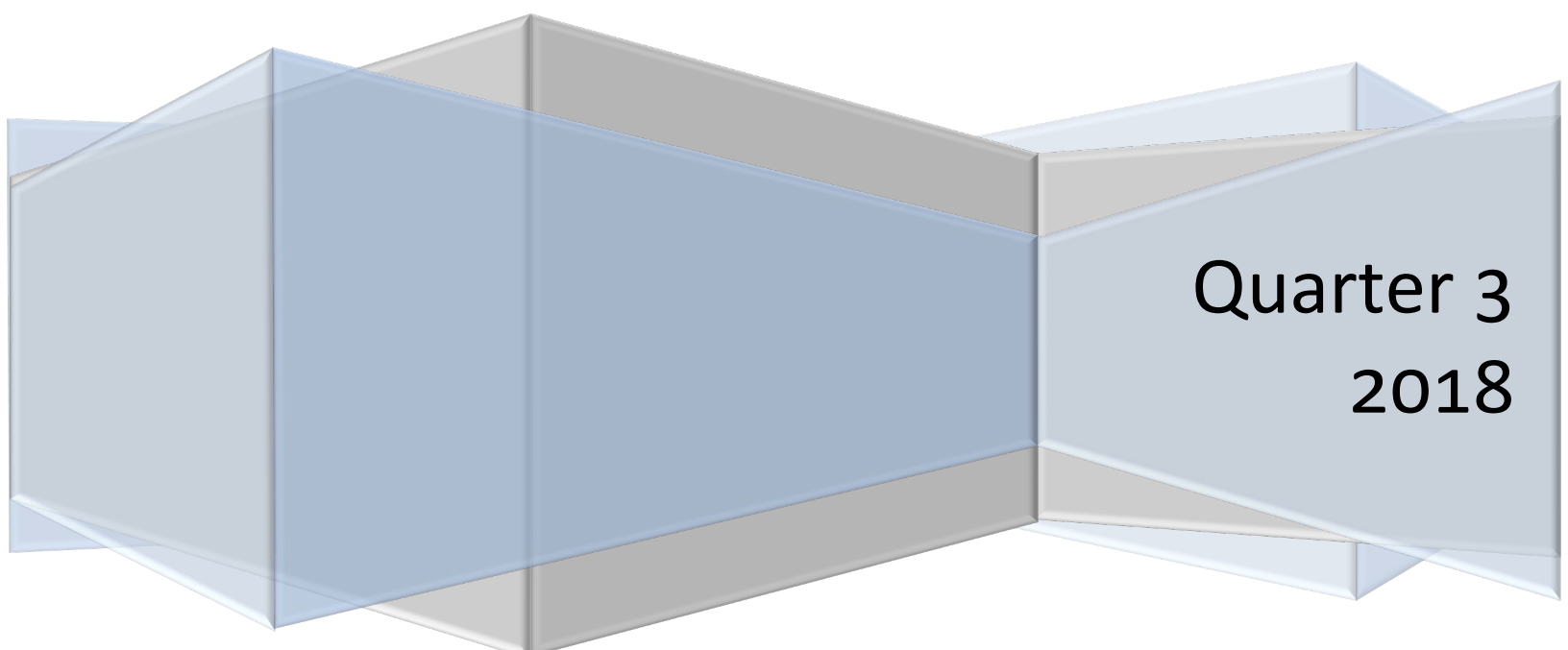
Demonstration Waiver 1115

Project 11 – W- 00297/3

Demonstration Year: 4 (01/01/2018 – 12/31/2018)

Quarter 3 (07/01/2018-09/30/2018)

Approval Period (1/12/2015-12/31/2019)



Quarter 3
2018

Governor's Access Plan

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 SMI. The initial GAP 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 to Medicaid Directors that highlighted new service delivery and funding opportunities for Medicaid members experiencing a Substance Use Disorder (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 SUD 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 2017, DMAS submitted an amendment to the GAP Demonstration Waiver to request approval to provide Medicaid coverage to former foster care youth (FFCY) 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. 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 Quarter 3 of the fourth year of the GAP waiver. This report is organized to reflect the GAP, ARTS, and FFCY components of the waiver.

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 waiver 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.

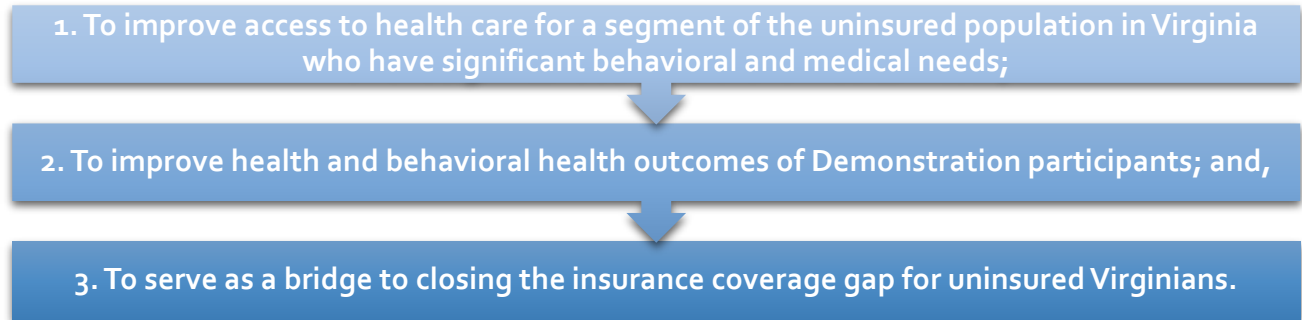
The implementation of the GAP waiver required DMAS to work with stakeholders and community mental health and healthcare providers, primary health care providers, Magellan of Virginia (the Behavioral Health Services Administrator) and DBHDS. To date, these partners continue to work together to ensure 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 of Virginia 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 of Virginia 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. We prefer they access these providers in lieu of the emergency rooms of hospitals. Identification, provision of training, and collaboration with these providers continues.

GOALS

The three key goals of the GAP waiver are to:



ELIGIBILITY AND BENEFIT INFORMATION

The Virginia GAP 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

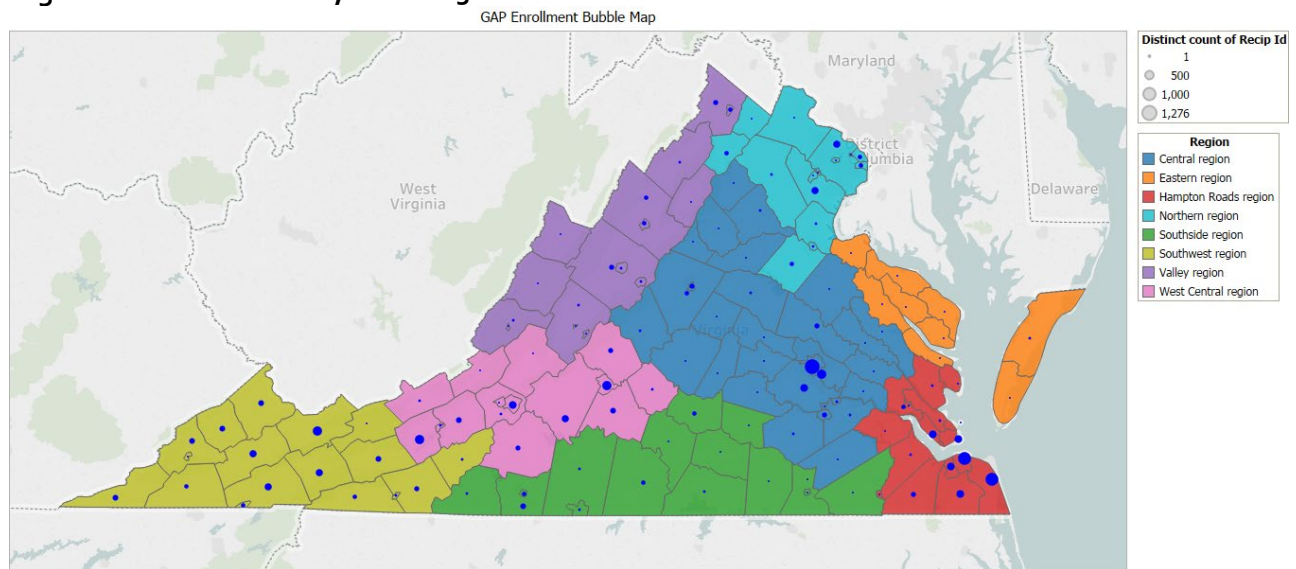
DMAS has continued to see increased enrollment with the GAP continuing during Quarter 3. Individuals are receiving information about the program and applying through their relationships with local entities. The partnerships between DMAS, the local Community Services Boards (CSBs) and Magellan of Virginia, in addition to a growing relationship with the FQHCs, are attributable to the continued success.

ENROLLMENT COUNTS FOR YEAR TO DATE

GAP MEMBER POPULATION

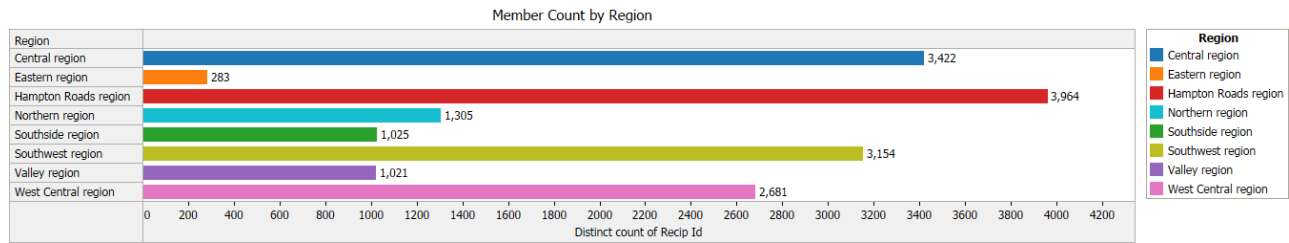
DMAS currently provides coverage to approximately 1.2 million Virginians enrolled in Medicaid. Approximately 1.12% of these beneficiaries are enrolled in GAP. In the following Figures and Tables, the population displayed includes GAP members categorized by location, race/ethnicity, gender, age group and primary diagnosis.

Figure 2: GAP Enrollment, Quarter 3



GAP membership continues to grow. In Quarter 3 (ending September 30, 2018), there were 16,855 individuals enrolled from 266 unique localities across the Commonwealth. The map shown in Figure 2 shows the location of those members enrolled.

Figure 3: GAP Members of the Commonwealth by Region, Quarter 3



The figure above displays the geographic distribution of the GAP population, broken down by regions in Quarter 3. As highlighted in the figure, the Hampton Roads region continues to serve the largest concentration of GAP members at 3,964 with the Central (3,422 members) and Southwest (3,154 members) regions closely following. These regions have remained the top three enrollment regions since the beginning of GAP.

Figure 4: GAP Enrollment, Quarter 3

Demonstration Population	Total Number of members Quarter Ending 9/30/2018	Total Number of members Quarter Ending 6/30/2018	Total Number of members Quarter Ending 3/31/2018	Members Enrolled Since 01/12/2015
GAP Members Enrolled	16,855	15,662	14,756	22,409

There have been 22,409 unique members enrolled since the implementation of the GAP. The difference between the unique members' number and the currently enrolled number may be related to those members that did not successfully complete the eligibility renewal/re-enrollment process or those that have moved to full Medicaid, or obtained other insurance coverage.

Figure 5: GAP Members by Age Group and Gender, Quarter 3

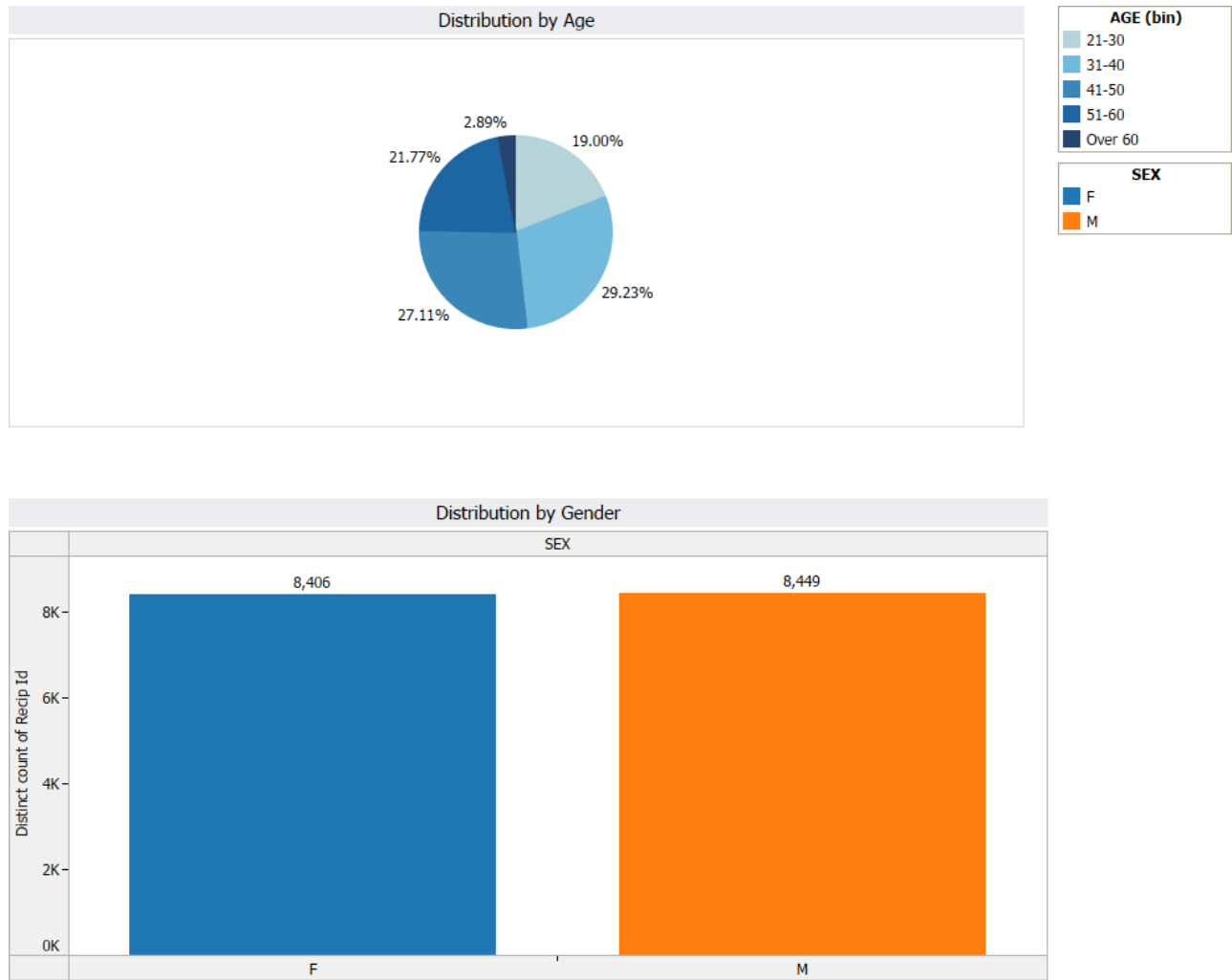


Figure 5 displays the distribution of GAP members by age group. The 31-40 age group remains the largest population of GAP members at 29.23% followed closely by the 41-50 age group at 27.11%. The age demographics of GAP members remain relatively equal across all eligible age groups with the exception of members over the age of 60, which only totals 2.89% of GAP population.

Figure 5 also highlights gender distribution of GAP members. The gender distribution has remained consistent since across implementation. During Quarter 3, males are slightly higher with 8,449 followed closely by females at 8,406.

Figure 6: GAP Members by Race, Quarter 3

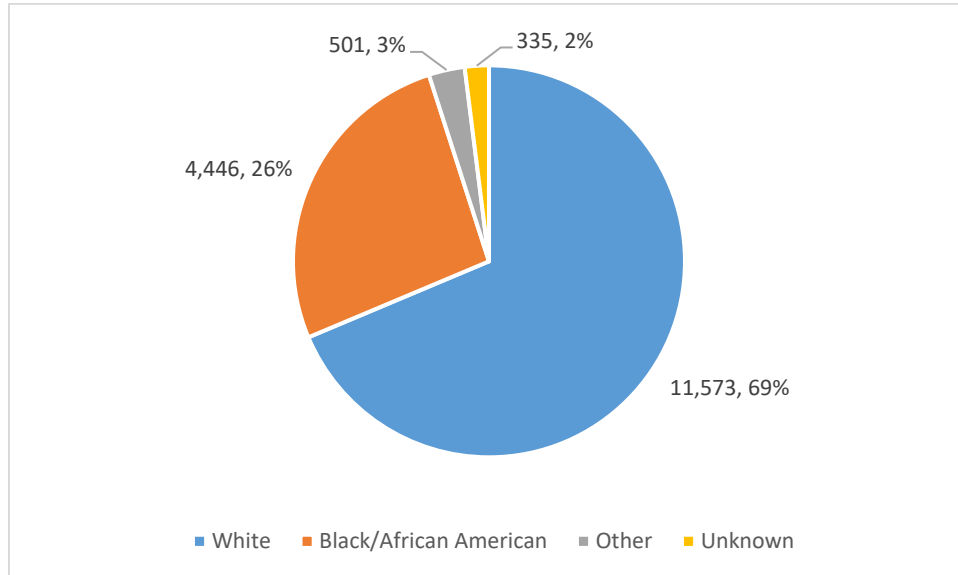


Figure 6 highlights the reported race of GAP members during application process in 2018. As noted in the figure above, the primary race selected was White followed by Black/African American.

Figure 7: Cover Virginia Renewals, Quarter 3

Of the 3,458 GAP renewals due to Cover Virginia in Quarter 3:	2,675 were approved
	184 were cancelled due to ineligibility
	515 were cancelled due to member inaction

In November 2015, Cover Virginia began the ex parte renewal process, which allowed for electronic systematic verification of information (such as income) to determine eligibility for members approaching their renewal. Figure 7 highlights the number of renewal approvals and cancellations completed in Quarter 3. Overall, in Quarter 3, 77% of the renewals were approved.

Magellan of Virginia has partnered with DMAS and Cover Virginia to increase the completion of renewals by reaching out to each member not

completing the ex parte process and remind them each month to respond to Cover Virginia. These outreach efforts have proven effective assist in decreasing the member inaction component of the renewal process.

OPERATIONAL UPDATES

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

In 2017, DMAS implemented the Commonwealth Coordinated Care Plus managed care program and, beginning August 2018, implemented the Medallion 4.0 managed care program. Both programs include a strong focus on care coordination by licensed professionals including those in mental health. This increase in workforce opportunities with the managed care organizations has created a workforce shortage for both direct service providers and for Magellan of Virginia. Magellan of Virginia has had a change in leadership positions and in clinical staffing that has created the need for closer monitoring of the GAP program by DMAS staff.

PERFORMANCE METRICS

DMAS continues to see an increase in utilization of behavioral health services by the GAP population. In Quarter 3, Magellan received 3,235 SMI screenings for review and Cover Virginia processed 4,948 financial applications for coverage. In 2018 year to date, 9,341 GAP members accessed preventive medical services, 709 GAP members have accessed Crisis Intervention services and 466 members have accessed Crisis Stabilization services. It is noteworthy that in 2018 year to date, 4,260 GAP members have utilized GAP case management services, which focuses on assisting individuals with accessing needed medical, behavioral health (psychiatric and substance use treatment), social, education, vocational, and other support services. A total of 8,255 GAP members have accessed/filled prescriptions for antidepressants in 2018, 5,247 members have accessed/filled prescriptions for antipsychotics, and 8,210 members have accessed/filled prescriptions for medical needs. This is an increase in utilization over previous quarters.

OUTREACH/INNOVATION ACTIVITIES TO ASSURE ACCESS

In an effort to increase the completion of applications and care coordination with this transient population, DMAS and Magellan of Virginia focused on efforts to ensure members and providers are aware that GAP members have access to receive free cell phone service through the SafeLink program. Through Magellan of Virginia, GAP members receive a free mobile phone, cellular minutes, and health messaging services. Members also receive 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. During Quarter 3, there were 741 GAP members enrolled in SafeLink Wireless.

During Quarter 3, DMAS approved Magellan of Virginia's plan for use of a text message platform, CareMessage for the GAP population. The platform allows SafeLink wireless members who have

opted to receive text messaging updates to provide recovery and resiliency tips from Care Message. Magellan is developing a topic schedule for DMAS review.

Magellan continues to execute the outreach plan to target peer run centers, recovery groups, networking with other providers and professionals in the field and criminal justice facilities around the Commonwealth to increase awareness of the GAP program.

DMAS and Magellan of Virginia staff host a monthly provider call and answer questions from the provider network as well as provide updates and announcements. A low number of GAP issues continue to be identified on these monthly calls. GAP questions and responses are monitored by DMAS staff to ensure accurate information is disseminated.

Another avenue for outreach is 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 GAP. This quarter, the majority of the emails received came from providers; most inquires involved questions regarding covered medical services and procedure codes.

DMAS' also maintains a GAP webpage on the DMAS website: <http://www.dmas.virginia.gov/#/gap>. The webpage includes sections for members, providers and other stakeholders. The webpage has links to Cover Virginia, Magellan of Virginia, and other helpful information for individuals who may be interested in applying for GAP, current GAP members and providers. The GAP webpage received 1,123 page views during Quarter 3, of which 935 were unique page views between July 2, 2018 and September 23, 2018. These numbers are less than previous quarters and DMAS is exploring whether they are accurate.

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 of Virginia's website has a link for provider communication, <https://www.magellanofvirginia.com/for-providers/gap-information>, including updates and announcements to providers about GAP. During Quarter 1, the list of updated SMI eligible codes were posted for providers. Magellan has a dedicated page for training for GAP for providers as well, <https://www.magellanofvirginia.com/for-providers/training/training-pdfs-and-videos/gap-training/>. They have also developed a GAP specific webpage, <https://www.magellanofvirginia.com/for-members/governors-access-plan-gap> for members, family members and advocates. Announcements and updates can be found on this page as well as application instructions, covered services, and information about how to contact Magellan of Virginia for coordination of care and Recovery Navigation services.

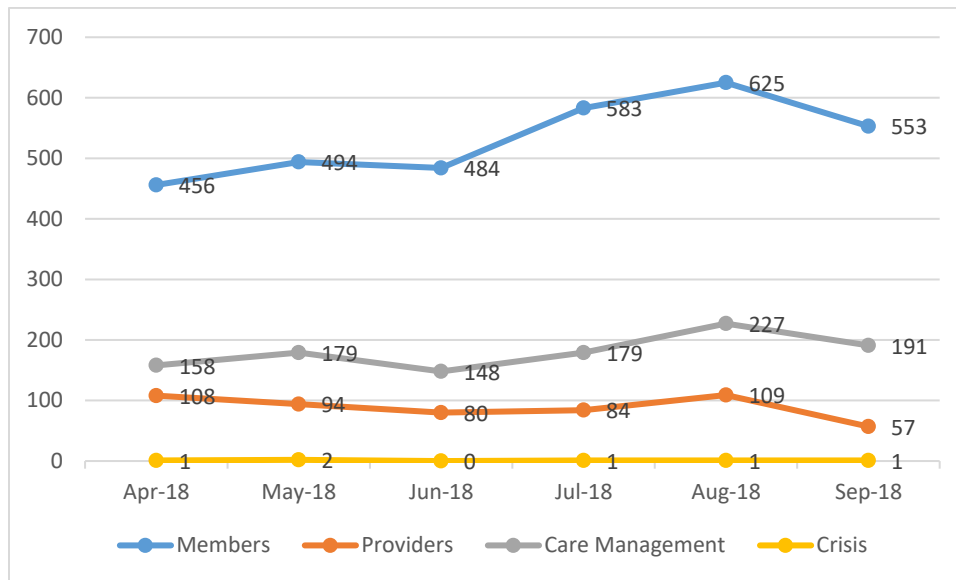
See additional outreach efforts located in Appendix A.

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

DMAS collects and reviews data from contractors (Magellan of Virginia and Cover Virginia) and uses data from its Medicaid Management Information System (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 of Virginia Call Center provides monthly data to DMAS about calls received related to GAP.

Figure 8: Magellan of Virginia Call Center Data, Quarter 3



It is noteworthy that there are significantly more contacts from GAP members than from providers. This has remained consistent since the implementation of GAP. Members are encouraged to contact Magellan of Virginia for physical and behavioral health care referrals and resources. This reflects the ongoing need for care coordination in order to assist members in finding referrals and accessing services.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix B of this report, an updated budget neutrality workbook for Quarter 3 that includes established baseline and member month data that meets all the reporting requirements for monitoring budget neutrality.

CONSUMER ISSUES

DMAS continues to hear from members that they are experiencing wait times to access appointments for SMI screenings, particularly in the Hampton Roads region and rural portions of the Commonwealth. DMAS continues to collaborate with Magellan of Virginia and investigate these allegations. Magellan of Virginia assists members with accessing other screening entities to avoid delays in the application process. Members have reported barriers to getting appointments with medical providers who are unsure of GAP coverage and limitations. DMAS has been working closely with Magellan of Virginia to ensure that provider referrals given to members are viable and verified prior to giving the provider contact information to members. DMAS reviews Magellan of Virginia during weekly conference calls.

CONTRACTOR REPORTING REQUIREMENTS

DMAS receives reports from Magellan regarding care coordination, Peer Supports/Recovery Navigator Services, the warm line and routine utilization. DMAS receives weekly reports from Cover VA regarding the number of eligibility applications being processed. During Quarter 3, DMAS continued to receive all necessary reports from contractors. When additional clarification is needed regarding reporting requirements, Magellan of Virginia and DMAS hold conference calls and provide details to ensure data received is accurate and timely. Cover Virginia continues to meet contractual expectations.

RECOVERY NAVIGATORS

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

The Recovery Navigators provide in person outreach and education at crisis stabilization facilities operated by CSBs. GAP members are automatically referred for Recovery Navigation services when a crisis stabilization request is submitted. This has led to an increase in the ability for the Recovery Navigator to be able to initiate support while the member is still in the facility. They continue to assist with transition back into the community and ensure supports are in place to make discharge successful.

In Quarter 3, there were 276 total referrals to Recovery Navigation with an average of 159 members enrolled. There was an average of 25 new members enrolled per month to Recovery

Navigation with an average number of days in Recovery Navigation of 128. There was a total of 61 calls in Quarter 3 to the “warmline”, an evening and weekend support line, staffed by the Recovery Navigators. Of the supports delivered to GAP members by Recovery Navigation, emotional support, empathy, caring, concern, was the 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 61-year-old male GAP member, with a diagnosis of Schizoaffective Disorder, PTSD and Alcohol Use Disorder was referred for Recovery Navigation following admission to a Crisis Stabilization Unit in March 2018. At that time, the member was experiencing increasing depressive symptoms and suicidal ideation. Until recently, the member had been doing well. However, the Recovery Navigator (RN) recently called the member to find him intoxicated and expressing suicidal ideation. The RN immediately got a GAP Care Manager (CM) on the line. The member reported he was wandering around his locality but was unable to give an exact location. The RN called the police to help locate the member for a wellness check while the CM stayed on the phone with the member. Based on updates from the CM, the police were eventually able to locate the member despite his shifting location. The police felt the member was stable enough to return home at that time and the member has since started an ARTS Partial Hospitalization program, which he is currently attending.

Figure 9: 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 9 describes each dimension.

PEER SUPPORTS: MENTAL HEALTH AND ARTS

GAP members began receiving Mental Health Peer Supports and ARTS 7/1/2017. 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.

During Quarter 3, there were no service authorizations for GAP members receiving Mental Health Peer Supports services, but there were 92 authorizations for ARTS Peer Support Services. There are 4 credentialed providers for this level of care in Magellan of Virginia's network for Mental Health Peer Support Services and 13 providers for ARTS peer supports. Four providers are credentialed to provide both levels of care. There are a total of 57 site locations between these providers.

GAP members are not able to receive both Recovery Navigation support and Peer Supports at the same time. If a GAP member elects to transition out of Recovery Navigation services through Magellan and receive Mental Health or ARTS Peer Support Services, the Recovery Navigator assists with the transition from the peer support navigation services provided by Magellan of Virginia. The transition period may last up to 30 consecutive calendar days and address discharge from Recovery Navigator services and engagement in peer support services. Magellan of Virginia continues to monitor and track any members with service authorizations for this service and are receiving Recovery Navigation to ensure appropriate transition if needed.

LESSONS LEARNED

DMAS continues to evaluate how processes and procedures can be refined and strengthened. At this stage of GAP, significant progress has been made to increase the awareness and outreach of the benefit plan since implementation. Below are some lessons learned:

- 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.
- Data 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.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

Robust data and analysis of service utilization, trends, and noteworthy data are reviewed by clinical staff to determine the need for further collaboration with contractors. The CMS independent evaluation required additional funding for DMAS to complete. Due to the delay in the signing of the budget by the Virginia General Assembly, the evaluation design draft was put on hold. In the interim, DMAS continued to review data and objectives related to the initial evaluation design.

CONCLUSION

During Quarter 3, DMAS continued to focus on increasing access to healthcare for the population in Virginia with significant behavioral health and medical needs and is committed to recognizing how access to care impacts the members ability to live, work, and function successfully. DMAS has seen increased enrollment in Quarter 2 and growth in the GAP program, which allows more individuals to 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 identify additional opportunities to better serve our members throughout the remainder of 2018.

Addiction and Recovery Treatment Services

INTRODUCTION

In September 2014, to address 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, CMS issued the 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 DMAS to make changes to its existing substance use disorder treatment services. Under this authority, DMAS developed, in collaboration with the DBHDS, the (VDH, DHP, the managed care organizations 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 with the State's implementation of the system transformation of the SUD treatment services: Addiction and Recovery Treatment Services (ARTS).

BACKGROUND

Virginia's 1.2 million members enrolled in Medicaid are disproportionately impacted by the substance use epidemic. Nearly 1,300 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. Medicaid members are also prescribed opioids at twice the rate of non-Medicaid members and are at three-to-six times the risk of prescription opioid overdose. 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. As part of the Governor's Task Force recommendations, 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. Even after ARTS implementation, Virginia continues to be impacted by the opioid epidemic. In 2017, VDH estimates that almost 1,450 individuals died as a result of drug overdoses involving fentanyl and/or heroin and prescription opioid overdoses; and over 10,000 individuals presented at an emergency department with either a heroin or opioid overdose.

GOALS

Virginia’s overall goal for the ARTS benefit is to achieve the triple aim of improved quality of care, to offer a continuum of care across the benefit plan, improved population health, and decreased costs for the Medicaid population with SUD. DMAS’ specific objectives for this benefit are outlined below:

Figure 10: DMAS Specific Objectives for ARTS

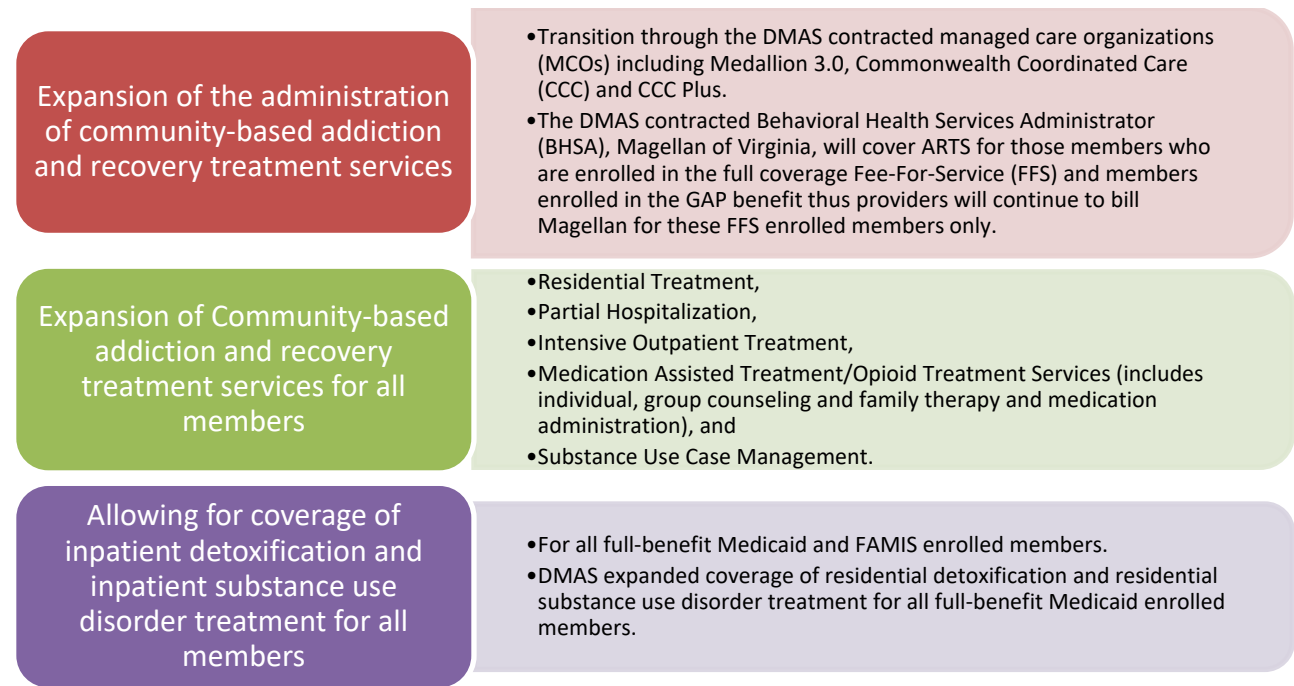


This report will provide an update on the goals of the Virginia ARTS program.

ELIGIBILITY AND BENEFIT INFORMATION

The ARTS benefit expanded 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 provided through the fee for service, Medallion 3.0 & Medallion 4.0 Managed Care, and Commonwealth Coordinated Care Plus (CCC Plus) Medicare/Medicaid Programs. All MCOs and Magellan of Virginia are covering the full range of ARTS services.

Figure 11: Full Range of ARTS Services



ENROLLMENT COUNTS FOR YEAR TO DATE

DMAS provides SUD treatment services and co-occurring substance use and mental health disorder treatment services to all 1.1 million¹ 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. Highlights of the first year of the programs implementation covering April 1, 2017 to April 1, 2018 are below.

¹ DMAS Monthly average enrollment as of September 2018

Key Findings

- The percent of Medicaid members with an opioid use disorder (OUD) who received any treatment increased from 46 percent before ARTS to 63 percent during the first year of ARTS.
- The percent of Medicaid members with a SUD who received any treatment increased from 24 percent before ARTS to 40 percent during the first year of ARTS (see Figure 12).
- The number of prescriptions for opioid pain medications among Medicaid members decreased by 27% during the first year of ARTS.

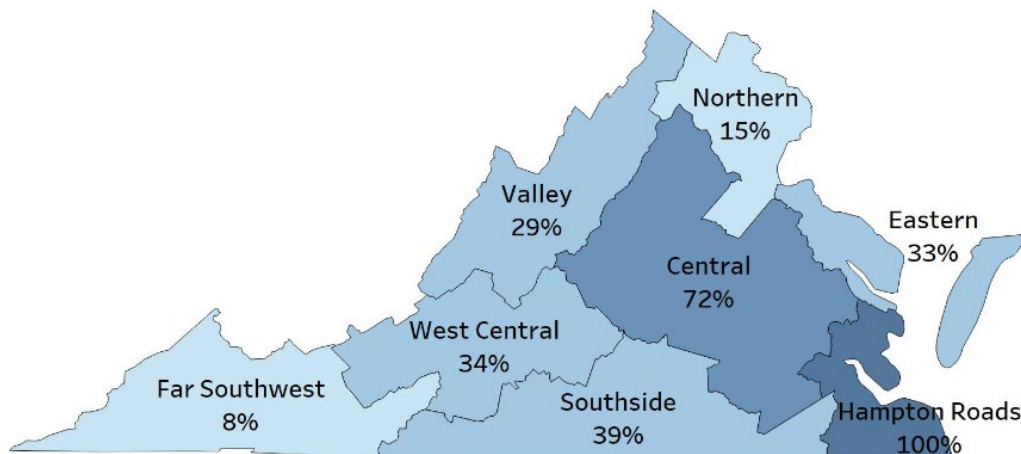
Figure 12: Members Receiving Treatment Services



Pharmacotherapy for OUD treatment increased in all regions of Virginia after ARTS implementation. During the first year of ARTS, the number of members receiving pharmacotherapy for OUD increased by 34%. Members receiving buprenorphine pharmacotherapy, the most widely prescribed medication for OUD, increased by 22%.

DMAS will provide updates from VCU on the next annual report.

Figure 13: Member Receiving Pharmacotherapy for OUD





DMAS continues to promote use and access of the Peer Services benefit which includes Peer and Family Support Services (Peer Services for Adults as well as for Parents/Caregivers of minors). There has been concern noted that a barrier may be that Peer Support Specialists must be certified through DBHDS as well as registered with DHP. DBHDS is working to enhance Peer Support Specialists in the emergency departments, funding for Peer Support Specialists in local health departments and offering stipends to those who have completed the education requirements for Peer Support Specialists to be able to have funding during their internship program.

OPERATIONAL UPDATES

During Quarter three of the second year post ARTS implementation, DMAS continued to monitor activity with the MCOs and Magellan of Virginia to determine if there were any significant operational, policy, systems, or fiscal developmental issues. While claims issues have significantly reduced since the implementation of the ARTS program there continued to be some claim issues related to MCO claims processing and errors identified by providers and reported to DMAS. DMAS worked with the MCOs to resolve provider's claims issues on a case-by-case basis when providers reached out to DMAS.

ARTS care coordination remains an important role within the ARTS program and DMAS continued to promote and provider community trainings on the importance of the MCO ARTS care coordinators. DMAS has facilitated two ARTS care coordinator calls to promote best practices and discuss cases that may have been more challenging to get peer feedback.

DMAS implemented an initiative this quarter to address the need for providers within the Preferred Office-Based Opioid Treatment (OBOT) setting. DMAS, DBHDS and VCU staff presented at the first Medication Assisted Treatment Summit for Federally Qualified Health Centers (FQHCs). The Virginia Health Care Association hosted the training and presentations covered the ARTS Preferred OBOT benefit, funding for FQHCs available through the State Opioid Response (SOR) grant, evidence based practice for Medication Assisted Treatment, and presentations from two FQHCs who are Preferred OBOTs and their experiences implementing the Preferred OBOT program in their community. At the end of the trainings one of the FQHCs committed to applying for Preferred OBOT status and several FQHCs expressed interest. DMAS will continue to work with Virginia Health Care Association in developing regional trainings and outreach to FQHCs.

PERFORMANCE METRICS

Each MCO and Magellan of Virginia are to use, and expand as necessary, their existing quality improvement infrastructures, quality improvement processes and performance measurement data systems to ensure continuous quality improvement of ARTS. At a minimum, each MCO and Magellan of Virginia must have an Annual Quality Management Plan that includes their plan to monitor the service delivery capacity as evidenced by a description of the current number, types and geographic distribution of SUD services. Monitoring of performance will include determining and analyzing the root causes for performance issues.

This quarter, DMAS has been working with the CMS as one of the six pilot states working with CMS to implement new quality metrics for the ARTS program. DMAS has submitted back to CMS all required and recommended quality measures the state will report on and is currently waiting on the technical specifications from CMS for those measures.

DMAS is working with the internal staff to ensure that all required quality measures are all housed within the ARTS Technical Manual in order to streamline the process for MCOs and Magellan of Virginia. DMAS plans to have this change implemented by January 1, 2019.

DMAS is working to implement external quality review organization (EQRO) requirements related to ARTS. DMAS is exploring the option to have Medication Assisted Treatment (MAT) providers evaluated as part of the quality reporting for MCOs.

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

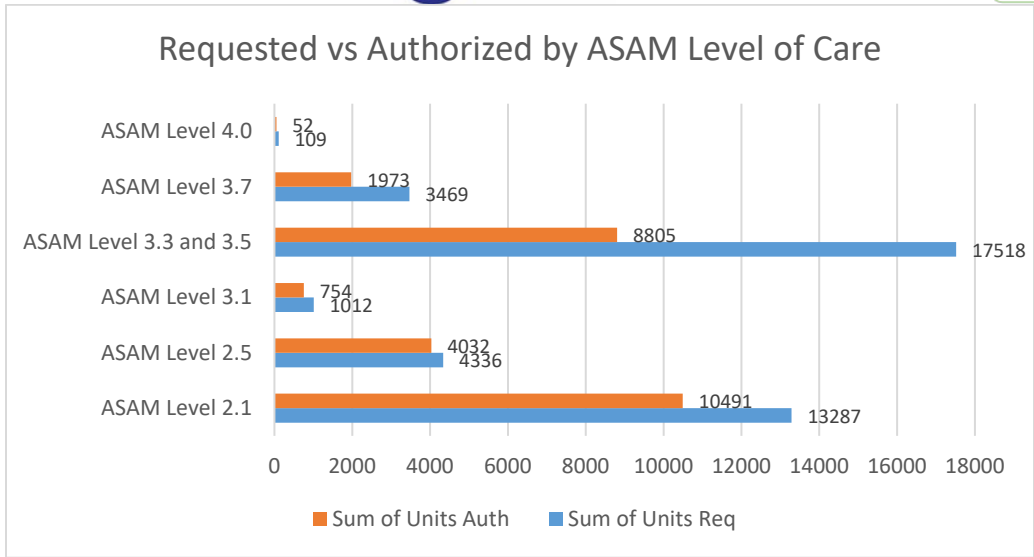
DMAS continues to work with the MCOs in collecting monthly data on service authorizations across all ASAM levels of care. DMAS will provide an update of the services authorizations in the next quarterly report due to data quality issues in this reporting period.

Figure 14: ASAM Levels of Care and Description

ASAM Level of Care	ASAM Description
4.0	Medically Managed Intensive Inpatient
3.7	Medically Monitored Intensive Inpatient Services (Adult) Medically Monitored High-Intensity Inpatient Services (Adolescent)
3.5	Clinically Managed High-Intensity Residential Services (Adults) / Medium Intensity (Adolescent)
3.3	Clinically Managed Population-Specific High-Intensity Residential Services (Adults)
3.1	Clinically Managed Low-Intensity Residential Services
2.5	Partial Hospitalization Services
2.1	Intensive Outpatient Services
0.5	SUD Case Management (Registration Only)

The data below shows services authorization data and looks at requested unit's verses authorized units based on medical necessity.

Figure 15: ARTS Service Authorization Quarter 3



BUDGET NEUTRALITY AND FINANCIAL REPORTING

There are no financial/budget neutrality developmental issues to date noted for ARTS.

CONSUMER ISSUES

Members have not reported any new issues concerning access to care during this quarter.

DMAS recognizes that there are still some gaps in service coverage and continues to work with the MCOs and Magellan of Virginia to build in-network providers capacity.

CONTRACTOR REPORTING REQUIREMENTS

The MCOs and Magellan of Virginia are required to report on ARTS specific measures on a monthly basis. This reporting is for the following ASAM levels of care: Opioid Treatment Programs (OTPs) and Preferred 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. Monthly reporting requirements include reporting on new service authorizations for the month, both approved and denied; Call center statistics, appeal and grievances filed for the month, patient utilization management program (PUMS); and provider network adequacy. DMAS will capture the roll up of call center statistics, appeal and grievances and PUMS during the annual report.

The MCOs and Magellan of Virginia have consistently been timely with ensuring monthly reporting submitted to DMAS. Currently DMAS is working to consolidate all ARTS monthly reporting along with CMS quality measures into one ARTS Technical Manual.

DMAS utilizes the monthly network adequacy reports to monitor network capacity. The table below represents the current network by ASAM Level of Care and details the increase of network providers.

Figure 16: ARTS Providers by ASAM Level of Care

Addiction Provider Type	# of Providers before ARTS	# of Providers after ARTS
Inpatient Detox (ASAM 4.0)	Unknown	103
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	94
Partial Hospitalization Program (ASAM 2.5)	0	16
Intensive Outpatient Program (ASAM 2.1)	49	136
Opioid Treatment Program	6	39
Office-Based Opioid Treatment Provider	0	89

DMAS maintains an ARTS google map, which has the ARTS providers listed by ASAM level of care. The map is currently being updated quarterly. The map is located: <https://www.google.com/maps/d/viewer?mid=1px9XvltNMrXZ6vrTgXgPGIHTew&hl=en&ll=37.81633144363703%2C-80.57419543505449&z=6>

LESSONS LEARNED

DMAS continues to evaluate the ARTS program and seeks to find areas to help improve overall outcomes for Medicaid members. During this quarter of the ARTS program the below are the lessons learned:

- DMAS issued a MAT memo and survey to residential, IOP and PHP providers to gauge how these providers would offer MAT to members post discharge and had little response to the survey results. DMAS realizes we need to work closely with providers to engage them on the importance of having access to MAT available to members upon discharge.
- VCU OBOT Quality Analysis revealed difficulty with MCO paying claims quickly and appropriately for some OBOT providers. DMAS has been encouraging feedback directly from providers to DMAS timely in order to resolve claims issue.
- DMAS discovered there were unresolved claims issues between Magellan of Virginia and OTPs billing lab codes and working to resolve those issues.
- DMAS has been working with the MCOs to pull in discharge data for residential services and learned that the MCOs report this data in a different system than encounter data is reported and their systems are not currently equipped to report this data within the encounters.
- DMAS discovered a need for more training to providers around the need for and importance of care coordination.

- Medicaid expansion population and estimating 20% with OUD, doubling current members services (20,000 to 40,000 or more). DMAS will work with MCOs to increase provider capacity and access to evidence based MAT.

EVALUATION ACTIVITIES AND INTERIM FINDINGS

DMAS continues to meet regularly with the VCU research team. The research has finalized the one year ARTS evaluation along with two OBOT case studies. Both of which can be found on the DMAS website at: <http://www.dmas.virginia.gov/#/artsresources>.

DMAS has hosted a total of seven Project ECHO Learning Collaborative for the Preferred OBOT providers in collaboration with VDH. Project ECHO is the platform being used to hold ongoing Learning Collaboratives with clinical staff of Preferred OBOT providers and OTP providers. The sessions have targeted the Medicaid Preferred OBOT providers for didactic sessions and case studies and are being held bi-weekly. DMAS plans to continue offering these learning collaboratives in 2019.

DMAS staff facilitated a total of four virtual "live" course to cover all medications and treatments for opioid use disorder, and provides the required education needed to obtain the waiver to prescribe buprenorphine. DMAS is working in collaboration with the VDH and the American Society of Addiction Medicine (ASAM). DMAS is working with VDH to see if they will host more waived trainings in 2019.

CONCLUSION

DMAS continues to work with providers, MCOs and Magellan of Virginia to identify issues and foster the lines of communication between the providers, MCOs and Magellan of Virginia. DMAS continues to be committed to improve the ARTS Network and work with stakeholders to increase access to care as well as expand evidenced-based, nationally recognized MAT in all ASAM Levels of Care.

DMAS is committed to increasing MAT access with FQHCs and CBSs to reduce OUD deaths across the state and working with criminal justice system to ensure MAT access upon release.

Former Foster Care Youth

INTRODUCTION

Individuals in foster care face a number of challenges after they are released from state custody, including access to health care. The “Former Foster Care Child Under Age 26 Years” Medicaid covered group provides an opportunity for this population to continue receiving Medicaid coverage until age 26, allowing these individuals time to transition into managing the responsibilities of living independently.

BACKGROUND

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 covered 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 former foster care 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 State Plan. States who wished to continue covering this population could do so under a 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 provide former foster care youth with the access to health services they need, through the GAP Demonstration Waiver.

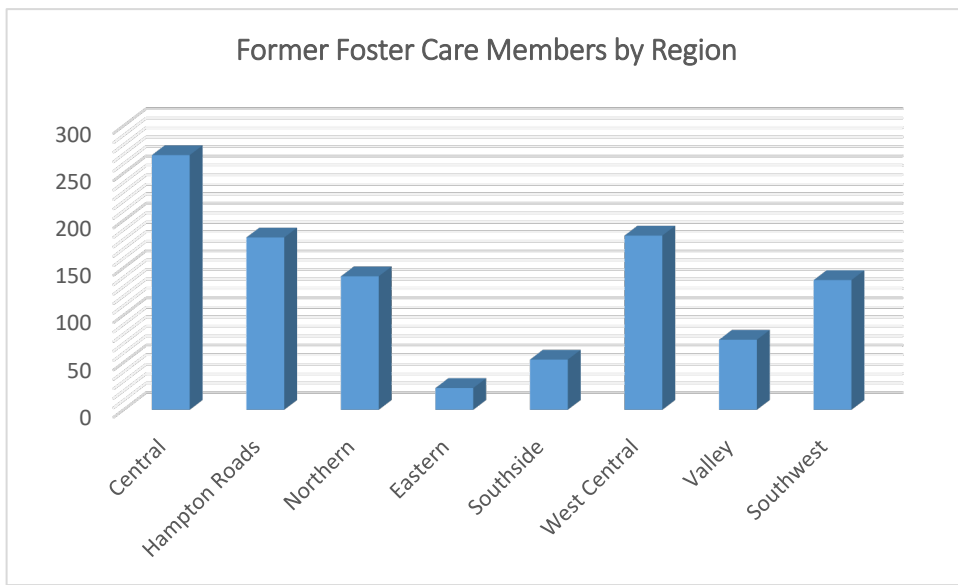
The goals of the FFCY demonstration are: (1) to increase and strengthen coverage of former foster care youth who were in Medicaid and foster care in a different state and (2) to improve or maintain health outcomes for these youth.

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. All individuals in the Former Foster Care Child Under Age 26 covered group receive the full Medicaid benefit package, including long-term supports and services, if medically necessary.

ENROLLMENT COUNTS FOR YEAR TO DATE

Figure 17: Member Enrollment by Region



The figure above displays the geographic distribution of the Former Foster Care population, broken down by regions in the 2nd quarter. As highlighted in the figure, the Central region continues to house the largest concentration at 269 with the West Central (184 members) and Hampton Roads (182 members) regions closely following.

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

By implementing the demonstration, Virginia anticipates increasing healthcare coverage for former foster care youth, while improving health outcomes. The design for evaluating the demonstration was approved by CMS in October 2018. As a result, interim evaluation findings will be available in late 2018. The evaluation will cover the September 2017 to December 2019

time period, representing the start and end dates of the demonstration. The evaluation addresses three questions:

1. Does the demonstration provide Medicaid coverage to former foster care individuals?
2. How did former foster care individuals in the demonstration use Medicaid-covered healthcare services?
3. What do health outcomes look like for individuals in the demonstration?

COLLECTION & VERIFICATION OF UTILIZATION & ENROLLMENT DATA

The evaluation will evaluate administrative data (enrollment, claims, and encounters) available in the MMIS at the end of the first (fall 2018) and second (winter 2020) demonstration years. The evaluation will only be conducted using existing administrative data and no prospective data (e.g., beneficiary surveys, interviews, focus groups, or other quantitative or qualitative data) will be collected due to resource limitations. The evaluation will not include pretest (or baseline) data because DMAS only has access to data on individuals in the demonstration after they receive Medicaid coverage.

BUDGET NEUTRALITY AND FINANCIAL REPORTING

The state provides, as Appendix B of this Report, an updated budget neutrality workbook for Quarter 3 Demonstration Year 2018 that includes established baseline and member month 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. There have been no appeals filed related to this population.

CONTRACTOR REPORTING REQUIREMENTS

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

RECOVERY NAVIGATORS

The FFCY demonstration does not utilize Recovery Navigators.

LESSONS LEARNED

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

EVALUATION ACTIVITIES

No evaluation activities have taken place and there are no interim findings. The evaluation will cover the September 2017 to December 2019 time period, representing the start and end dates of the demonstration.

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 the application process for these individuals or how they receive Medicaid coverage. The evaluation design is still under review; 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 B- GAP, ARTS, and FFCY Budget Neutrality Reports

STATE CONTACT(S)

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APPENDIX B: GAP, ARTS, and FFCY Budget Neutrality Reports

DEMONSTRATION WITH WAIVER (WW) BUDGET REPORT: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	Budget Neutrality DY 3 Full year estimate	1/4 of Full Year Estimate	DEMONSTRATION YEAR 4 (CALENDAR YEAR 2018) QUARTER 2			
			April 2018	May 2018	June 2018	TOTAL QUARTER
Non-LTC Disabled Adults with SMI						
Pop Type: Medicaid						
Eligible Member Months	971,771	242,943	73,517	71,554	72,110	217,181
PMPM Cost	\$ 2,200.84	\$ 2,200.84	\$ 2,042.57	\$ 1,976.85	\$ 1,955.55	\$ 1,992.02
Total Expenditure	\$ 2,138,712,488	\$ 534,678,122	\$ 150,163,620	\$ 141,451,533	\$ 141,014,762	\$ 432,629,915
GAP Population						
Pop Type: Expansion						
Eligible Member Months	189,301	47,325	14,756	15,088	15,495	45,339
PMPM Cost	\$ 417.82	\$ 417.82	\$ 379.98	\$ 378.87	\$ 387.38	\$ 382.14
Total Expenditure	\$ 79,093,744	\$ 19,773,436	\$ 5,607,055	\$ 5,716,343	\$ 6,002,509	\$ 17,325,906
Former Foster Care Transfers from Out of State						
Pop Type: Expansion						
Eligible Member Months	830	208	68	67	67	202
PMPM Cost	\$ 508.28	\$ 508.28	\$ 466.04	\$ 512.10	\$ 610.30	\$ 529.17
Total Expenditure	\$ 421,869	\$ 105,467	\$ 31,691	\$ 34,310	\$ 40,890	\$ 106,892
SUD Waiver Services Recipients						
Pop Type: Expansion						
Eligible Member Months	879	220	116	212	108	436
PMPM Cost	\$ 2,656.06	\$ 2,656.06	\$ 3,557.57	\$ 4,628.71	\$ 3,357.32	\$ 4,028.79
Total Expenditure	\$ 2,334,675	\$ 583,669	\$ 412,678	\$ 981,286	\$ 362,591	\$ 1,756,554

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.

The 1115 Demonstration waiver initially provided a limited coverage benefit to individuals with severe mental illness at or below 60% FPL. It was expanded to include those at or below 80% FPL as of July 1, 2016 and has increased to 100% FPL as of October 1, 2017.