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Virginia Medicaid Section 1115 Demonstration Waiver for the Addiction and Recovery Treatment Services (ARTS) Program

Midpoint Assessment

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Authors

Peter Cunningham, Ph.D.
Vimbainashe Dihwa

Department of Health Policy, Virginia Commonwealth University School of Population Health

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Executive Summary

Virginia's Addiction and Recovery Treatment Services (ARTS) Demonstration was enacted to provide an expanded package of Medicaid benefits for the treatment of substance use disorders (SUD). ARTS expanded SUD benefits along the entire continuum of care – including coverage of inpatient detoxification and residential treatment services – implemented measures to improve quality of care through evidence-based best practices; ensure that providers meet the highest standards of care; and redesigned the delivery system to emphasize integration and coordination of SUD treatment with other mental health, physical health, and social needs. Initially approved by the Center for Medicare and Medicaid Services (CMS) in December 2016, the Demonstration that includes the ARTS program was approved by CMS for renewal in December 2019, and extends through December 2024.

As part of the demonstration renewal, CMS requires Virginia to conduct an independent midpoint assessment to examine implementation progress, identify factors and risks affecting milestone completion, and provide recommendations for state actions. This report presents the analysis and conclusions from the midpoint assessment that was conducted by Virginia Commonwealth University's Department of Health Policy (DHP).

The assessment was conducted based on the guidelines issued by CMS for conducting mid-point assessments for Section 1115 SUD Demonstrations. The primary source of information for the assessment was a review of critical metrics identified by CMS and the state, as well as various action items undertaken by the state to achieve the six milestones over the course of the demonstration. In addition, we used results from the ongoing independent evaluation of the ARTS benefit being conducted by Virginia Commonwealth University to assess consistency with critical metrics, provide more in-depth understanding on interpretation of metric trends, and to assess consistency with trends established prior to the renewal period. To assess progress, we compared metrics for 2020 (the baseline year of the renewal) to 2021, the latest year for which complete data on critical metrics were available from the state at the time of report preparation.

The primary goal of the assessment is to assess the risk if the state does not achieve each of the six milestones required for SUD demonstrations during the reporting period. The results for each of the milestones are summarized in the following table. In sum, we conclude that the state is at low risk for not achieving 5 of the 6 milestones, based on most of the critical metrics being on target, completion of action items by the state, and supporting evidence from the ARTS evaluation. For Milestone 4 (Sufficient Provider Capacity at Each Level of Care), we assess the state is at medium risk for not achieving the milestone, based on slow

growth of provider capacity at a time of increased demand for SUD treatment services. While ARTS evaluation results show that Virginia has made substantial effort and progress in increasing provider capacity since implementation of the ARTS demonstration in 2017 and Medicaid expansion in 2019, the state is constrained by a more general shortage of behavioral health providers, as well as the dearth of SUD treatment capacity that existed prior to the ARTS benefit. Recent changes to federal regulations that make it easier for practitioners to prescribe buprenorphine treatment may present new opportunities for the state to increase SUD treatment capacity.

Table 1. Summary of Risk Assessment at Midpoint

Milestone	Critical metrics on target	Action items on target	Survey and other evaluation results	Risk Assessment
1. Access to Critical Levels of Care for OUD and other SUDS	4 of 7 (57%)	4 of 4 (100%)	Member survey self-reported access to SUD treatment relative to other health services	Low
2. Use of Evidence-Based, SUD-Specific Patient Placement Criteria	2 of 2 (100%)	4 of 4 (100%)	Member survey self-reported unmet need for residential treatment and other SUD services	Low
3. Residential and ASAM requirements	Not applicable	5 of 5 (100%)	Assessment by Manatt concluded that ARTS offered strong benefit that covered the full spectrum of ASAM levels of care	Low
4. Sufficient Provider Capacity at Each Level of Care	1 of 2 (50%)	5 of 5 (100%)	Fewer buprenorphine waivered prescribers relative to other states. Not every county has providers representing all ASAM levels of care.	Medium
5. Implementation of Comprehensive Treatment and Prevention Strategies	3 of 3 (100%)	4 of 4 (100%)	Member survey respondents report high levels of satisfaction with treatment providers and positive outcomes of treatment	Low
6. Improved Care Coordination and Transitions between Levels of Care	10 of 13 (77%)	3 of 3 (100%)	Member survey respondents report receiving help with other mental, physical, and social needs. Care coordinators report providing a wide range of activities for members with SUD.	Low

Background

On April 1, 2017, Virginia's Department of Medical Assistance Services (DMAS) launched the ARTS demonstration to enhance SUD treatment services for all Virginia Medicaid members. The ARTS benefit was approved in December 2016 as an amendment to Virginia's section 1115 demonstration, "The Virginia Governor's Access Plan" (Project No. 11-W-00297/3), which was subsequently renamed to "The Virginia Governor's Access Plan (GAP) and Addiction and Recovery Treatment Services (ARTS) Delivery System Transformation."[1] CMS approved a renewal of the ARTS program for a 5-year period that expires in December 2024, as part of the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" Demonstration (Project Number 11-W-00297/3) (originally approved in December 2019 and amended in July 2020).[2] The ARTS demonstration and extension were enacted to provide an expanded SUD benefit package to all Medicaid recipients and introduces policy, practice and system reforms consistent with the CMS State Medicaid Director (SMD) letter #17-003 of November, 2017.[3]

The ARTS benefit promotes sustainable recovery and treatment for Medicaid members by improving access to comprehensive and high-quality SUD care. The five-year extension of the demonstration through December 2024 includes continued access to treatment services and the authority to provide the following services:

- Expanded community-based addiction and recovery treatment services and coverage of inpatient detoxification and residential SUD treatment;
- Providing a continuum of care modeled after the American Society of Addiction Medicine Criteria (ASAM Criteria) for SUD treatment services;
- Improve the health of Medicaid recipients while decreasing other health care system (such as ED and inpatient hospital) costs;
- Implementing policy and program measures to ensure providers meet the standards of care;
- Integrating SUD treatment services into a comprehensive managed care delivery system for those recipients receiving managed care;
- Increasing reimbursement rates for SUD treatment services to increase provider capacity and access to services for members;
- Implementing strategies to improve the quality of care through evidence-based best practices; and

In alignment with SMD letter #17-003, key goals of the ARTS demonstration are to:

Goals

1. Increase rates of identification, initiation, and engagement in treatment;
2. Increase adherence to and retention in treatment;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduce utilization of ED and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services;
5. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries.

In pursuit of these goals, CMS requires the state to achieve certain milestones over the course of the demonstration, and to maintain progress during the renewal period. These milestones include:

Milestones

1. Access to critical levels of care for OUD and other SUDs.
2. Widespread use of evidence-based, SUD-specific patient placement criteria.
3. Use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications.
4. Sufficient provider capacity at each level of care.
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD.
6. Improved care coordination and transitions between levels of care.

Midpoint Assessment. As part of CMS' approval of the demonstration renewal, the state is required to conduct an independent midpoint assessment to report on progress towards achieving the milestones identified above. The midpoint assessment was conducted by Virginia Commonwealth University's Department of Health Policy (DHP). The objectives of the assessment are:

Objective 1. To quantitatively assess whether progress is being made towards achieving or maintaining the ARTS benefit milestones, based on having achieved monitoring metric targets at the demonstration midpoint.

Objective 2. To assess progress on Action Items engaged in by the state under each milestone.

Objective 3. To use findings from the ongoing independent evaluation of the ARTS program to support, explain, or further understand progress on achieving milestones based on findings from objective's 1 and 2.

The below section details the methodology used for this assessment, followed by a progress assessment towards each milestone and the risk of not meeting the milestones. Recommendations are included for the state to consider in the event a medium or high risk is assessed.

Methodology

A mixed methods approach was used to conduct the midpoint assessment. The primary sources of data are the monitoring metrics computed by DMAS that are consistent with the metrics identified in the CMS technical assistance document for midpoint assessments.[4] DMAS also provided implementation action items for each milestone, as well as whether these items were completed. To complement the assessment of monitoring metrics and action items, we also included results from the ongoing independent evaluation of the ARTS benefit being conducted by Virginia Commonwealth University. Evaluation results discussed in this assessment are available in evaluation reports and published papers.

Data Sources

The primary data sources are the critical metrics constructed by the state for monitoring the demonstration. The critical metrics correspond to Milestones 1,2 and 4-6 of the demonstration, and are listed below in Table 1. Metric #27 – overdose death rates – for Milestone 5 is not available for the Midpoint Assessment. There are no metrics for Milestone 3.

Table 2. Critical Metrics for Assessing Progress for the Midpoint Assessment

METRIC NUMBER AND DESCRIPTION	
Milestone #1. Access to critical levels of care for OUD and other SUDs	
7	Early Intervention[1]
8	Outpatient Services[1]
9	Intensive Outpatient and Partial Hospitalization Services[1]
10	Residential and Inpatient Services[1]
11	Withdrawal Management[1]
12	Medication Assisted Treatment[1]
22	Continuity of Pharmacotherapy for Opioid Use Disorder
Milestone #2. Use of evidence-based, SUD-specific patient placement criteria	
5	Medicaid Beneficiaries Treated in an IMD for SUD [2]
36	Average Length of Stay in IMDs (in days/year)[2]
Milestone #4. Sufficient provider capacity at each level of care	
13	Provider Availability[2]
14	Provider Availability – MAT [2]
Milestone #5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	
18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940) [1]

21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175) [1]
23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries [1]
27	Overdose death rate (not available for Midpoint Assessment)
Milestone #6. Improved care coordination and transitions between levels of care	
15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)
17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605).
17(2)	Follow-up after Emergency Department Visit for Mental Illness (NQF #2605).
25	Readmissions Among Beneficiaries with SUD

[1] The baseline and midpoint measures are for the calendar years 2020 and 2021 respectively.

[2] The baseline measures are for Demonstration Year 4 (April 2020 – March 2021), and the midpoint measures are for Demonstration Year 5 (April 2021 – March 2022).

As required by CMS, the baseline year for most metrics is the first 12 months of the extension, or calendar year 2020. The follow up period is calendar year 2021. For metrics 5, 13, 14, and 36, the baseline year is April 2020 through March 2021, while the follow up year is April 2021 through March 2022.

The baseline year coincides with the outbreak of the COVID-19 pandemic as well as actions taken by the federal and state governments in response to the Public Health Emergency (PHE) declared on January 31, 2020 by the Secretary of the United States Department of Health and Human Services. As described in the CMS document, "Implications of COVID-19 for Section 1115 Demonstration Monitoring: Considerations for States,"[5] the onset of the pandemic and the PHE may affect reporting metrics as well as comparability with future time periods based on changes in the way the metrics were computed (e.g. including billing codes for telehealth visits). Furthermore, metrics may be affected by increases in Medicaid enrollment due to maintenance of effort (MOE) requirements as part of the federal Families First Coronavirus Response Act (FFCRA) of March 2020.

While CMS guidance permits consideration of an alternate baseline period to avoid overlapping with the onset of COVID-19 and PHE, there is no obvious alternative baseline period for this assessment, since the demonstration extension began at the beginning of 2020. It is not possible to use calendar year (CY) 2021 as the baseline period (with CY 2022 as follow up year), as 2021 is the latest available year for most metrics at the time of the report preparation. The year before the demonstration began (CY 2019) is also a possibility, since reporting metrics are available for that year. However, this does not resolve the potential problem of skewed trends due to changes in billing and enrollment noted above. In addition, 2019 was the beginning of Medicaid expansion in Virginia, which greatly

increased the number of members receiving SUD services over the course of the year.

We will assess potential bias in trends between CY 2020 and 2021 in several ways. First, when results for individual metrics are discussed, we will note any changes in the way these metrics were computed in 2020 and 2021, and discuss potential implications of these changes on the trends observed (2020 metrics are based on Version 4.0 of the Technical Specifications for Monitoring Metrics, while 2021 are based on Version 5.0). Second, we will draw upon other analyses conducted as part of the evaluation of the ARTS demonstration to provide additional insight on the changes observed in the metrics, as well as to assess potential COVID-19 effects.

ARTS member survey. VCU conducted a survey of members receiving ARTS services in 2020 and 2021 to understand their experiences with treatment and the effects of treatment on their daily lives. The survey is based on a stratified random sample of Medicaid members who were diagnosed and/or received treatment for OUD. The sample was identified through Medicaid enrollment and claims data, and was equally divided into the following four groups: (1) members who received treatment at Preferred Office-Based Opioid Treatment providers (OBOT) – now referred to as Office-Based Addiction Treatment (OBAT) providers – a new model of care delivery created through the ARTS benefit; (2) members who received treatment through Opioid Treatment Programs (OTP), which provides methadone treatment for OUD; (3) members who received treatment at other outpatient providers which may include outpatient clinics or office-based providers that provide OUD treatment, and; (4) members who were diagnosed with OUD, but received no ARTS services based on paid claims. The survey was conducted by mail, and included $2 incentives. Out of a total 10,250 persons in the initial sample draw, about 1,845 returned completed surveys, for a survey response rate of 18%. Survey weights adjusted for differences between respondents and nonrespondents on age, sex, race/ethnicity, and Virginia region. A survey report includes additional detail on the survey design and analysis.[6]

Results from the survey are used to complement findings for Milestone's 1, 2, and 6. In addition, since the survey field period lasted from January 2020 through August 2021 – roughly the same time period as the assessment – we are able to compare early responders to later responders to assess changes in member experiences that correspond with the onset of the COVID-19 pandemic. Specifically, we compare survey responses received by April 2020 – which mostly includes experiences prior to the COVID pandemic – and survey responses received after August, 2020. The survey field period was suspended between April and August, 2020 due to the pandemic. We also discuss variation in survey responses by race/ethnicity and urban/rural residence.

Survey of MCO Care Coordinators. Results from a survey of care coordinators employed by the Managed Care Organizations (MCOs) are used to complement findings for Milestone #6. In Virginia, the majority of Medicaid members are enrolled in one of six MCOs, each of which provides a care coordinator for its members per the contract with DMAS. The care coordinator's main role is to help ensure that Medicaid members can access the services that they need. DMAS has required the MCOs to expand of the role of care coordinators. In the ARTS benefit, care coordinators play a key role in identifying members with a need for SUD services, facilitating entry into treatment, and following up after residential treatment stays or discontinuations with treatment. Therefore, care coordinators are in a unique position to comment on the strengths and challenges of the ARTS benefit in helping members with SUD.

To better understand the experiences of care coordinators, the specific types of care they provide to members, and the challenges they face in providing this care, VCU conducted a web-based survey of Medicaid care coordinators from May to July of 2022. The objective of the survey was to obtain information on care coordinators' personal and professional backgrounds; client characteristics; care coordinator activities, both generally and for members with SUD; tools used by coordinators for data gathering; and barriers faced by coordinators.

The survey was conducted by obtaining lists of care coordinators employed by the six MCOs and their contact information. These lists included the universe of care coordinators employed by the MCOs to serve Medicaid members, a total of 1,318. These include care coordinators primarily serving members enrolled in the Commonwealth Coordinated Care Plus program, members receiving SUD treatment and recovery services through the ARTS benefit, members with serious mental illness, and others. While the survey did not focus entirely on ARTS care coordinators or SUD services, we identified care coordinators who provided services to members with SUD, and asked specific questions about how they identified members with SUD, and specific activities they performed for members with SUD. The survey was completed online between April and July, 2022. A total of 329 surveys were completed, for a response rate of 24%. A survey report includes additional detail on the survey design and analysis.[7]

Analysis of buprenorphine waivered prescribers. VCU used original analyses of buprenorphine waivered prescribers to complement the findings for Milestone #4.[8] As part of the evaluation of the ARTS benefit, VCU used a Freedom of Information Act request to obtain national historical data on buprenorphine waivered prescribers from the Drug Enforcement Administration. The objective of the analysis was to examine changes in the number of prescribers in Virginia compared to other states and the overall U.S. Specifically, the analysis assessed

whether the combination of the ARTS demonstration in 2017 and Medicaid expansion in 2019 increased the supply of buprenorphine waivered prescribers to a greater extent than a group of comparison states. While the time period for this analysis (2015-2020) precedes the current demonstration renewal period, the historical analysis provides important context for understanding provider capacity during the renewal period. We also report on more recent changes in the number of prescribers during 2020-2022.

Analytic Methods

To assess progress on the monitoring metrics, we calculated changes between the baseline period and the follow-up period, using the formula from the CMS Mid-Point Assessment Technical Assistance document:[9]

$$\text{Percent change} = \frac{\text{Value of metric at midpoint} - \text{value of metric at baseline}}{\text{Value of metric at baseline}}$$

The critical monitoring metrics are the primary source of data used to assess progress towards each milestone, and to assess overall risk of not meeting the milestone. Following CMS guidance, we used the above analysis to assess risk for not meeting milestones as low, medium, or high based on the share of critical metrics that show change in the direction of their goals. We assess the risk level based on the following criteria:

- Low risk for not achieving milestone: State is moving in the expected direction relative to its goals for at least 75% of the monitoring metrics.

- Medium risk for not achieving milestone: State is moving in the expected direction relative to its goals for 25% to 75% of the relevant monitoring metrics.

- High risk for not achieving milestone: State is moving in the expected direction relative to its goals for 25% or fewer of the relevant monitoring metrics.

The assessment of risk also takes into account the completion status of action items at the midpoint, identifying whether each action item had been completed on time. The percentage of action items completed on time is computed for each milestone. For example, if the state was moving in the expected direction for 75% or more of the monitoring metrics within a certain milestone, but had

completed less than 50% of action items, then the risk level for not meeting the milestone goals could be judged to be "medium risk" instead of "low risk."

Finally, we also consider findings from the ARTS evaluation (described above) in the assessment of risk. In general, these supplemental analyses will not change our assessment of risk based on the monitoring metrics and action items, but they can provide important context if the state is at risk for not meeting certain milestones. These additional analyses are especially important to consider given that this assessment covers only the first year of the renewal (between 2020 and 2021) and does not cover the time period between implementation of the ARTS demonstration (2017) and the renewal period. In some cases, it is important to consider whether the trends in monitoring metrics at midpoint of the renewal is consistent with longer term trends based on prior evaluation analyses of the ARTS program.

Limitations

We are unable to report on progress with metric #27 – overdose death rates – due to the lack of data. These metrics require linkage of the cause of death data with Medicaid enrollment and claims data. As part of vital records information maintained by the Virginia Department of Health (VDH) – a separate state agency – obtaining these data requires an Interagency Agreement that would give VDH authority to share the data with DMAS. Obtaining such an agreement is in progress, but we do not have an estimated time for this deliverable, and therefore is unavailable for this report.

A second limitation is that the period between baseline (2020) and mid-point (2021) corresponds with the beginning of the COVID-19 pandemic as well as the Public Health Emergency (PHE). Drug-related overdoses surged nationally and in Virginia during the initial period of the pandemic, while PHE resulted in a number of policy changes. For example, in March 2020, as part of the Families First Coronavirus Response Act (FFCRA), Congress provided increased Medicaid funding to states. To receive this funding, states had to meet several conditions, including a "continuous coverage" requirement that prohibited states from terminating most Medicaid enrollees' coverage until after the end of the PHE. The result is that Medicaid enrollment and SUD prevalence increased between 2020 and 2021, which likely affected changes on key metrics. For example, utilization metrics for Milestone 1 may show increases due in part to increases in enrollment and SUD prevalence. This is further discussed below under the results for Milestone 1.

Milestone 1: Access to Critical Levels of Care for OUD and Other SUDS

The first milestone is to improve access to critical levels of care for OUD and SUD across the continuum of care. During the preceding demonstration period (2016-2020), a major expansion of SUD treatment benefits was implemented in April 2017 as part of the ARTS benefit. ARTS expanded coverage of many addiction treatment services for Medicaid members aligning with the American Society of Addiction Medicine (ASAM) levels of care, including community-based services, short-term residential treatment and inpatient withdrawal management services. The Section 1115 demonstration waiver under which ARTS was enacted (and approved by CMS in December, 2016), allows federal Medicaid payment for addiction treatment services provided in inpatient and short-term residential facilities with 16 or more beds (Institutions of Mental Disease, or IMDs). ARTS also increased provider reimbursement rates for many existing services, and introduced a new care delivery model for treatment of Opioid Use Disorders (OUD), the Preferred Office-Based Opioid Treatment (OBOT) provider, which integrated medications for OUD (MOUD) with co-located behavioral and physical health services by incentivizing increased use of care coordination activities. To further increase integration of addiction treatment services with other health services covered by Medicaid, SUD services are administered by the six MCOs that manage medical and behavioral health benefits for all Medicaid members, offering a comprehensive care delivery system.

While ARTS greatly increased the availability and quality of treatment services to Medicaid members, eligibility for these services increased on January 1, 2019 when Virginia expanded Medicaid eligibility for adults ages 19-64 with family incomes of up to 138 percent of the federal poverty level, as allowed for under the Patient Protection and Affordable Care Act. By December 2021, 610,729 low-income Virginians were enrolled through Medicaid expansion.[10]

Evaluation of the ARTS benefit conducted under the Section 1115 waiver demonstration has documented the impact of ARTS and Medicaid expansion on access to and utilization of ARTS services. The number of Medicaid members using ARTS treatment services more than doubled, from 17,120 in 2017 to 46,520 in 2019.[11] Among those with OUD, the percent using MOUD treatment increased from 35% in 2016 to 53% in 2019, an increase that was far greater than for Medicaid members in twelve other states. At the same time, ED visits among those with OUD decreased (relative to Medicaid members who did not have OUD).[12]

Both the ARTS benefit and Medicaid expansion were in place at the time that renewal of the demonstration was approved by CMS (December 2019), and before the start of the COVID-19 pandemic in March 2020. To offset potential barriers to

treatment access due to pandemic-related restrictions, DMAS implemented a number of new initiatives and procedural flexibilities that the federal government permitted as part of the emergency response to COVID-19. These include allowing take-home dosages of methadone and buprenorphine for up to 28 days (which otherwise must be administered at Opioid Treatment Programs (OTPs)), allowing a member's home to serve as the originating site for prescription of buprenorphine, allowing a 90-day supply of buprenorphine, increased use of telemedicine, waiver of drug copayments, and fewer restrictions on the use of certain unlicensed providers. In compliance with federal legislation, eligibility redeterminations and coverage cancellations were suspended in order to increase continuity of coverage and prevent coverage lapses during the pandemic. While continuous coverage provisions have been discontinued with the end of the federal PHE, many of the access initiatives and procedural flexibilities will be maintained.

Performance on Monitoring Metrics

Critical Metrics. Milestone 1 Critical Metrics are summarized in Table 3. The expectation of the demonstration renewal is that there will be continued increases in access to critical levels of care, especially an increase in services represented in metrics 7-9 and 12, and continued increases in members with greater continuity of MOUD treatment as shown in metric #22. Despite the uncertainties and potential barriers to access due to the onset of the COVID-19 pandemic, expectations of increases were met on 4 of 5 of these metrics, with the largest increase between baseline and mid-point time periods reported for metric #22 – continuity of pharmacotherapy for OUD (27.7%). Increases in utilization for metrics #8-12 ranged from 16.5% (#8 outpatient services) to 21.9% (#12 medication assisted treatment).

An increase was also expected for metric #7 (early intervention), although the findings show a 15.9% decrease between baseline and midpoint. It should be noted that utilization of early intervention services overall is very low, from 88 members using these services at baseline to 74 members using these services at mid-point. It is possible that many providers are providing early intervention services to members but not submitting claims for reimbursement.

Table 3. Performance on Monitoring Metrics for Milestone 1.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
7	Early Intervention	88	74	14	-15.9%	Increase	Decrease	No
8	Outpatient services	20,078	23,395	3,317	+16.5%	Increase	Increase	Yes
9	Intensive outpatient and partial hospitalization services	1,823	2,090	267	+14.6%	Increase	Increase	Yes
10	Residential and inpatient services	902	1,052	150	+16.6%	Decrease	Increase	No
11	Withdrawal management	1,145	1,351	206	+18.0%	Decrease	Increase	No
12	Medication Assisted Treatment	18,872	23,005	4,133	+21.9%	Increase	Increase	Yes
22	Continuity of pharmacotherapy for opioid use disorder	15,662	20,003	4,341	+27.7%	Increase	Increase	Yes

There was also an increase in use of residential and inpatient services (#10) as well as withdrawal management services (#11) at midpoint. This is contrary to the demonstration goal of a decrease in these services, based on the assumption that greater availability and utilization of treatment services would decrease untreated or uncontrolled SUD and the need for higher level residential, inpatient, and withdrawal management services. Expectations of a decrease were also based on requirements that provider and MCOs utilize the ASAM Criteria and multidimensional assessment for determining the most appropriate level of care. DMAS has also implemented a standardized service authorization form requirement for ASAM Levels 2.1 through 4.0 which is based on the multidimensional assessment. These services require the MCO to perform an independent review of requests for these levels of care to ensure the individual meets the criteria for admission based on ASAM for approval of the service authorization.

One explanation for the increase in residential and withdrawal management services is that Medicaid enrollment increased from a 1.28 million monthly average in State Fiscal Year 2019 (July 2019 to June 2020) to 1.74 million in SFY 2021, a 36% increase.[8] The increase in enrollment likely reflects both Medicaid expansion (beginning January, 2019) as well as federal Maintenance of Effort requirements in response to the COVID-19 pandemic. In addition, evaluation reports during this period showed that the number of members with diagnosed SUD increased from 106,000 in calendar year 2020 to 123,810 in 2021.[13] Taking into account the increase in SUD prevalence, the utilization of residential and inpatient services per 1,000 members with SUD held steady at 8.5 for baseline and mid-point, while the

number of withdrawal management services per 1,000 members with SUD increased only slightly, from 10.8 at baseline to 10.9 at midpoint.

It should also be noted that waiving the Institution for Mental Disease (IMD) exclusion for federal payment through the SUD demonstration greatly increased the availability of residential treatment services to Medicaid members. Prior to the ARTS demonstration in 2016, there were only four ASAM Level 3 facilities that served Medicaid patients. Following the implementation of the demonstration in 2017, the number of ASAM 3 facilities serving Medicaid patients increased to 52 and 72 in 2020 and 2021, respectively.[13] Shortages of residential facilities in prior years and pent-up demand likely increased utilization to a greater extent than if capacity had not changed. Despite the growth in residential treatment capacity and utilization, the share of total ARTS spending on residential treatment services has remained constant at about 16% through 2022, indicating balanced growth across the continuum of care.[13]

The state's expectations about a decrease in residential treatment and withdrawal management services also did not take into account an increase in the severity of the opioid epidemic, as demonstrated in a surge of fatal overdoses nationwide as well as Virginia in recent years.[14] The surge in overdoses has been attributed to increased availability of more deadly and addictive forms of opioids – especially fentanyl – as well as the COVID-19 pandemic. This surge may be leveling off in Virginia, as both SUD prevalence and OUD-related overdoses decreased slightly among Medicaid members between 2021 and 2022.[13]

In sum, the state's original expectations about a decrease in residential and withdrawal management services did not take into account growth in the supply and availability of these services as well as increases in Medicaid enrollment and SUD prevalence. Nevertheless, additional analysis suggests that utilization of these services is not growing faster relative to the change in prevalence and use of other ARTS services. As enrollment and SUD prevalence stabilizes, it may be more reasonable to expect decreases in residential and withdrawal management services in the future.

There were changes in the technical specifications for two metrics that may have some impact on the results. Most significantly, telehealth was added to outpatient services for the 2021 version of metric #8 (outpatient services). As use of telehealth services increased with the start of the COVID-19 pandemic in 2020, this change likely accounts for at least some of the increase in the use of outpatient services. For metric #10 (residential and inpatient services), the specifications for 2021 included greater clarification of the claims to use for residential treatment, although it is less clear what impact this had on the results.

Action items. Milestone 1 Action items are summarized in Table 4. All five items were completed to coincide with the beginning of the demonstration in 2017 and included receiving approval from CMS for the waiver and coverage of other services not included in the waiver; regulatory changes; updating managed care contracts with the SUD benefits; and increasing reimbursement rates for existing SUD services. All actions were completed on time well before the demonstration renewal.

Table 4. Status of State Action Items for Milestone 1.

Milestone and Description	**Status**
Milestone 1: Access to critical levels of care for OUD and other SUDs	CMS approved Virginia's 1115 SUD waiver to allow for coverage in an institution of mental disease on 12/16/2016. **COMPLETE** CMS approved the state plan including coverage of the full continuum of care for services not included in the 1115 SUD Demonstration on 8/25/2017. **COMPLETE** DMAS implemented regulatory changes and developed the policy manual effective 4/1/2017. **COMPLETE** DMAS updated the managed care contracts starting 4/1/2017 to carve-in the SUD benefit for the MCOs to manage networks and ensure access to the full continuum of care. **COMPLETE** Increased rates starting 4/1/2017 for existing SUD treatment services currently covered by Medicaid including SUD Case Management, SUD Partial Hospitalization (ASAM Level 2.5), SUD Intensive Outpatient (ASAM Level 2.1), and Opioid Treatment – counseling component of MAT to align with current industry standards. **COMPLETE**

Changes in Utilization Based on ARTS Billing Codes

The independent evaluation of the ARTS demonstration includes an analysis of changes in utilization based on the billing codes used for the ARTS program, which are similar but not identical to the above metrics. These analyses also have the advantage that the measure specifications are identical for the time periods being compared (including telehealth codes), and they are adjusted for changes in Medicaid enrollment.

Table 5 shows the number of members using ARTS services per 100,000 members for State Fiscal Years 2020 and 2021 (comparing July 2019-June 2020 to July 2020-June 2021). Even when adjusting for increases in enrollment and the inclusion of telehealth, utilization increased across all service types at similar levels to the monitoring metrics shown above.

Table 5. Number of members using ARTS services per 100,000 members, State Fiscal Years 2020 and 2021.

	Members using services per 100,000 members		
	SFY 2020	**SFY 2021**	**Percent change**
Used any ARTS service	2,627	2,912	10.8%
Type of service			
ASAM 1	2,162	2,442	12.9%
OBOT/OTP	806	901	11.8%
Care Coordination[1]	573	674	17.5%
ASAM 2	279	299	7.1%
ASAM 3	258	276	6.9%
ASAM 4	4	8	103.0%
Pharmacotherapy	1,120	1,283	14.5%
Case management	226	233	3.2%
Peer recovery support services	68	83	22.0%

[1]Care coordination services are a subset of services also counted as part of OBOT/OTP services.

Member Survey Findings

Survey respondents were asked about their ability to obtain treatment for drug or alcohol use: "Was there any time in the past 12 months that you needed but did not receive treatment for drug or alcohol use." Similar questions were also asked regarding other health services, including mental health counseling, prescription drugs, medical care, and dental care.

Overall, 14.7% of survey respondents reported that they had "unmet need" with respect to treatment for drug or alcohol use, as shown in Table 6. Although there are no pre-ARTS estimates of unmet need, survey respondents reported less difficulty accessing drug and alcohol treatment compared to other health services. For example, 22.5% reported unmet need for mental health counseling, 29.9% reported unmet need for prescription drugs, 27.8% for general medical care, and 50.8% for dental care. Levels of unmet need for drug and alcohol use did not differ significantly for members surveyed prior to the beginning of the COVID-19 pandemic compared to members surveyed during the pandemic.

Table 6. Member survey results on perceived unmet needs for health services.

	Percent with unmet need in the past year for health services				
	Drug or alcohol counseling	Mental health counseling	Prescription drugs	Medical care	Dental care
All (n=1,845)	14.7%	22.5%	29.9%	27.8%	50.8%
Adjusted percentage[#]					
Race					
Non-Hispanic White	8.6%	18.9%	28.4%	27.1%	53.2%
Non-Hispanic Black	13.0%*	20.7%	29.7%	24.3%	50.5%
Other	12.1%*	16.7%	27.1%	30.3%	46.3%*
Survey period					
Before COVID	10.3%	19.3%	30.7%	28.5%	51.4%
During COVID	8.9%	19.0%	27.1%	25.3%	53.0%
RUCA Classification					
Urban	9.0%	19.5%	28.3%	26.5%	52.7%
Rural	10.9%	18.3%	29.2%	27.0%	51.4%

Source: 2020-21 ARTS Member Survey

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[#]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, rural/urban residence, and whether they had been in prison or jail in the past 12 months.

Overall Risk Assessment for Milestone 1: LOW

Table 7. Summary of Overall Risk of Not Achieving Milestone 1.

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
57%	100%	Self-reported access to SUD services is good relative to other health services	Low	Not applicable	Not applicable

Although only 4 of 7 monitoring metrics met their expected targets (57%), we assess the risk level for not meeting this milestone as "low". As described in detail above, we expect the state is more likely to be able to meet its target of decreases in metrics 10 and 11 during a period of greater stability in Medicaid enrollment and SUD prevalence.

Milestone 2: Use of Evidenced-Based, SUD-Specific Patient Placement Criteria.

Milestone 2 involves the use of national ASAM guidelines for treatment placement,[15] especially regarding placement in IMDs (ASAM 3 level facilities) as permitted by the Demonstration Waiver.

DMAS is partnering with the Virginia Department of Behavioral Health and Developmental Services (DBHDS) and the MCOs to ensure that licensing aligns with ASAM, Medicaid providers are credentialed using ASAM criteria, and providers are trained to deliver Medicaid SUD services with fidelity to ASAM criteria.

Performance on Monitoring Metrics

Critical Metrics. Milestone 2 metrics are shown in Table 8. The number of Medicaid beneficiaries treated in an IMD for SUD increased from 3,773 at baseline to 4,379 at midpoint, a 16.1% increase. Utilization of IMDs was low in the initial period after implementation of the ARTS benefit and IMD waiver in 2017 due in part to relatively few facilities available to Medicaid beneficiaries for this purpose. There were only 4 residential treatment providers billing Medicaid prior to the ARTS demonstration, compared to 95 as of 2022.[16]

The demonstration waiver requires an average length of stay of less than 30 days at IMD facilities per CMS. Based on metric #36, the average length of stay slightly increased between baseline (13.03 days on average) and midpoint (13.56 days). Although a 4.1% increase, it is still well within the demonstration requirements and DMAS targets. With greater availability of residential treatment facilities, it is possible that greater capacity has reduced waiting lists leading to longer lengths of stay.

Table 8. Performance on Monitoring Metrics for Milestone 2.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
5	Medicaid Beneficiaries treated in an IMD for SUD	3,773	4,379	+606	+16.1%	Increase	Increase	Yes
36	Average length of stay in IMDs	13.03	13.56	+0.53	4.1%	No change	Increase	Yes

Action items. Milestone 2 Action Items are shown in Table 9. All four action items were completed on time and at the time of the demonstration implementation in 2017.

Table 9. Status of Action Items for Milestone 2.

Milestone and Description	Status
Milestone 2: Use of evidence-based, SUD-specific patient placement criteria	ASAM and Medicaid SUD benefit trainings offered over to Providers starting October 2016 through April 2017 with Continuing Education Credits as incentive. Completed over 30 trainings across the Commonwealth before implementation. **COMPLETE** 25 ASAM Train the Trainers to target clinical experts in field 2017. **COMPLETE** Added ASAM requirements to the MCO contracts April 2017. **COMPLETE** Worked with Program Integrity to add these services to the audit plan starting in 2017. **COMPLETE**

Member Survey Findings

Survey respondents receiving OUD treatment also reported on specific services that they needed but were unable to use (Table 10). About 6% reported unmet need for residential treatment services in 2020-2021. This compares with 10.1% having unmet need for doctor's office or clinic, 3.6% for inpatient hospitalization, and 15.9% for MOUD. Unmet need for residential treatment was somewhat higher during COVID than before COVID, among racial/ethnic minorities, and patients in urban areas. However, none of the differences were statistically significant.

Table 10. Member survey results on self-report unmet need for SUD services.

	Needed or wanted to use service, but not able to						
	AA/NA, self-help (%)	Church or religious (%)	Doctor's office/ clinic (%)	Inpatient hosp. (%)	**Residential treatment (%)**	MOUD (%)	Any of the above (%)
All (n=1,057)	5.9%	3.8%	10.1%	3.6%	**6.2%**	15.9%	28.5%
Adjusted percentages[#]							
Race							
Non-Hispanic White	2.4%	1.9%	9.5%	1.2%	**3.6%**	11.3%	23.1%
Non-Hispanic Black	3.5%	1.8%	6.2%	3.5%	**5.3%**	11.7%	25.2%
Other	12.2%	7.6%	15.1%	3.1%	**9.8%**	16.0%	31.6%
							Survey period
Before COVID	3.8%	1.7%	8.9%	1.2%	**3.4%**	12.0%	21.9%
During COVID	2.0%	2.3%	9.3%	1.8%	**4.5%**	11.0%	25.6%
RUCA Classification							
Urban	2.2%	1.5%	8.2%	1.2%	**4.2%**	10.1%	21.9%
Rural	4.5%	3.6%	11.8%	2.4%	**3.4%**	15.6%*	28.5%

Source: 2020-21 ARTS member survey

*Difference with reference groups (other outpatient, Non-Hispanic White, Before COVID, Urban classification) is statistically significant at .05 level.

[#]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Overall Risk Assessment for Milestone 2: LOW

Table 11. Summary of Overall Risk of Not Achieving Milestone 1

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
100%	100%	Low rate of self-reported unmet need for residential treatment services relative to other services	Low	Not applicable	Not applicable

Milestone 3: Provider Qualifications for Residential Treatment Facilities.

Milestone 3 is the use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications. DMAS is requiring ASAM Criteria to be used in residential levels of care. DMAS is also requiring residential providers to assess and refer members for MOUD treatment.

Performance on Monitoring Metrics

Critical Metrics. This milestone does not have Critical Metrics

Action Items. Milestone 3 action items are shown in Table 12. All four Action Items were completed on time. Two of the Action Items were implemented after the demonstration renewal, including actions affecting the licensing of providers, training webinars, and a process for technical assistance to providers. In addition, Virginia contracted with two organizations to conduct an assessment of provider adherence to ASAM placement criteria, utilization management, prior authorization priorities, and strategies to improve care coordination strategies.

Table 12. Status of Action Items for Milestone 3.

Milestone and Description	**Status**
Milestone 3: Use of nationally recognized SUD-specific program standards to set provider qualifications for residential treatment facilities	DMAS contracted with a vendor in 2017 to perform reviews and site visits for SUD Residential providers to certify them if they met the ASAM Criteria for the particular ASAM Level of Care they were attesting to meet. **COMPLETE** DMAS issues a policy memorandum effective 12/1/2018 requiring providers to ensure that members with OUD admitted to any level of care have access to evidence-based MOUD, including buprenorphine. **COMPLETE.** DMAS revised the managed care contracts to require ASAM Criteria is met and ensure coverage of MOUD in all levels of care. **COMPLETE**. The Department of Behavioral Health and Developmental Services (DBHDS) was mandated by the General Assembly to implement the ASAM Criteria into licensing regulations. Emergency actions were published 2/1/21 and effective 2/20/21 and implemented 7/1/21. DMAS also updated regulations and policies to align with licensing. **COMPLETE** Between March 2020 to March 2022, DMAS had hosted 235 SUD training webinars to promote evidence-based practices for SUD treatment and recovery, that were attended by more than 12,750 individuals. Some of the most popular events were:

	• A series of trainings developed specifically for Department of Social Services staff, • A series of trainings reviewing ASAM criteria, • Individual webinars focused on: o ARTS care coordination for MCOs, o HCV care provision, o Opioids and Stimulants, o SUD Treatment Basics o Suicide Assessment, Screening, and Intervention o Client Engagement, o Buprenorphine (provided to Virginia Pharmacists Association), o Incorporating PRSS, and o Racial Trauma and Incorporating Culturally Sensitive Practices. In addition to these webinars, DMAS also developed a process for providers to request provider-specific technical assistance. Over two rounds of requests, DMAS received 22 applications and provided tailored, specific technical assistance to 16 SUD providers. As part of the work performed by Manatt Health described above, Manatt and State Health Partners completed an assessment of Virginia SUD residential treatment options, including a review of payment rates for residential treatment, provider fidelity to the ASAM level of care criteria, and utilization management and prior authorization policies. This review found DMAS offered a strong benefit (ARTS) that covered the full spectrum of ASAM levels of care. Manatt also analyzed MCO contracting strategies, with a focus on improving care coordination between MCOs and providers. Manatt also presented a webinar to public behavioral health providers and MCO care coordinators regarding collaboration, data sharing, and privacy. **COMPLETE**

Overall Risk Assessment for Milestone 3: **LOW**

Table 13. Summary of Overall Risk of Not Achieving Milestone 3

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
Not applicable	100%	Assessment by Manatt concluded that ARTS offered strong benefit that covered the full spectrum of ASAM levels of care	Low	Not applicable	Not applicable

Milestone 4: Sufficient Provider Capacity at Each Level of Care

Milestone 4 is to ensure sufficient provider capacity at each level of care. To ensure sufficient provider capacity, DMAS utilized the managed care contracts to be responsible for managing their network and ensuring access to appropriate care. Specifically, DMAS requires the MCOs by contract, to monitor and assure that the MCO's behavioral health network, including SUD, is adequate (in terms of service capacity and specialization) to serve child, adolescent, and adult populations timely and efficiently for all behavioral health services covered by the MCO. DMAS monitors the MCO's inpatient and outpatient networks to verify that the levels of capacity and specialization are adequate in terms of service.

DMAS and DBHDS also conducted extensive outreach and training sessions with a variety of treatment providers prior to implementation of ARTS in 2017, and they also explored the needs within the provider community to address concerns and issues in being a Medicaid provider. Virginia also received a grant from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (or the SUPPORT Act) for Patients and Communities Act of 2018 to further develop initiatives to enhance provider capacity, including additional trainings and outreach.

Critical Metrics. Milestone 4 Critical Metrics are shown in Table 14. There was an overall decrease in SUD certified providers between the baseline and mid-point, from 4,789 providers in 2020 to 4,633 providers in 2021, a 3.3% decrease. However, the number of certified MOUD providers increased by 1.3%.

Table 14. Performance on Monitoring Metrics for Milestone 4.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
13	Provider availability	4,789	4,633	-156	-3.3%	Increase	Decrease	No
14	MAT Provider availability	3,375	3,418	+43	1.3%	Increase	Increase	Yes

The relative lack of change in provider availability at midpoint of the renewal is in contrast to the large increases in all types of SUD providers observed during the initial demonstration period. Based on analysis conducted by VCU for the ARTS evaluation, there were relatively few Medicaid providers at all ASAM levels of care in 2016 (prior to implementation of ARTS), although the number of providers increased greatly by 2020 (Table 15).

Table 15. Changes in ARTS service providers before and after initial demonstration period.

Addiction Provider Type	# of Providers before ARTS (2017)	# of Providers in 2020
Inpatient Detox (ASAM 4.0)	N/A	51
Residential Treatment (ASAM 3.1, 3.3, 3.5, 3.7)	4	123
Partial Hospitalization Programs (ASAM 2.5)	N/A	41
Intensive Outpatient Programs (ASAM 2.1)	49	252
Opioid Treatment Programs (OTP)	6	40
Preferred Office-Based Opioid Treatment Providers (OBOT)	N/A	154
Outpatient practitioners billing for ARTS services (ASAM 1)	1,087	5,089

Action items. Milestone 4 Action Items are shown in Table 16. All four Action Items have been completed or are ongoing. Since the demonstration renewal, DMAS initiated World Café events in different regions of Virginia and attended by 115 stakeholders, as part of the Support Act Grant. The ongoing evaluation of the ARTS program show large and continuing increases in DEA-waivered buprenorphine prescribers, with especially large increases in nurse practitioner and physician assistant prescribers since passage of the Comprehensive Addiction and Recovery Act of 2016.

Table 16. Status of Action Items for Milestone 4.

Milestone and Description	Status
Milestone 4: Sufficient provider capacity at each level of care	DMAS carved in SUD treatment services to manage care in 2017. The MCOs are required to meet or exceed Federal network adequacy standards at 42 CFR § 438.68. **COMPLETE** DMAS implemented a public facing Provider Network map using Google Maps in 2017 and updated on a quarterly basis. **COMPLETE** DMAS initiated six World Cafes events in 2020, in different regions of Virginia – Abingdon (southwestern region), Charlottesville (central), Manassas (northern), Norfolk (eastern), Richmond (central), and Roanoke (western). These sessions were held to better understand the depth, breadth, and nuance of the issues facing both Medicaid members with SUD, as well as SUD service providers. In all, over 115 stakeholders attended these meetings. **COMPLETE** Independent evaluations performed by VCU to report number of providers by levels of care. **ONGOING**

	DMAS partnered with VCU Department of Health Behavior and Policy (DHBP) to perform an analysis of Drug Enforcement Administration (DEA) data concerning buprenorphine waivered prescribers (BWPs). Results of this analysis are discussed below. **COMPLETE**

Trends in buprenorphine waivered prescribers.

On a per capita basis, the number of prescribers per 100,000 persons in Virginia increased from 5.4 in 2015 to 18.3 in 2020, a 240% increase that is comparable to the total U.S (Table 17). However, a more meaningful comparison may be with other states in the same region that had not expanded Medicaid during the 2015-2020 period (i.e. similar states that did not take the same policy actions as Virginia). In 2015, Virginia and these comparison states had almost identical numbers of buprenorphine prescribers per 100,000 people (5.4 in Virginia and 5.6 in the other states). Starting in 2017 (the year of ARTS implementation), Virginia began to see higher increases in the number of prescribers, continuing after Medicaid expansion. By 2020, Virginia had 18.3 prescribers per 100,000 people compared to 14.8 in the comparison states. In total, the number of prescribers increased 240% in Virginia vs. 166% in other Southern non-expansion states.

Table 17. Number of buprenorphine-waivered prescribers per 100,000 persons (as of April June for each year.

	2015	2016	2017	2018	2019	2020	% change 2015-18	% change 2018-20	% change 2015-20
Virginia	5.4	6.1	7.7	10	13.1	18.3	87.3	81.8	240.4
Non-expansion states in South	5.6	6.2	7.3	9	11.2	14.8	61.3	65.1	166.3
Expansion states in South	10.6	12.1	14.4	19.2	25.9	35.7	80.9	86.2	236.9
Total U.S.	7.8	8.8	10.6	14.1	19.3	27	81.5	90.8	246.2

Moreover, much of the increase since 2017 resulted from an increasing number of nurse practitioners and physician assistants receiving waivers, permitted under the federal Comprehensive Addiction and Recovery Act of 2016. Between 2018 and 2020, buprenorphine waivers among nurse practitioners increased by 283%, among physician assistants by 200%, and among medical doctors (MDs) by 54% (Table 18). As of 2020, nurse practitioners and physician assistants comprise over one-fourth of waivered practitioners in the Commonwealth.

Table 18. Number of buprenorphine waivered prescribers in Virginia (as of April-June for each year).

	2015	2016	2017	2018	2019	2020	% change 2015-18	% change 2018-20	% change 2015-20
All prescribers	432	491	621	818	1,074	1,495	89.4%	82.8%	246%
Patient limit									
30	288	320	411	570	763	1,029	97.9%	80.5%	257%
100 or 275	144	171	210	248	311	466	72.2%	87.9%	224%
License type									
MD	432	491	605	708	863	1090	63.9%	54.0%	152%
Nurse practitioner	0	0	13	90	181	345	NA	283%	NA
Physician assistants	0	0	3	20	30	60	NA	200%	NA

More recent estimates show this trend continuing through the pandemic. The number of waivered prescribers increased 51% between 2020 and 2022, driven primarily by an increase in nurse practitioner prescribers (95% increase) and physician assistants (151%) (findings not shown).

Despite these increases, Virginia still lags behind the overall U.S. in terms of the number of waivered prescribers (27 per 100,000 persons nationally compared to 18.3 in Virginia). While the supply of prescribers has surpassed other states in the U.S. South that did not expand Medicaid by 2020, Virginia has only about half the number of prescribers among other states in the U.S. South that expanded Medicaid. In addition, 37.8% of respondents to the MCO Care Coordinator survey reported that finding in-network providers for SUD treatment was a "major problem", while another 34.7% reported that it was "somewhat of a problem." [17] However, the level of difficulty in finding SUD providers was no greater than other Medicaid providers, suggesting more general issues regarding provider capacity in Virginia Medicaid.

The state acknowledges that Virginia is experiencing a behavioral workforce shortage not only for SUD but also mental health. DMAS is collaborating with DBHDS and other state agencies to address the shortage. For example, to address more serious shortage areas in the state, there has been a process in place since April 2017 where DMAS can request that DBHDS move applications for licenses up in the queue for providers in these shortage areas. The state is also focusing on provider recruitment and training for their Project BRAVO (Behavioral Health Redesign for improved Access, Value, and Outcomes) initiative implemented in 2021, which is an interagency partnership to align systems for developing an evidence-based, trauma-informed and prevention-oriented array of behavioral health services.

Also, as of January 2023, practitioners are no longer required to apply for federal waivers to prescribe buprenorphine as a result of Section 1262 of the Consolidated Appropriations Act, 2023. By removing this administrative barrier to prescribing buprenorphine, this change presents an opportunity for the state to provide additional outreach and education to potential new prescribers. An assessment of the impact of the ending of the federal waiver requirement on the number of prescribers will be included in the ongoing evaluation of the ARTS benefit.

Overall Risk Assessment for Milestone 4: Medium

Table 19. Summary of Overall Risk of Not Achieving Milestone 4.

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
50%	100%	ARTS evaluation analyses show large increase in buprenorphine waivered prescribers since ARTS and Medicaid expansion implementation	Medium	Continue to offer provider education and training on ARTS billing and MOUD, and to increase awareness of federal end of requirement for waiver application. Use ARTS evaluation to assess impact of the end of federal requirement for waiver application in ARTS evaluation.	DMAS will update the state plan, Virginia Administrative Code and provider manuals to reflect the removal of the buprenorphine waiver requirement. DMAS will schedule meetings with the MCOs to address increasing capacity for prescribers.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone 5 is the implementation of comprehensive treatment and prevention strategies to address OUD. DMAS explored opportunities to enhance efforts through managed care and revising language in policies and contracts to include appropriate prescribing of opioids for pain management. DMAS also explored additional opportunities with the Prescription Drug Monitoring Program (PDMP) and Patient Utilization Management Service (PUMS) to increase prescriber's ability to identify patients at high risk for opioid abuse.

Critical Metrics. As mentioned earlier, Metric #27 (overdose death rate) was not available for Milestone 5 and is excluded from the assessment of this milestone. The other three metrics decreased from the baseline and midpoint, consistent with expectations. The share of members without cancer using opioids at high dosage decreased 24%, while the percent with concurrent use of opioids and benzodiazepines decreased 3.4%. It is possible that some of this decrease may reflect changes in the technical specifications for the metrics in 2021, which added palliative care to the list of exclusions from the measure. Emergency department use for SUD per 1,000 Medicaid beneficiaries also decreased by 6.3%, from 3.22 visits per 1,000 members in 2020 to 3.02 visits in 2021.

Table 20. Performance on Critical Metrics for Milestone 5.

Metric	Name	Baseline	Mid-point	Change	% change	State Target	Direction at midpoint	Progress
18	Use of Opioids at High Dosage in Persons Without Cancer (%)	5.0%	3.8%	-1.2%	-24%	Decrease	Decrease	Yes
21	Concurrent use of opioids and benzodiazepines (%)	11.9%	11.5%	-0.4%	-3.4%	Decrease	Decrease	Yes
23	ED visits for SUD per 1,000 Medicaid beneficiaries	3.22	3.02	-0.20	-6.3	Decrease	Decrease	Yes
27	Overdose death rate	Not available for Midpoint Assessment						

Action items. Table 21 shows the status of the action items for Milestone 5. All four action items have been completed. Two of these actions were initiated before the demonstration renewal, while two activities were initiated after the renewal. Of the latter, DMAS contracted with two organizations as part of the SUPPORT Act to identify best practices and work with DMAS to assess key strengths and opportunities to build on SUD treatment access and delivery.

Table 21. Action Items for Milestone 5

Milestone and Description	Status
Milestone 5: Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	In February 2019, DMAS issues an Evidence-Based Practices and Medication Assisted Treatment for OUD memo and facilitated a provider training. **COMPLETE** From July 2020 through August 2021, DMAS contracted with Manatt Health and State Health Partners who completed the following activities: • Assessed SUPPORT Act and federal and state SUD-related policy requirements and opportunities; • Interviewed 44 stakeholders, consisting mostly of providers and advocates; • Identified promising practices implemented in other states related to access and delivery of SUD services; • Conducted monthly working sessions with DMAS, other state agencies, and additional stakeholders on opportunities to strengthen access to and quality of SUD services in the state; • Hosted a webinar on privacy considerations for coordinating care for patients with SUD; • Presented project findings and recommendations to DMAS leadership and stakeholders; and • Provided ongoing technical assistance to DMAS as questions and issues arose. Manatt identified a series of key strengths and opportunities that the state can build on to strengthen SUD treatment access and service delivery for Medicaid beneficiaries. DMAS's strengths include: • Offering a benefits package that covers the full spectrum of the ASAM levels of care for SUDs; • Having an ongoing focus on seeking to better understand and address the full scope of SUDs (e.g., polysubstance use and the recent rise in deaths due to methamphetamines and cocaine use); • Leveraging data to better understand racial/ethnic disparities and inform future priorities; developing strategies to enroll eligible justice-involved individuals in Medicaid coverage; and • Offering ongoing support to providers (e.g., training and webinars) to increase SUD knowledge and improve service delivery. **COMPLETE** DMAS updated PUMS language in the managed care contracts in 2018 addressing high use of opioids, lock in programs, and care coordination. **COMPLETE**

	DMAS executed an Interagency Agreement with the Virginia Department of Health Professions (DHP) to match Medicaid prescribers who have reported to the PDMP. Effective July 1, 2021 to June 30, 2022. **COMPLETE**

Member Survey Findings

Positive experiences with treatment by members are also crucial for preventing recurrence of illicit opioid use and overdoses. Member survey respondents receiving treatment for SUD services reported high levels of satisfaction with their treatment providers. For example, members responded "usually" or "always" to the following statements:

- Explained things in a way you can understand (84%)
- Showed respect for what you had to say (85%)
- Often felt safe at place of treatment (89%)
- Involved you as much as you wanted in your treatment (84%)
- Provided information on different kinds of treatment (72%).

In addition, 74% of survey respondents reported that they felt able to refuse treatment. Survey findings in Table 22 also showed there were no statistically significant differences in member satisfaction between those surveyed before the COVID-19 pandemic and those surveyed during the pandemic. However, Non-Hispanic Black respondents had somewhat less positive perceptions of their treatment providers compared to Non-Hispanic White respondents.

Table 22. Survey findings on satisfaction with treatment providers.

	Perceptions of practitioners where treatment received					
	Explained things in a way you can understand[1]	Showed respect for what you had to say[1]	Often felt safe at place of treatment[1]	Involved as much as you wanted in your treatment[1]	Provided information on different kinds of counseling or treatment[2]	Felt able to refuse treatment[2]
All (n=1,057)	83.7%	85.2%	88.8%	84.4%	72.0%	74.2%
Adjusted percentages*						
Race						
Non-Hispanic White	86.9%	88.9%	92.6%	89.3%	75.4%	78.4%
Non-Hispanic Black	80.2%*	85.5%*	92.4%	83.0%*	68.2%*	60.7%*
Other	85.9%	74.4%	83.8%*	81.7%*	65.7%*	68.1%*
Survey period						
Before COVID	85.8%	86.5%	91.8%	87.7%	74.5%	74.3%
During COVID	86.1%	89.4%	92.8%	88.7%	73.6%	77.1%
RUCA Classification						
Urban	84.9%	87.7%	92.4%	88.2%	74.3%	76.7%
Rural	88.3%	88.9%	92.3%	88.4%	73.3%	73.5%

Source: 2020-21 ARTS Member Survey

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Estimates reflect percent who responded "usually" or "always" to statement.

[2]Estimates reflect percent who responded "yes" to statement.

*Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, mental health co-morbidity, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

In addition, survey respondents generally reported positive perceptions of how they were helped by treatment. Members "agreed" or "strongly agreed" with the following statements:

- Confident they were no longer dependent on alcohol or drugs (79%).
- Able to deal more effectively with daily problems (79%)
- Felt better about themselves (78%)
- Better able to deal with a crisis (73%)
- Able to get along better with family (79%)
- Do better in social situations (65%)
- Able to enjoy leisure activities (72%)
- Improved housing situation (60%)
- Improved employment situation (43%)

Somewhat surprisingly, more respondents reported an improved employment situation during COVID (43%) than before COVID (36%). Non-Hispanic Black

respondents reported somewhat less positive outcomes on five of the nine measures.

Overall Risk Assessment for Milestone 5: LOW

Table 23. Summary of Overall Risk of Not Achieving Milestone 5

% of monitoring metric goals met[1]	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
100%	100%	ARTS member survey respondents report high levels of satisfaction with treatment providers and positive outcomes of treatment	Low	Not applicable	Not applicable

[1]Excludes Metric #27 (overdose death rate), which was not available for this study.

Milestone 6: Improved Care Coordination and Transitions Between Levels of Care

Milestone 6 is improved care coordination and transitions between levels of care. Care coordinators employed by the six MCOs serving Virginia Medicaid members play a vital role in linking Medicaid members with necessary services, including treatment for SUD, mental health, physical health, and social needs. In addition, DMAS has explored the Emergency Department Care Coordination (EDCC) system for identifying overdoses through a statewide real-time communication and collaboration program among healthcare providers and health plans. DMAS has also added discharge planning requirements for providers.

Performance on Monitoring Metrics

Critical Metrics. Milestone 6 critical metrics are summarized in Table 24, and are broadly consistent with DMAS goals that reflect greater care coordination and transitions between levels of care. The four measures of treatment initiation showed little change or small decreases, while the four measures of treatment engagement showed increases of between 8.7% and 56.6%. Rates of follow-up after discharge from the ED for mental illness or SUD also showed increases of between 10.0% and 29.9%. Readmission rates among beneficiaries with SUD decreased by 2.4%.

Table 24. Critical Metrics for Milestone 6.

Metric	Name	Baseline	Mid-point	Change	% Change	State Target	Direction at Midpoint	Progress
15	*AOD treatment initiation*							
15	Alcohol (%)	41.5%	42.6%	+1.1%	+2.7%	Increase	Increase	Yes
15	Opioid (%)	63.5%	63.5%	0%	0%	Increase	No change	No
15	Other (%)	45.6%	43.8%	-1.8%	-3.9%	Increase	Decrease	No
15	Total (%)	47.3%	46.3%	-1.0%	-2.1%	Increase	Decrease	No
15	*AOD treatment engagement*							
15	Alcohol (%)	7.6%	11.9%	+4.3%	+56.6%	Increase	Increase	Yes
15	Opioid (%)	39.2%	42.6%	+3.4%	+8.7%	Increase	Increase	Yes
15	Other (%)	8.4%	13.0%	+4.6%	+54.8%	Increase	Increase	Yes
15	Total	16.6%	19.2%	+2.6%	+15.7%	Increase	Increase	Yes
17	*Followup after Discharge for alcohol or opioid use disorder*							
17	Within 30 days (%)	18.0%	22.0%	+4.0%	+22.2%	Increase	Increase	Yes
17	Within 7 days (%)	10.7%	13.9%	+3.2%	+29.9%	Increase	Increase	Yes
17	Followup after discharge from ED for mental illness							
17	Within 7 days	28.8%	32.7%	+3.9%	+13.5%	Increase	Increase	Yes
17	Within 30 days	41.8%	46.0%	+4.2%	+10.0%	Increase	Increase	Yes
25	Readmission rate among beneficiaries with SUD	21.1%	20.6%	-0.5%	-2.4%	Decrease	Decrease	Yes

Action items. Table 25 shows action items for Milestone 6. All three action items have been completed, including training programs for providers and health systems, encouraging discharge planning, and requirements that MCOs have addiction care specialists as care coordinators.

Table 25. Status of Action Items for Milestone 6.

Milestone and Description	Status
Milestone 6: Improved care coordination and transitions between levels of care	DMAS facilitated a training with Medicaid MOUD providers and health systems in 2020 on the EDCC program. This was done to help facilitate relationships for bridging members from health system to community providers. **COMPLETE** DMAS added discharge planning to the service authorization as well as the policy manual in 2018. This encourages the provider to communicate the discharge plan to the MCO in order for the service to be approved. **COMPLETE** DMAS carved in the SUD benefit to managed care and required the MCOs to have a licensed clinician who specializes in addiction care to serve as the care coordinator to help with transitions of care for their members. **COMPLETE**

Member Survey Findings

The ARTS member survey asked respondents whether they had received assistance with their other health and personal needs from their SUD treatment provider (see Table 26). Overall, 60% of respondents receiving SUD treatment reported receiving assistance with other non-SUD services, including 26% who received help for a medical problem, 38% who received help with a mental health problem, and 18% who received help with housing, food, or employment. Assistance reported by respondents decreased during the pandemic relative to before the pandemic, and was also lower among Non-Hispanic Black respondents compared to Non-Hispanic White respondents.

Table 26. Survey findings on members with OUD receiving help with other health and social needs from treatment providers

	Received help with other health and social needs			
	Received any help with other health or personal needs	Received help for a medical problem	Received help with a mental health problem	Received help with housing, food, or employment
All (n=1,057)	59.6%	25.6%	38.2%	17.9%
Adjusted percentages[1]				
Race				
Non-Hispanic White	60.8%	25.8%	38.3%	16.3%
Non-Hispanic Black	55.0%*	21.3%*	33.1%*	14.9%
Other	71.7%*	16.1%*	39.6%	26.4%*
Survey period				
Before COVID	64.7%	24.8%	39.0%	15.7%
During COVID	57.2%*	24.4%	36.5%	16.9%
RUCA Classification				
Urban	60.2%	24.1%	37.3%	19.7%
Rural	60.8%	26.0%	38.1%	9.2%*

Source: 2020-21 ARTS member survey

*Statistically significant difference at .05 level with reference groups (other outpatient, Non-Hispanic White, Before COVID, urban classification).

[1]Adjusted percentages are derived from logistic regression analysis that included the following independent variables: sample group, race/ethnicity, survey period, age, gender, general perceived health, serious mental illness, polysubstance use, urban/rural residence, and whether they had been in prison or jail in the past 12 months.

Care Coordinator Survey Findings

Most care coordinators reported that they identify members with SUD either through a referral by the MCO (31.3%) or through a health risk assessment (35.6%) (Table 27). Many care coordinators (38%) also report identifying members who overdosed through the EDCC program, which is a statewide real-time communication and collaboration program among healthcare providers and health plans.

Care coordinator survey respondents report that the most important factors in getting members engaged with SUD treatment are time to initial appointment (37%), and having the support of family, friends, or peers (22%). Somewhat surprisingly, fewer report that convenience of treatment providers (12%) and overcoming stigma (10%) are the most important factors for getting members engaged with treatment.

Table 27. Care coordinator survey findings on identifying members with SUD and engaging them in treatment.

	Number	%
How care coordinators learn about Medicaid members having a substance use disorder		
Member is referred by the MCO	87	31.3
Member is referred by healthcare provider	42	15.1
Member screens positive during a health risk assessment	99	35.6
Member requests help	50	18.0
Most important factor for member engagement with treatment		
Convenience of treatment providers to home	30	11.5
Time to initial appointment	96	36.6
Member satisfaction with quality of care	38	14.5
Support of family, friends or peers	57	21.8
Overcoming stigma of having a substance use disorder or people finding out	16	6.1
Other	25	9.5
Use EDCC reports to identify Medicaid members in the ED due to an overdose		
Yes	105	37.6
No	37	13.3
Don't know what EDCC reports are	137	49.1

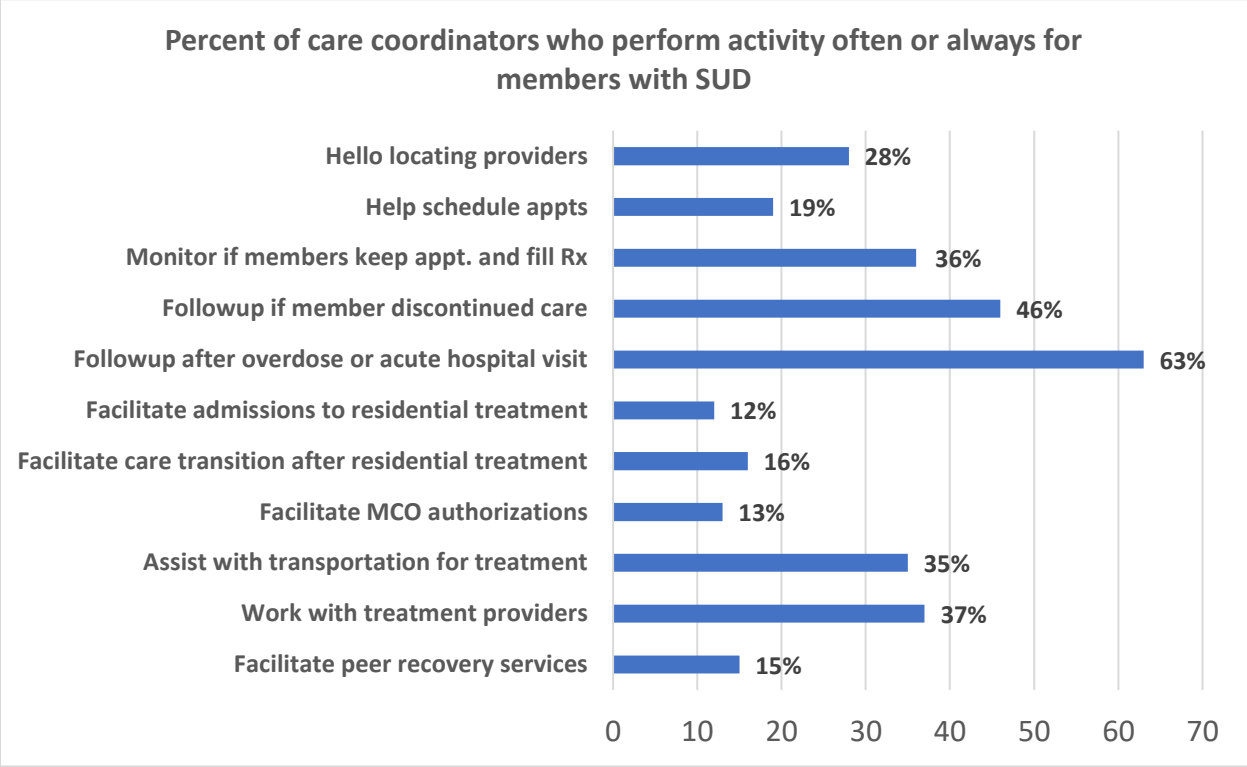
The survey also asked an open-ended question on the steps they take when they learn that a patient with SUD also has complex mental or physical health conditions. Below is a sampling of responses:

If the member is cooperative and will participate in care coordination, I assist member to schedule appointments and contact providers as needed. Education also plays a large role. Sometimes it is a chronic illness that will help member to get clean
We get notified of member admissions to EDCD program by the member's assigned CC or via the daily census. The CC will get notified of member and then refer to out EDCD LTSS program. Then I would pick up the member when admitted to the hospital or SNF
If pain is related to the chronic condition that must be addressed first. Using physical activity and medication management to engage them in their own health management at first. Frequent calls if receptive to contact.
Complete the face to face assessment to gather all information needed, set up ICT to collaborate with providers, staff the case with the team in rounds. Develop care plan with member and determine how frequently contact is needed.
Make sure that member reveals SUD to treating and prescribing physicians. Provide education about the danger of mixing prescription and recreational/street drugs. Part of our assessment asks the patient if we have their permission to share this kind of information with their primary care physician. If they say no- make that an ongoing goal to keep discussing and addressing barriers.
Address physical / mental health problems. A lot of members in pain self medicate with substances. Attempting to manage pain with pain specialist/peer supports etc. is beneficial.

Establishing a rapport with the member, completing an HRA assessment, developing service plan goals, and follow up.
Review clinical information when available (I rarely have access to discharge clinicals these days) to see if there is a treatment plan and/or follow-up appointments. Review the follow-up appointments with the member if I can get in contact with them for the post ER follow up call. Ensure member is aware of discharge appointments. Assess the member's understanding of their complex medical condition. Provide contact information for specialists if needed. Provide education re; the effects of alcohol or substance use on medication adherence, efficacy and possibility for adverse interactions. Review to see if member needs a referral to an internal program for chronic health conditions where a specialized care coordinator can discuss the specific impacts the alcohol or substance use have relative to the chronic or complex condition. New chronic conditions may require a triggering assessment and revision to the Plan of care and an ICT meeting
Review my concerns about worsening medical conditions if ongoing drug use. Review their level of support in the home and community and try and link to healthy supports. Provide hotlines for after hours.
There are a few facilities in this area who offer comprehensive care for SUD patients - they have providers on-site who can treat the whole person. This has been a valuable asset for this category of patients. I can also request a complex-care RN within the MCO to also follow the member's case to ensure all medical concerns are being addressed. Unfortunately, most of the time, I find when a patient has ongoing substance use disorder difficulty they remain less focused on the physical health needs and often engage in activities that continue to have a negative health effect.

Care coordinators provide a wide range of activities for members with SUD (see Figure 1). Among the activities they provide the most frequently include following up after an overdose or acute hospital visit (63%), follow up if the member discontinued care (46%), working with treatment providers (37%), monitor if members are keeping appointments and filling prescriptions (36%), and assist with transportation to treatment providers (35%).

Figure 1. Frequency of activities for members with SUD performed by care coordinators



The survey also asked an open-ended ended question on the specific steps that care coordinators take when they learn that a Medicaid member has been in the ED due to an overdose or SUD-related problem. Below are examples of these responses:

Refer to ARTS, facilitate a provider for follow up or outpatient treatment facility. Assist in gathering resources like food and housing.
I obtain the discharge summary from the facility to see what was done medically for the member to stabilize the member. I also follow up with the behavioral health provider that the member was referred to. I check to see if the provider is in-network and if the provider can provide the correct services that the member is in need of. I will contact the provider to offer a history and to assist with safe discharge planning.
I read the notes from transition coordinator and read any hospital records and I also sometimes call the facility. I always call member after discharge and attempt to do a triggering assessment.
Contact the medical staff.
Attempt to reach facility to discuss dc planning needs, attempt to reach member within 30 days following dc to discuss discharge appointments (would like to be able to reach out to member within one week but due to case load, its typically near the end of the 30 day period), reach out to case manager at CSB to inquire about member follow up if unable to reach member. No BH assistance within MCO other than providing case managers with directories of in network specialist (which our MCO Case managers already have access to therefore we very rarely reach out to our BH case management team any longer. If we attempt to refer a member to our ARTs/BH

care coordinators, we typically receive a message from our BH staff within the MCO stating that the ARTS/BH team will not accept the referral to work with the member due to the member NOT currently being enrolled in ARTS/BH services---which is the entire reason we were attempting to refer the member to the ARTs/BH team: for assistance connecting the member to BH/ARTS services).
Place call the member for follow up and offer assistance with locating services. Sometimes, I speak with providers at the ED to learn more about the nature of the problem
Talk to patient, assess motivation and desire for assistance. Provide education and information about substance abuse, specific dangers of their particular patterns of abuse, etc. Continue to track discussion and education despite initial resistance. If patient wants assistance, refer to health plan ARTS program and/or community services such as where to find 10-step programs.
Recommend psychiatric care services and help them find the services
Take case to high-risk rounds with Medical Director; contact and collaborate with outpatient and inpatient providers

Survey respondents also report a number of obstacles and barriers in assisting Medicaid members, including caseload size (58%), finding in-network providers for SUD treatment (38%), and delays in appointments or admissions to treatment facilities (37%) (findings not shown). A smaller percentage (17%) reported delays in authorization from the MCO for services as a barrier to treatment.

Overall Risk Assessment for Milestone 6: LOW

Table 28. Summary of Overall Risk of Not Achieving Milestone 6

% of monitoring metric goals met	% of Action items completed	Results from surveys and other evaluation analyses	Risk level	Independent assessor's recommendation if medium or high risk	State responses and planned modifications
77%	100%	ARTS member survey respondents report receiving help with other mental, physical, and social needs. Care coordinators report providing a wide range of activities for members with SUD.	Low	Not applicable	Not applicable

Discussion

This report assesses progress on the renewal of the ARTS demonstration. Initially approved in December, 2016 as an amendment to Virginia's section 1115 demonstration, "The Virginia Governor's Access Plan" (Project No. 11-W-00297/3), CMS approved a renewal of the ARTS program for a 5 year period from January 2020 through December 2024, as part of the "Building and Transforming Coverage, Services, and Supports for a Healthier Virginia" Demonstration (Project Number 11-W-00297/3).

The assessment was conducted based on the guidelines issued by CMS for conducting mid-point assessments for Section 1115 SUD Demonstrations. The primary source of information for the assessment was a review of critical metrics for the six milestones, as well as various action items undertaken by the state to accomplish the goals and objectives of the demonstration. In addition, we used results from the ongoing independent evaluation of the ARTS benefit being conducted by Virginia Commonwealth University, Department of Health Policy, to complement the findings from critical metrics, provide more context to the findings, and to assess consistency with trends established prior to the renewal period. Specifically, we used information from the ARTS member survey conducted in 2020-21, the survey of MCO Care Coordinators conducted in 2021-2022, and analyses of buprenorphine waivered prescribers.

The table below summarizes progress on each milestone based on the findings of the assessment. In sum, our findings show that the state was at low risk of not achieving milestones 1-3, 5, and 6, and was at medium risk of not achieving milestone #4. For milestone #1 in particular, we observed large increases in the number of members receiving various SUD treatment services that were started, expanded, or enhanced as part of the ARTS Demonstration. Although the state expected a decrease in residential treatment (#10) and withdrawal management services (#11), the assessment observed an increase in the utilization of these services, which we attribute to increases in Medicaid enrollment, SUD prevalence, and treatment facilities during this period. When these factors are accounted for, we conclude that the state is still at low risk for not achieving milestone #1.

Table 29. Summary of Assessment of Risk on Milestones

Milestone	Critical metrics on target	Action items on target	Survey and other evaluation results	Risk Assessment
1. Access to Critical Levels of Care for OUD and other SUDS	4 of 7 (57%)	4 of 4 (100%)	Member survey self-reported access to SUD treatment relative to other health services	Low
2. Use of Evidence-Based, SUD-Specific Patient Placement Criteria	2 of 2 (100%)	4 of 4 (100%)	Member survey self-reported unmet need for residential treatment and other SUD services	Low
3. Residential and ASAM requirements	Not applicable	5 of 5 (100%)	Assessment by Manatt concluded that ARTS offered strong benefit that covered the full spectrum of ASAM levels of care	Low
4. Sufficient Provider Capacity at Each Level of Care	1 of 2 (50%)	5 of 5 (100%)	Despite increases, still fewer buprenorphine waivered prescribers relative to other states. Not every county has providers representing all ASAM levels of care.	Medium
5. Implementation of Comprehensive Treatment and Prevention Strategies[1]	3 of 3 (100%)	4 of 4 (100%)	Member survey respondents report high levels of satisfaction with treatment providers and positive outcomes of treatment	Low
6. Improved Care Coordination and Transitions between Levels of Care	10 of 13 (77%)	3 of 3 (100%)	Member survey respondents report receiving help with other mental, physical, and social needs. Care coordinators report providing a wide range of activities for members with SUD.	Low

[1]Excludes Metric #27 (overdose death rate), which was not available for the study.

Greater access to and use of SUD treatment services should be consistent with reductions in misuse of opioids and adverse outcomes related to SUD, as shown in Milestone #5. Indeed, the use of opioids at high dosage decreased 28.8% between 2020 and 2021, concurrent use of opioids and benzodiazepines decrease 7.6%, while SUD-related ED visits decreased 6.2%.

It is possible that the increase in the number of members using treatment services may be in part an artifact of an increase in enrollment due to the Maintenance of Effort requirement, which required state Medicaid programs to suspend eligibility redeterminations during the federal Public Health Emergency (PHE) (which ended in May, 2023). While enrollment did increase during the PHE, analysis from the ongoing independent evaluation of the ARTS benefit for approximately the same time period showed that utilization of ARTS services on a per member basis also increased. In sum, the increase in utilization was not driven primarily by an increase in enrollment.

It is also possible that changes in other critical metrics between 2020 and 2021 were affected by the COVID-19 pandemic. Ideally, the baseline and follow up periods for the assessment would not have overlapped with the beginning of the pandemic, although there were few alternatives given the start of the renewal period on January 2020, and the availability of critical metric data only through 2021 for the purposes of this report. Nevertheless, we do not believe that the pandemic affected the change in metrics between the baseline and follow up periods to a significant degree. As evidence, the ARTS member survey showed few changes before and after the start of the pandemic on self-reported measures of access, utilization, quality, and outcomes among members with OUD.

Milestone 4 was the only milestone for which we assessed there was a medium risk for not achieving the milestone. Metric #13 (Provider Availability) decreased by 3.3% between 2020 and 2021, while MAT Provider Availability increased by only 1.3%. Evaluation analyses of the supply of buprenorphine waivered prescribers show that Virginia has a relatively low supply compared to other states, although similar to other states in the U.S. South that had not expanded Medicaid prior to 2017. With the increase in demand for ARTS services (and MAT in particular), there is an ongoing risk of provider shortages. We do note that the state has made considerable effort in recruiting and training SUD providers, and evaluation analyses has shown large gains in buprenorphine waivered provider supply since implementation of the ARTS benefit in 2017 and Medicaid expansion in 2019. In many respects, the state is still trying to catch up from the dearth of SUD treatment capacity that existed prior to the ARTS benefit. The lifting of the federal waiver requirement for prescribing buprenorphine may present new opportunities for the state to increase supply by attracting other practitioners who may have previously viewed the waiver requirement as an administrative barrier.

Overall, the findings in this report show positive gains on almost all of the milestones, and in most respects is a continuation of the gains in SUD treatment access, utilization, and the supply of treatment providers that was observed during

the original demonstration period. Reports from the independent ARTS evaluation shows that a major transformation of the Medicaid system for treating SUD has occurred through the ARTS demonstration, and that the combination of ARTS and Medicaid expansion has more than tripled the number of Medicaid members receiving treatment services through the ARTS benefit. Qualitatively, some providers have referred to ARTS as representing a major "cultural shift" in the state's approach to treating Medicaid members with SUD, with the expansion of services, increased payments, new forms of care delivery, and outreach and training to providers as signifying a major and ongoing commitment by the state to addressing SUD among some of its most vulnerable residents.[18]

The state also reported several opportunities for growth and improvement of the ARTS demonstration, including: (1) Strengthening the role of Medicaid for justice involved populations by working with the Department of Corrections to strengthen Medicaid enrollment processes and linkages to post-release care; (2) strengthening and evolving the current care coordination system by increasing information sharing and taking a more coordinated and consistent approach; (3) Increasing the use of peer recovery support services; (4) Working with MCOs and community-based organizations to address racial/ethnic disparities, and; (5) Advancing the use of telehealth for SUD treatment by building on the flexibilities implemented during the COVID-19 pandemic.

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